MEDICARE PLATINO CONTRACT

APPENDIX E (23)

CMS CONTRACT 2022

CY 2023 Platino Certification

June 6, 2022

Data Request

Information Required

			TRIPLE S ADVANTAGE, INC.	TRIPLE S ADVANTAGE, INC.	TRIPLE S ADVANTAGE, INC.	TRIPLE S ADVANTAGE, INC	TRIPLE S ADVANTAGE, INC.	TRIPLE S ADVANTAGE, INC.
Company Name								
Contract/Plan Number			H5774-024-000	H5774-025-000	H5774-026-000	H5774-028-000	H5774-035-000	H5774-036-000
Part C BPT								
	'MA Req Rev' tab							
(1)	F67	Plan Cost Sharing	$0.98	$0.99	$1.34	$0.72	$1.06	$0.61
(2)	G67	Actual Cost Sharing	$0.98	$0.99	$1.26	$0.72	$1.06	$0.61
(3)	H98	Net Medical Expenses	$851.25	$967.12	$698.38	$764.69	$1,175.83	$813.09
(4)	H106	Non Benefit Expenses	$171.65	$187.24	$135.46	$142.08	$202.50	$130.95
(5)	H107	Gain/Loss Margin	$229.89	$209.88	$154.96	$130.44	$96.92	$11.69
	'MA Bnchmk' tab							
(6)	F12	Non-DE# Member Months	-	-	-	-	-	-
(7)	G12	DE# Member Months	242,058	56,096	55,122	152,230	11,604	57,482
(8)	E14	MSP Adjustment	0.03%	0.06%	0.01%	0.03%	0.04%	0.03%
(9)	F15	Non-DE# Risk Score	2.2731	2.2227	1.8900	1.9670	2.3809	1.9221
(10)	G15	DE# Risk Score	2.2731	2.2227	1.8900	1.9670	2.3809	1.9221
Part D BPT								
	'Standard Coverage' tab							
(11)	H11	Risk Score	2.1190	2.1650	1.8443	1.8801	2.3408	1.8782
(12)	L11	LIS Member Months	-	-	-	-	-	-
(13)	L12	Non-LIS Member Months	249,024	57,456	56,652	155,280	14,508	58,548
(14)	I33	Cost Sharing	$190.28	$212.93	$133.98	$157.08	$219.41	$158.29
(15)	M33	Federal Reinsurance	$183.15	$249.91	$100.23	$125.75	$243.04	$128.06
(16)	N33	Plan Liability	$91.98	$111.86	$55.92	$71.70	$108.32	$71.85
(17)	D40	Non Benefit Expenses	$14.10	$17.23	$8.16	$10.07	$15.71	$9.35
(18)	D44	Gain/Loss Margin	$6.95	$3.91	$3.33	$0.29	-$5.80	-$8.46
	'Script Projection' tab							
(19)	sum(F11,F15,F23,F27)	Generic Scripts	720,600	172,194	137,956	374,571	51,742	138,500
(20)	sum(F12:F14,F16:F18,F24:F26,F28:F30)	Brand Scripts	165,331	41,182	27,153	81,287	11,749	30,658
Gain Margin PMPM for Dual Eligibles (if available)		Part C BPT 'MA Req Rev' tab						
Part C BPT								
	'MA Req Rev' tab							
(1)	R123	Medicaid Projected Revenue	$10.00	$10.00	$10.00	$10.00	$10.00	$10.00
(2)	R124	Medicaid Proj Cost not in bid	$149.10	$165.54	$105.31	$126.25	$165.54	$125.14

TRIPLE-S ADVANTAGE

I, Juan R. Serrano Carney, hereby certify that Triple S Advantage Inc. will be turning in to ASES the First Draft of the CMS contract once CMS releases it through the Health Plan Management System (HPMS). As of today, the contract had not been released in the CMS System.

Juan R. Serrano Carney
Chief Strategy Officer and President
Triple S Salud Inc.

6/8/2022
Date

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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EMR

CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)

CONTRACT (H5774)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS) and

TRIPLE S ADVANTAGE, INC.

(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS's authorized representative through December 31, 2023, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan in the same area as required under 42 CFR §422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price. The MA Organization agrees to comply with the requirements of this contract, the regulations at 42 CFR Part 422, §§ 1851 through 1859 of the Act, and all other applicable Federal statutes and regulations and the policies outlined in guidance, such as the Medicare Managed Care Manual, the Medicare Communications and Marketing Guidelines, CMS Participant Guides, Health Plan Management System memos, Rate Announcement and trainings.

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[42 CFR § 422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2022 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2022 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2022 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA Organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §§422.100 and 422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112. **[42 CFR § 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.[42 CFR § 422.504(a)(1)]

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMS-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[42 CFR § 422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[42 CFR § 422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.**[42 CFR § 422.504(a)(13)]**

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(3.a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization in accordance with the requirements of 42 CFR § 422.504(g)(1).

(3.b) The MA Organization must provide for continuation of enrollee health care benefits- as required by 42 CFR § 422.504(g)(2).

(3.c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in 42 CFR § 422.504(g)(1)(i), the MA Organization may use—

(3.c.i) Contractual arrangements;

(3.c.ii) Insurance acceptable to CMS;

(3.c.iii) Financial reserves acceptable to CMS; or

(3.c.iv) Any other arrangement acceptable to CMS. **[42 CFR § 422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable requirements for health care providers, including physicians, practitioners, providers of services (as defined in section 1861 of the Act), and suppliers, in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements,provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to

A. Notwithstanding any relationship(s) that the MA Organization may have with first tier, downstream, or related entities, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[42 CFR § 422.504(i)(1)]**

B. The MA Organization agrees to require all first tier, downstream, and related entities to agree that—

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS's contract with the MA Organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, or related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA Organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

5. **They will ensure that payments are not made to individuals and entities included on the preclusion list, defined in 42 CFR §422.2, in accordance with the provisions in 42 CFR § 422.222 and 422.224. [42 CFR § 422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with first tier, downstream, and related entities shall contain the provisions required by 42 CFR § 422.504(i)(3),

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, all contracts or written arrangements with any related entity, contractor, subcontractor, or provider must meet the requirements of 42 CFR § 422.504(i)(4).

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[42 CFR § 422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[42 CFR § 422.208]**

Article VI
Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices in accordance with the requirements of 42 CFR § 422.504(d).

2. Access to facilities and records. The MA Organization agrees that the

(2.a) Department of Health and Human Services, the Comptroller General, or their designee may evaluate, audit and inspect the records and facilities of the MA Organization in accordance with 42 CFR § 422.504(e).

(2.b)This right extends through 10 years from the final date of the contract period or completion of audit, whichever is later, except as provided in 42 CFR § 422.504(e)(4).

B. REPORTING REQUIREMENTS

1. The MA Organization agrees to comply with the reporting requirements in 42 CFR § 422.516 and the requirements in 42 CFR § 422.310 for submitting data to CMS. **[42 CFR § 422.504(a)(8)]**

2. The MA Organization agrees to submit to CMS and, as applicable, its enrollees, information as described in 42 CFR § 422.504(f).

3. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[42 CFR § 422.504(b)]**

4. The MA Organization acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 422, Subpart K, and 42 CFR Part 423, Subpart K:

(4.a) summary reconciled Part C and Part D payment data after the reconciliation of Part C and Part D payments, as provided in 42 CFR §422.504(n)(1) and 42 CFR §423.505(o)(1);

(4.b) MA bid pricing data submitted during the annual bidding process, as described at 42 CFR §422.272;

(4.c) Part C Medical Loss Ratio data for the contract year, as described at 42 CFR §422.2490, and, for Part D plan sponsors, Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.**[42 CFR § 422.504(n)]**

The MA Organization agrees that it must subject information collected pursuant to 42 CFR §422.516(a) to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. [422.516(g)]

Article VII
Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[42 CFR § 422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[42 CFR § 422.505(d)]**

3. CMS has not provided the MA Organization with notice of its intention not to renew.

B. NONRENEWAL OF CONTRACT

1. In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

2. If the MA Organization does not intend to renew its contract, it must notify—

(2.a) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(2.b) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

3. If the MA Organization submits a request to end the term of its contract after the deadline in 42 CFR §422.506, CMS and the MA Organization may mutually consent to terminate the contract pursuant to 42 CFR §422.508 when a nonrenewal notice is submitted after the applicable annual non-renewal notice deadline if—

(3.a) The contract termination does not negatively affect the administration of the Medicare program; and

(3.b) The MA Organization notifies its Medicare enrollees of any changes that CMS determines are appropriate for notification within the timeframes specified by CMS; and

(3.c) Included as a provision of the termination agreement is language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type or service area of

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the previous contract.

4. If the MA Organization does not renew a contract under this subparagraph, CMS may deny an application for a new contract or a service area expansion from the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(4), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract.**[42 CFR §§ 422.506(a)(4) & 422.508(c) and (d)]**

Article VIII

Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(1.a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[42 CFR § 422.508(a)(2)]**

(1.b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[42 CFR § 422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article.**[42 CFR § 422.508(b)]**

3. As a condition of the consent to a mutual termination, CMS will require as a provision of the termination agreement language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[42 CFR § 422.508(c)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(1.a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following: **[42 CFR §422.510(a)(1)-(3)]**

(1.a.i) has failed substantially to carry out the terms of its contract with CMS.

(1.a.ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(1.a.iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(1.b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the conditions listed in 42 CFR §422.510(a)(4) occur.

(1.c) Notice. If CMS decides to terminate a contract , it will give notice of the termination as follows: **[42 CFR §422.510(b)(1)]** (1.c.i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(1.c.ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(1.c.iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organization's Web site.

(1.c.iv) In the event that CMS issues a termination notice to the MA Organization on or before August 1 with an effective date of the following December 31, the MA Organization must issue notification to its Medicare enrollees at least 90 days prior to the effective date of termination.

(1.d) Expedited termination of contract by CMS. [42 CFR §422.510(b)(2)]

(1.d.i) For terminations based on violations prescribed in 42 CFR §422.510(a)(4)(i), if the MA Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists, or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(1.d.ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS's decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the MA Organization of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(1.d.iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS's decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(1.e) Corrective action plan [42 CFR §422.510(c)]

(1.e.i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(d)(i) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(1.e.ii) Exceptions. If a contract is terminated under subparagraph 1(d)(i) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(1.f) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization [42 CFR §422.512]

(2.a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(2.b) Notice. The MA Organization must give advance notice as follows:

(2.b.i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(2.b.ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(2.b.iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(2.c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(2.d) CMS's liability. CMS's liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(2.e) Effect of termination by the organization. CMS may deny an application for a new contract or service area expansion from the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[42 CFR § 422.512]**

Article IX

Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.), and the anti-kickback statute (§ 1128B(b) of the Act); and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.**[42 CFR § 422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[42 CFR § 422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

E. The MA Organization agrees to comply with applicable anti-discrimination laws, including Title VI of the Civil Rights Act of 1964 (and pertinent regulations at 45 CFR Part 80), §504 of the Rehabilitation Act of 1973 (and pertinent regulations at 45 CFR Part 84), and the Age Discrimination Act of 1975 (and pertinent regulations at 45 CFR Part 91). The MA Organization agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92,including submitting assurances that the MA Organization's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.4.

Article X
Severability

The MA Organization agrees that, upon CMS's request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[42 CFR § 422.504(k)]**

Article XI
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. The MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR §422.504(a)(14).

D. The MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(16).

E. The MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars under the 5-star rating system specified in 42 CFR Part 422 subpart D, as required by 42 CFR §422.504(a)(17).

F. CMS may determine that the MA Organization is out of compliance with a Part C requirement and take compliance actions as described in 42 CFR § 422.504(m) or issue intermediate sanctions as defined in 42 CFR Part 422 Subpart O. **[42 CFR § 422.504(m)]**

G. The MA Organization agrees to comply with all requirements that are specific to a particular type of MA plan offered under this contract, such as the special rules for private fee-for-service plans in 42 CFR §§422.114 and 422.216; the rules for special needs plans in 42 CFR §§ 422.101(f), 422.107, 422.152(g) and 422.629 through 422.634; and the MSA requirements in 42 CFR §§422.56, 422.103, and 422.262

H. The MA Organization agrees to comply with the requirements for access to health data and plan information in 42 CFR §§ 422.119 and 422.120. **[42 CFR § 423.504(a)(18)]**

I. **Business Continuity:** The MA Organization agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §422.504(o).

ATTACHMENT A

ATTESTATION OF ENROLLMENT
INFORMATION RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING
TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

Juan Serrano
Contracting Official Name

9/9/2022 2:58:03 PM
Date

TRIPLE S ADVANTAGE, INC.
Organization

PO Box 11320
San Juan, PR 00922
Address

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
23-002

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

9/22/2022 10:52:58 AM
Date

EMR

H5774

MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into 9/9/2022 2:58:03 PM

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd.,Baltimore, MD 21244

and

TRIPLE S ADVANTAGE, INC. (hereinafter "Licensee"),
with offices located at PO Box 11320
San Juan, PR 00922

CMS Contract ID: H5774

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning October 15, 2022.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Communication and Marketing Guidelines (currently located at https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines). The Mark usage policies, including any updates made after this Agreement, are incorporated into this Agreement by reference. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2023, concurrent with the execution of the Part D contract (or Part D addendum to a Medicare Managed Care contract). This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2023, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Medicare Managed Care contract).
7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement and the underlying contract, CMS Contract ID H5774 is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized officers as of the date first set forth above.

This document has been electronically signed by:

FOR THE LICENSEE

Juan Serrano

Contracting Official Name

9/9/2022 2:58:03 PM

Date

TRIPLE S ADVANTAGE, INC.

Organization

PO Box 11320
San Juan, PR 00922

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/22/2022 10:52:58 AM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,

H5774

DATA USE ATTESTATION

The sponsor shall restrict its use and disclosure of Medicare data obtained from CMS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare managed care and/or outpatient prescription drug benefits for which it has contracted with the Centers for Medicare & Medicaid Services (CMS) to administer. The sponsor shall only maintain data obtained from CMS information systems that are needed to administer the Medicare managed care and/or outpatient prescription drug benefits that it has contracted with CMS to administer. The sponsor (or its subcontractors or other related entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system, to support any line of business other than the Medicare managed care and/or outpatient prescription drug benefit for which the sponsor contracted with CMS.

The sponsor further attests that it shall limit the use of information it obtains from its Medicare plan members to those purposes directly related to the administration of such plan. The sponsor acknowledges two exceptions to this limitation. First, the sponsor may provide its Medicare members information about non-health related services after obtaining consent from the members. Second, the sponsor may provide information about health-related services without obtaining prior member consent, as long as the sponsor affords the member an opportunity to elect not to receive such information.

CMS may terminate the sponsor's access to the CMS data systems immediately upon determining that the sponsor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare members beyond the scope for which CMS has authorized under this agreement. A termination of this data use agreement may result in CMS terminating the sponsor's Medicare contract(s) on the basis that it is no longer qualified as a Medicare sponsor. This agreement shall remain in effect as long as the sponsor remains a Medicare managed care organization and/or outpatient prescription drug benefit sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS makes available to the general public on our website.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
23-002

This document has been electronically signed by:

Juan Serrano

Contracting Official Name

9/9/2022 2:58:03 PM

Date

TRIPLE S ADVANTAGE, INC.

Organization

PO Box 11320
San Juan, PR 00922

Address

H5774

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ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and TRIPLE S ADVANTAGE, INC., a Medicare managed care organization (hereinafter referred to as MA-PD Sponsor) agree to amend the contract H5774 governing MA-PD Sponsor's operation of a Part C plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") or a Medicare cost plan to include this addendum under which MA-PD Sponsor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart L of 42 CFR Part 417 (in the case of cost plan sponsors offering a Part D benefit) and Subpart K of 42 CFR Part 422 (in the case of an MA-PD Sponsor offering a Part C plan).

NOTE: For purposes of this addendum, unless otherwise noted, reference to an "MA-PD Sponsor" or "MA-PD Plan" is deemed to include a cost plan sponsor or a MA private fee-for-service contractor offering a Part D benefit.

Article I
Voluntary Medicare Prescription Drug Plan

A. MA-PD Sponsor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and in compliance with the provisions of this addendum, which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2023 Contracts*, released on January 11, 2022 (hereinafter collectively referred to as "the addendum"). MA-PD Sponsor also agrees to operate in accordance with the regulations at 42 CFR Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies (e.g., policies as described in the Medicare Prescription Drug Benefit Manual, and Medicare Marketing and Communications Operations Guide, etc.). This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to MA-PD Sponsor consistent with the regulations at 42 CFR Part 423 (with the exception of Subparts Q, R, and S), §§1860D- 1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on MA-PD Sponsor. This provision does not apply to new requirements mandated by statute.

D. If MA-PD Sponsor had an MA-PD Addendum with CMS for Contract Year 2022 under the contract ID number designated above, this document is considered a renewal of the existing addendum. While the terms of this document supersede the terms of the 2022 addendum, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2022 or prior year addendums.

E. This addendum is in no way intended to supersede or modify 42 CFR, Parts 417, 422 or 423. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to MA-PD Sponsor and CMS.

Article II
Functions to be Performed by MA-PD Sponsor

A. ENROLLMENT

1. MA-PD Sponsor agrees to enroll in its MA-PD plan only Part D-eligible beneficiaries as they are defined in 42 CFR §423.30(a) and who have elected to enroll in MA-PD Sponsor's Part C or §1876 benefit.

2. If MA-PD Sponsor is a cost plan sponsor, MA-PD Sponsor acknowledges that its §1876 plan enrollees are not required to elect enrollment in its Part D plan.

B. PRESCRIPTION DRUG BENEFIT

1. MA-PD Sponsor agrees to provide the required prescription drug coverage as defined under 42 CFR §423.100 and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423. MA-PD Sponsor also agrees to provide Part D benefits as described in MA-PD Sponsor's Part D bid(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. MA-PD Sponsor agrees to calculate and collect beneficiary Part D premiums in accordance with 42 CFR §§423.286 and 423.293.

3. If MA-PD Sponsor is a cost plan sponsor, it acknowledges that its Part D benefit is offered as an optional supplemental service in accordance with 42 CFR §417.440(b)(2)(ii).

4. MA-PD Sponsor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

5. MA-PD Sponsor agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

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C. DISSEMINATION OF PLAN INFORMATION

1. MA-PD Sponsor agrees to provide the information required in 42 CFR §423.48.

2. MA-PD Sponsor acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 423, Subpart K:

(a) summary reconciled Part D payment data after the reconciliation of Part D payments, as provided in 42 CFR §423.505(o)(1);

(b) Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.

3. MA-PD Sponsor agrees to disclose information related to Part D benefits to beneficiaries in the manner and the form specified by CMS under 42 CFR §423.128 and 423 Subpart V.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. MA-PD Sponsor agrees to operate quality assurance, drug utilization management, drug management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 CFR Part 423.

2. MA-PD Sponsor agrees to address and resolve complaints received by CMS against the Part D sponsor through the CMS complaint tracking system as required in 42 CFR §423.505(b)(22).

3. MA-PD Sponsor agrees to maintain a Part D summary plan rating score of at least 3 stars as required by 42 CFR §423.505(b)(26).

4. MA-PD Sponsor agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the current year. 42 CFR §423.505(b)(27).

E. APPEALS AND GRIEVANCES

MA-PD Sponsor agrees to comply with all requirements in Subpart M of 42 CFR Part 423 governing coverage determinations, grievances and appeals, and formulary exceptions and the applicable provisions of Subpart U. MA-PD Sponsor acknowledges that these requirements are separate and distinct from the appeals and grievances requirements applicable to MA-PD Sponsor through the operation of its Part C or cost plan benefits.

F. PAYMENT TO MA-PD SPONSOR

MA-PD Sponsor and CMS agree that payment paid for Part D services under the addendum is governed by the rules in Subpart G of 42 CFR Part 423.

G. BID SUBMISSION AND REVIEW

If MA-PD Sponsor intends to participate in the Part D program for the next program year, MA-PD Sponsor agrees to submit the next year's Part D bid, including all required information on premiums, benefits, and cost-sharing, by the applicable due date, as provided in Subpart F of 42 CFR Part 423 so that CMS and MA-PD Sponsor may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal. MA-PD Sponsor acknowledges that failure to submit a timely bid under this section may affect the sponsor's ability to offer a Part C plan, pursuant to the provisions of 42 CFR §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. MA-PD Sponsor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 CFR Part 423.

2. MA-PD Sponsor agrees to comply with Medicare Secondary Payer procedures as stated in 42 CFR §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. MA-PD Sponsor agrees to provide Part D benefits in the service area for which it has been approved by CMS to offer Part C or cost plan benefits utilizing a pharmacy network and formulary approved by CMS that meet the requirements of 42 CFR §423.120.

2. MA-PD Sponsor agrees to provide Part D benefits through out-of-network pharmacies according to 42 CFR §423.124.

3. MA-PD Sponsor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 CFR §423.100), and long-term care pharmacies (as defined in 42 CFR §423.100) according to 42 CFR §423.505(b)(17).

4. MA-PD Sponsor agrees to contract with any pharmacy that meets MA-PD Sponsor's reasonable and relevant standard terms and conditions according to 42 CFR §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

(a) If MA-PD Sponsor has demonstrated that it historically fills 98% or more of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor (or presents compelling circumstances that prevent the sponsor from meeting the 98% standard or demonstrates that its Part D plan design will enable the sponsor to meet the 98% standard during the contract year), this provision does not apply to MA-PD Sponsor's plan. 42 CFR§423.120(a)(7)(i)

(b) The provisions of 42 CFR §423.120(a) concerning the retail pharmacy access standard do not apply to MA-PD Sponsor if the Sponsor has demonstrated to CMS that it historically fills more than 50% of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor. MA-PD Sponsors excused from meeting the standard are required to demonstrate retail pharmacy access that meets the requirements of 42 CFR §422.112 for a Part C contractor and 42 CFR §417.416(e) for a cost plan contractor. 42 CFR§423.120(a)(7)(i)

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

MA-PD Sponsor agrees to adopt and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 CFR §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

MA-PD Sponsor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 CFR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

MA-PD Sponsor agrees to afford its enrollees protection from liability for payment of fees that are the obligation of MA-PD Sponsor in accordance with 42 CFR §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. MA-PD Sponsor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum. 42 CFR §423.503(i).

2. MA-PD Sponsor shall ensure that any contracts or agreements with first tier, downstream, and related entities performing functions on MA-PD Sponsor's behalf related to the operation of the Part D benefit are in compliance with 42 CFR §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

MA-PD Sponsor must provide certifications in accordance with 42 CFR §423.505(k).

O. MA-PD SPONSOR REIMBURSEMENT TO PHARMACIES (42 CFR §§ 423.505(b)(21), 423.520)

1. If MA-PD Sponsor uses a standard for reimbursement of pharmacies based on the cost of a drug, MA-PD Sponsor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA-PD Sponsor will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA-PD Sponsor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA-PD Sponsor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but no more than 90 days) to submit claims to MA-PD Sponsor for reimbursement.

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Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

MA-PD Sponsor agrees to maintain records and provide access in accordance with 42 CFR §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

MA-PD Sponsor agrees to submit information to CMS according to 42 CFR §§423.505(f) and 423.514, and the applicable "Final Medicare Part D Reporting Guidance."

C. CMS LICENSE FOR USE OF PLAN FORMULARY

MA-PD Sponsor agrees to submit to CMS each plan's formulary information, including any changes to its formularies, and hereby grants to the Government and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. MA-PD Sponsor agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §423.136.

B. MA-PD Sponsor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of- pocket costs.

Article V
Addendum Term and Renewal

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A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2023. This addendum shall be renewable for successive one-year periods thereafter according to 42 CFR §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 CFR §423.507, MA-PD Sponsor will be determined qualified to renew this addendum annually only if MA-PD Sponsor has not provided CMS with a notice of intention not to renew in accordance with Article VII of this addendum.

2. Although MA-PD Sponsor may be determined qualified to renew its addendum under this Article, if MA-PD Sponsor and CMS cannot reach agreement on the Part D bid under Subpart F of 42 CFR Part 423 and CMS declines to accept the bid pursuant to 42 CFR § 423.265(b)(3), no renewal takes place, and, in accordance with 42 CFR § 423.502(d)(2), the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 CFR Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VI
Nonrenewal of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may non-renew this addendum in accordance with 42 CFR § 423.507(a).

B. If MA-PD Sponsor non-renews this addendum under this Article, CMS cannot enter into a Part D addendum with the organization or with an organization whose covered persons, as defined in 42 CFR §423.507(a)(4), also served as covered persons for the nonrenewing sponsor for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 CFR 423.508. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 CFR 423.509. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article IX
Termination of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may terminate this addendum only in accordance with 42 CFR 423.510.

B. CMS will not enter into a Part D addendum with an MA-PD Sponsor that has terminated its addendum or with an organization whose covered persons, as defined in 42 CFR §423.508(f), also served as covered persons for the terminating sponsor within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

C. If the addendum is terminated under section A of this Article, MA-PD Sponsor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article X
Relationship between Addendum and Part C Contract or 1876 Cost Contract

A. MA-PD Sponsor acknowledges that, if it is a Medicare Part C contractor, the termination or nonrenewal of this addendum by either party may require CMS to terminate or non-renew the Sponsor's Part C contract in the event that such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c), in which case the Sponsor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 CFR Part 422. MA-PD Sponsor also acknowledges that Article IX.B. of this addendum may prevent the sponsor from entering into a Part C contract for two years following an addendum termination or non-renewal where such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c).

B. The termination of this addendum by either party shall not, by itself, relieve the parties from their obligations under the Part C or cost plan contracts to which this document is an addendum.

C. In the event that MA-PD Sponsor's Part C or cost plan contract (as applicable) is terminated or nonrenewed by either party, the provisions of this addendum shall also terminate. In such an event, MA-PD Sponsor and CMS shall provide notice to enrollees and the public as described in this contract as well as 42 CFR Part 422, Subpart K or 42 CFR Part 417, Subpart K, as applicable.

Article XI
Compliance and Enforcement Actions

A. INTERMEDIATE SANCTIONS

Consistent with Subpart O of 42 CFR Part 423, MA-PD Sponsor shall be subject to sanctions and civil money penalties.

B. COMPLIANCE ACTIONS AND PAST PERFORMANCE

CMS may determine that the MA-PD sponsor is out of compliance with a Part D requirement and take compliance actions as described in 42 CFR § 423.[illegible] or issue intermediate sanctions as defined in 42 CFR Part 423 Subpart O. 42 CFR § 423.505(n).

Article XII
Severability

Severability of the addendum shall be in accordance with 42 CFR §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 422 or Part 417.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

MA-PD Sponsor agrees that it has not altered in any way the terms of the MA-PD addendum presented for signature by CMS. MA-PD Sponsor agrees that any alterations to the original text MA-PD Sponsor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

MA-PD Sponsor agrees to include in this addendum other terms and conditions in accordance with 42 CFR §423.505(j).

D. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), MA-PD Sponsor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

E. MA-PD sponsor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR §423.505(b)(23).

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F. **Business Continuity:** MA-PD Sponsor agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §423.505(p).

G. The MA-PD sponsor agrees to comply with applicable anti-discrimination laws, including Title VI of the Civil Rights Act of 1964 (and pertinent regulations at 45 CFR Part 80), §504 of the Rehabilitation Act of 1973 (and pertinent regulations at 45 CFR Part 84), and the Age Discrimination Act of 1975 (and pertinent regulations at 45 CFR Part 91). The MA-PD sponsor agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the MA-PD sponsor's health programs and activities are operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.4.

In witness whereof, the parties hereby execute this contract. This document has been electronically signed by:

FOR THE MA ORGANIZATION

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
2 3 - 0 0 2

Juan Serrano

Contracting Official Name

9/9/2022 2:58:03 PM

Date

TRIPLE S ADVANTAGE, INC.

Organization

PO Box 11320
San Juan, PR 00922

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/22/2022 10:52:58 AM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

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H5774

ADDENDUM TO CONTRACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN FOR PARTICIPATION IN THE PART D SENIOR SAVINGS MODEL (the "Addendum")

The Centers for Medicare & Medicaid Services ("CMS") and TRIPLE S ADVANTAGE, INC., a Medicare Part D Prescription Drug Plan Sponsor("**Part D Sponsor**"), agree to amend the contract H5774, including all attachments, addenda, and amendments thereto (the "Underlying Contract"), governing Part D Sponsor's operation of a Voluntary Medicare Prescription Drug Plan pursuant to §§ 1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Social Security Act ("**Act**"), to include this addendum to provide for Part D Sponsor's participation in the Part D Senior Savings Model ("**Model**").

This voluntary Model, conducted pursuant to Section 1115A of the Act, is intended to exist for five plan years of the Part D Program, and commenced with plan year 2021. The purpose of this Model is to test a change to the Medicare Coverage Gap Discount Program to allow Part D sponsors, through eligible enhanced alternative plans, to offer a Part D benefit design that includes predictable, stable copays throughout the deductible, initial coverage, and coverage gap phases by offering supplemental benefits that apply, in the coverage gap, after manufacturers provide a discounted price for applicable drugs included in the Model without regard for the Special Rule for Supplemental Benefits.

The parties hereby amend the Underlying Contract by adding the following:

Article I
Model Term and Part D Sponsor Participation

A. This Addendum becomes effective on the date it is signed by CMS ("Effective Date") and will remain in effect through December 31, 2023, unless sooner terminated in accordance with Articles 5 or 7 of this Addendum. This Addendum covers Plan Year 2023 for the Part D Senior Savings Model, which will start on January 1, 2023 ("Start Date"). If Part D Sponsor wishes to participate in the Model during a subsequent Plan Year, it must timely submit for CMS review a Model application for the relevant Plan Year in addition to its annual Part D bid submission and enter into a contract addendum for participation in the Model for that plan year.

B. Part D Sponsor may participate in the Model only with the eligible plan benefit packages (PBPs) providing Enhanced Alternative Coverage that are identified in the Approved Proposal (each a "Model PBP").

C. The following plan types and programs are not eligible plan benefit packages and may not participate in the Model: PBPs for dual-eligible special needs plans (D-SNPs); Private Fee-For-Service (PFFS) plans; Employer/Union Group Waiver Plans (EGWPs); cost plans offered under section 1876 of the Act; Health Care Prepayment Plans (HCPP) offered under section 1833 of the Act; Programs of All-Inclusive Care for the Elderly (PACE);Medicare-Medicaid Plans (MMP) and other demonstration plans; and Religious Fraternal Benefit (RFB) plans.

Article II
Definitions

"Approved Proposal" means Part D Sponsor's final approved application including, if applicable, any Part D RI Programs, allowing for Part D Sponsor's participation in the Model in plan year 2023 and all corresponding bid submissions as finalized

"Diabetes " has the meaning set forth in 42 CFR § 410.18(a).

"Enhanced Alternative Coverage" has the meaning set forth in 42 CFR § 423.100.

"Model Beneficiary" means an applicable beneficiary as defined in 42 CFR § 423.100 enrolled in a Model PBP.

"Model Guidance" refers to documentation provided by CMS outlining requirements related to participation in the Model, including guidance on Model monitoring and necessary data submissions, and guidance on marketing and other communications for Part D sponsors participating in the Model.

"Model Drug" means an applicable drug as defined in 42 CFR § 423.100 that is, or contains, a drug classified as insulin in American Hospital Formulary Service (AHFS) Drug Information or the DRUGDEX Information System compendia, and is marketed by and available from a Model-participating manufacturer.CMS lists Model Drugs on the Model website.

"Model PBP" stands for Model plan benefit package and has the meaning set forth in Section B of Article 1.

"Model-Specific Supplemental Benefits " means supplemental benefits that conform to the Model requirements in Section C of Article 3.

"PDP" stands for prescription drug plan and has the meaning set forth in 42 CFR § 423.4.

"Part D RI Program" stands for Part D Rewards and Incentives Program and means a program, as identified in Part D Sponsor's Approved Proposal, that offers certain rewards and incentives that are connected to the Part D Prescription Drug Benefit.

"Plan Selected Model Drug" means a Model Drug identified in Part D Sponsor's Approved Proposal for which Part D Sponsor offers Model-Specific Supplemental Benefits.

"Pre-diabetes" has the meaning set forth in 42 CFR § 410.18(a).

"Special Rule for Supplemental Benefits" means § 1860D-14A(c)(2) of the Act.

"Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of Part D Sponsor's Model PBPs and who is targeted by Part D Sponsor to receive rewards and incentives in Part D Sponsor's RI program based on the Approved Proposal.

Article III
Functions to be Performed by Part D Sponsor

A. PART D BID AND BENEFIT PACKAGE SUBMISSION AND REVIEW.

Part D Sponsor certifies that its annual benefit and bid submission for each Model PBP is consistent with the Approved Proposal (unless otherwise authorized in writing by CMS) and in accordance with all program and bid instructions issued by CMS for applicants to the Model.

B. MODEL IMPLEMENTATION REQUIREMENTS

1. Part D Sponsor shall comply with all applicable laws governing its operation and offering of qualified prescription drug coverage, except as specifically waived in writing in accordance with Section 1115A of the Act.

2. Part D Sponsor shall implement the Model in each Model PBP on the Start Date and in accordance with the Approved Proposal and this Addendum, including without limitation Appendix 2.

3. Part D Sponsor shall:

(3.a) Carry out this Addendum in a manner that is consistent with the efficient and effective implementation of 42 CFR Part 423 (as applicable) and Section 1115A of the Act;

(3.b) Comply with the Model Guidance, including, without limitation, requirements regarding the timely submission of data to facilitate Model monitoring

(3.c) Not take any action that threatens the health or safety of an enrollee; and

(3.d) Ensure Part D Sponsor's participation in the Model does not result in lower quality of care or other adverse outcomes for enrollees

C. MODEL-SPECIFIC SUPPLEMENTAL BENEFITS

1. Part D Sponsor shall comply with all applicable laws, regulations, and guidance regarding formulary design, except as expressly modified by this Addendum.

2. For each Model PBP, Part D Sponsor shall furnish Model-Specific Supplemental Benefits for Plan Selected Model Drugs in accordance with the Approved Proposal and the following requirements:

(2.a) Copayment. Part D Sponsor's Part D benefit will specify a copayment of no more than thirty five dollars ($35) for a month's supply of any Plan Selected Model Drug in the deductible, initial coverage, and coverage gap phases. If Part D Sponsor covers a Plan Selected Model Drug in larger increments than a month's supply, such as 2 or 3 month's supply, the copayment on such increment must be equal to or less than the multiple of the month's supply copayment (i.e., 2 times for 2 months and 3 times for 3 months) consistent with current CMS requirements.

(2.b) Drug Type. Plan Selected Model Drugs must include at least one Model Drug of each the following types of insulins: rapid-acting, short-acting, intermediate-acting, and long-acting.

(2.c) Dosage Form. Plan Selected Model Drugs must include both a vial dosage form at U-100 concentration and pen dosage form at U-100 concentration for all Plan

Selected Model Drugs, unless a Plan Selected Model Drug is not manufactured in both dosage forms at a U-100 concentration.

(2.d) Supply Duration. Part D Sponsor shall determine a month's supply of any Plan Selected Model Drug in a manner consistent with how it determines month's supplies of other Part D drugs.

(2.e) Pharmacy Type. Part D Sponsor shall provide Model-Specific Supplemental Benefits for Plan Selected Model Drugs without regard to pharmacy type. Part D Sponsor may continue to offer a lower copay for a Plan Selected Model Drug at preferred or mail-order pharmacies in accordance with Part D program guidelines.

3. Nothing in this section prevents a Part D Sponsor from offering supplemental benefits for Model Drugs that are not Plan Selected Model Drugs

D. PART D REWARDS AND INCENTIVES PROGRAMS

1. Part D Sponsor shall implement any Part D RI Program under this Addendum only in the Model PBPs for which the Approved Proposal includes a Part D RI Program. Part D Sponsor shall implement any Part D RI Program on the Start Date and in a manner that is consistent with the Approved Proposal and this Addendum, including without limitation Appendix 2.

2. The methodologies and criteria used by Part D Sponsor to implement any Part D RI Program must be specified in the Approved Proposal and able to be replicated by CMS, applied uniformly to all enrollees who meet the defined criteria, be evidence-based, and be expected to materially impact the health of the targeted population. The targeted population for the Part D RI Program must be limited to enrollees in a Model PBP with Diabetes or Pre-diabetes.

3. Part D Sponsor shall identify the Targeted Enrollees who met the eligibility criteria to receive rewards and incentives under the Part D RI Program based on Part D Sponsor's Approved Proposal and information known to Part D Sponsor.

4. Part D Sponsor shall submit to CMS all targeting and engagement data used in the Part D RI Program (e.g., data regarding outreach to Targeted Enrollees) in a form, manner, and on the timeline specified by CMS in this Addendum or the Model Guidance.

5. Part D Rewards and Incentives are not benefits and may not be listed in the Evidence of Coverage or Annual Notice of Change (ANOC).In any marketing materials regarding Part D RI Programs, Part D Sponsor shall include: (1) the intended goal of the reward and incentive program(s); (2) what must be done to receive the rewards and incentives; (3) the per unit value of the reward and incentive; (4) the total value that an enrollee can receive; and (5) how to ask questions or receive help on understanding the rewards and incentives program.

6. Because eligibility for a particular reward or incentive under any Part D RI Program is not assured or cannot be determined before a plan year for a specific enrollee or enrollees, Part D Sponsor shall provide a disclaimer on all materials describing the reward, incentive, or Part D RI Program. Such disclaimer must clearly state that eligibility for the Part D reward or incentive under the Model is not assured and will be determined by the Part D Sponsor after enrollment based on relevant criteria (e.g., clinical diagnosis of Pre-diabetes or Diabetes, participation in a disease state management program).

E. COMPLIANCE WITH MODEL GUIDANCE.

1. In addition to the requirements in the Underlying Contract and this Addendum, Part D Sponsor shall comply with any Model Guidance, including for monitoring, communication and marketing, issued by CMS.

2. As applicable, Part D Sponsor shall submit any Model-related communications materials to CMS using the Health Plan Management System as specified by CMS.

3. In the event of a conflict between the marketing requirements in the Underlying Contract and the Model Guidance such that Part D Sponsor cannot comply with both, Part D Sponsor must comply with any Model Guidance..

F. NOTICE OF CHANGES

Part D Sponsor shall not make any changes to the Approved Proposal without prior, written CMS approval, except that Part D Sponsor may make formulary changes and provide notice (when required) in accordance with existing Part D requirements. For example, consistent with the process for Part D formulary maintenance changes, the Part D sponsor may submit a request to update plan selected model drug coverage to add an interchangeable insulin and remove the reference biologic insulin. In addition, Part D Sponsor agrees to provide CMS written notice of any change in circumstances that would constitute a material change to a fact or representation made in Part D Sponsor's Approved Proposal, including not implementing a Part D RI Program or not providing Model-Specific Supplemental Benefits.

G. RELEASE OF INFORMATION

1. Part D Sponsor shall obtain prior approval from CMS during the term of this Addendum and for six months thereafter for the publication or release of any press release, external report, or statistical/analytical material or other similar material that references Part D Sponsor's participation in the Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. When reviewing these materials, CMS intends to disapprove only those materials containing material misstatements of fact or conclusions based on improper methodology or inaccurate data, or that are inconsistent with the implementation of the Model or other applicable laws, regulations, or CMS instructions. CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by CMS, or where CMS has requested additional time to review, within 30 calendar days after receipt by CMS will be deemed approved.

2. Part D Sponsor agrees to include the following statement on the first page of all external reports and statistical/analytical material that are subject to this Section: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

H. NON-DISCRIMINATION

Part D Sponsor shall not discriminate against enrollees in any Model PBP.

Article IV
Additional Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS.

1. Part D Sponsor shall maintain records relating to the Model for 10 (ten) years from the expiration or termination of this Addendum or from the date of completion of any Model-related monitoring, auditing, or evaluation, whichever is later. Part D Sponsor shall provide access to such records in accordance with the record retention provisions of the Underlying Contract.

B. DATA REPORTING & COOPERATION WITH MONITORING AND EVALUATION.

1. Part D Sponsor shall cooperate with CMS's efforts to evaluate the effectiveness of the Model and shall participate in all Model-related monitoring, auditing, evaluation, and learning and diffusion activities. The obligation to cooperate in Model-related monitoring, auditing, and evaluation shall survive termination of Part D Sponsor's participation in the Model.

2. Part D Sponsor shall submit to CMS, in a form, manner, frequency, and by a deadline specified by CMS data to monitor the real-time impact of the Model and to perform the requisite Model evaluation. Part D Sponsor shall comply with any instructions regarding the collection and submission of data regarding Part D Sponsor's participation in Model, including without limitation the data outlined in Appendix 2. CMS will make a reasonable effort to limit data submission from Part D Sponsors to data that is not readily available to CMS, such as any implementation of Part D RI Programs.

Article V
Termination of Addendum or Model PBP Participation by CMS

A. CMS may terminate this Addendum, or terminate one or more particular PBP(s) from the Model at any time, with or without advance notice if:

1. CMS terminates the Model pursuant to Section 1115A(b)(3)(B) of the Act or otherwise

2. CMS determines that Part D Sponsor or a particular PDP, MA-PD, or its subcontractor or downstream entity (as defined at 42 CFR § 423.4):

(2.a) Has failed to comply with any term of this Addendum or any document incorporated herein;

(2.b) Has carried out this Addendum in a manner that is inconsistent with the efficient and effective implementation of 42 C.F.R. Part 423 or Section 1115A of the Act;

(2.c) Has failed to continually meet the applicable eligibility conditions, or does not have an exception to one or more eligibility conditions, of the Model;

(2.d) Has failed to implement or fully comply with the terms of a corrective action plan or other intermediate sanction;

(2.e) Has taken an action that threatens the health or safety of an enrollee, or Part D Sponsor's participation in the Model is resulting in lower quality of care or any

other adverse outcomes for enrollees;

(2.f) Has submitted false data or made false representations, warranties, attestations or certifications in connection with any aspect of the Model;

(2.g) Is subject to sanctions or other enforcement or correction actions of an accrediting organization or federal, state, or local government agency;

(2.h) Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct,including being subject to the filing of a complaint, or a criminal charge, being subject to an indictment, or being named as a defendant in a False Claims Act qui tam matter in which the government has intervened or similar action;

(2.i) Assigned or purported to assign any of the rights or obligations under the Underlying Contract or this Addendum voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the written consent of CMS;

(2.j) Experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists;

(2.k) Has committed any act that would be cause for termination of the Underlying Contract or imposition of any penalty or sanction thereunder, regardless of whether such termination, penalty or sanction is actually imposed by CMS; or

(2.l) Has engaged in prohibited discrimination against a Medicare beneficiary.

B. Prior to terminating the Addendum or a particular Model PBP's participation in the Model pursuant to this Article 5, CMS may afford Part D Sponsor an opportunity to develop and implement a corrective action plan to correct deficiencies in accordance with the procedures of 42 CFR § 423.509(c)(1).

C. In addition to any sanction or penalty authorized under 42 CFR § 423.750, CMS may rescind or make inapplicable on a prospective basis one or more waivers provided to Part D Sponsor, or limit the benefits or Part D RI Programs that may be offered by Part D Sponsor if CMS determines that an event identified in Paragraph A.2 of this Article has occurred.

Article VI
Modifications of Addendum

A. This Addendum may be modified at any time by written mutual consent

B. CMS may modify this Addendum without the consent of Part D Sponsor for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, or accreditation standards. To the extent practicable, CMS shall provide Part D Sponsor with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date. If Part D Sponsor does not wish to be bound by the unilateral amendment, it may terminate this Addendum by providing CMS with 30 days advance written notice.

Article VII
Procedure upon Termination and Surviving Obligations

A. As the term of this Addendum is from the Start Date through the 2023 plan year, if Part D Sponsor does not wish for its Model PBPs to continue participating in the Model for the upcoming plan year, it must notify CMS in writing by the first Monday in June that precedes the start of the upcoming plan year.

B. If Part D Sponsor does not wish to continue participation in the Model, Part D Sponsor must notify enrollees in the Model PBP by including a notification in the ANOC for the PBP. Such notice must comply with Part D communications and marketing requirements, including without limitation any Model Guidance.

C. Part D Sponsor shall ensure timely transfer to CMS of any data or files that CMS deems necessary for monitoring, assessment, transition or close-out of Part D Sponsor's Model-related activities and shall comply with all other CMS-specified close-out procedures.

D. Termination of this Addendum by either party shall not affect the rights and obligations of the parties accrued prior to the effective date of the termination or expiration of this Addendum. The termination of this Addendum does not relieve either party of any claims against it that arise under this Addendum before the Addendum is terminated.

E. Upon any termination of this Addendum (other than pursuant to Article 5), Part D Sponsor shall continue to provide coverage for items and services consistent with applicable law and the Underlying Contract as if this Addendum had never been executed. Should this occur, CMS may require Part D Sponsor to make appropriate adjustment(s) to its bid submission for a plan year and submit its revised bid in a form and manner specified by CMS. Additional specifics about this bid revision and submission process will be provided at a later date, as necessary.

Article VIII
Order of Precedence & Relationship to Other Agreements

A. This Addendum does not supersede or modify Sections 1860D-1 through 1860D-43 of the Act, or 42 CFR Part 423, except as specifically waived in Appendix 1 of this Addendum for purposes of carrying out this Model.

B. This Addendum specifies additional rights and obligations of the parties with respect to the Model, and does not relieve the parties from, or modify their rights and obligations with respect to, the operation of a prescription drug plan in general or pursuant to the Underlying Contract.

C. If Part D Sponsor also has an agreement to participate in the Medicare Advantage Value-Based Insurance Design Model (MA-VBID) and has proposed to offer rewards and incentives associated with the Part C or Part D benefit under such other model, the following additional requirements apply to Part D Sponsor under this Model.

1. Part D Sponsor shall not conduct a Part D RI Program in a Model PBP that conditions eligibility for a reward or incentive on the Targeted Enrollee completing the same healthcare activity (or service) that the enrollee must complete for a reward or incentive to be available to that enrollee under the MA-VBID Model. Upon request, Part D Sponsor shall provide documentation and data related to compliance with this requirement.

2. Part D Sponsor shall limit the provision of rewards and incentives to each enrollee to a maximum annual aggregate amount of $600.00 for all rewards and incentives under this Model and the MA-VBID Model, and shall include the per unit value of each reward and incentive it offers to a Targeted Enrollee under MA-VBID Model when determining whether a reward or incentive to such Targeted Enrollee would exceed the annual aggregate cap on the total value of rewards and incentives that Part D Sponsor can provide to a Targeted Enrollee under this Model. Upon request, Part D Sponsor shall provide documentation and data related to compliance with these requirements.

D. In the event of any conflict among the documents or other requirements that govern the conduct of CMS and Part D Sponsor in their administration of or participation in the Model, the order of priority to interpret the obligations of the parties shall be as follows:

1. This Addendum;
2. The Underlying Contract to which this Addendum is attached, and other addenda;
3. Any Model Guidance, including, without limitation, guidance on marketing, and data collection; and
4. Part D Sponsor's Approved Proposal.

E. The termination of this Addendum by either party shall not, by itself, relieve the parties of their obligations under the Underlying Contract and its other addenda, if any.

Article IX
Attestation of Compliance

Part D Sponsor hereby attests that:

A. Part D Sponsor will implement their Approved Proposal;

B. Each Model PBP's bid pricing tool (BPT) has been completed in a manner consistent with all CMS guidelines and Model Guidance; and

C. Part D Sponsor has not made changes to the Model PBP's benefit structure, formulary, network, or otherwise that discriminate against enrollees in any Model PBP.

Article X
Limitation on Review

A. Limitations on Review. There is no administrative or judicial review under Sections 1869 or 1878 of the Act or otherwise for the following:

1. The selection of Part D sponsors to participate in the Model, including the decision by CMS to terminate this Addendum or to direct the termination of any Model PBPs;

2. The selection of manufacturers to participate in the Model, including the decision by CMS to terminate a manufacturer's participation in the Model;

3. The elements, parameters, scope, and duration of the Model;

4. Determinations regarding budget neutrality under Section 1115A(b)(3);

5. The termination or modification of the design and implementation of a Model under Section 1115A(b)(3)(B) of the Act; or,

6. Decisions about expansion of the duration and scope of a model under Section 1115A(c), including the determination that a model is not expected to meet criteria described in subsection (c)(1) or (c)(2).

Article XI
Severability

In the event that one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Addendum, but this Addendum shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

Article XII
Miscellaneous

A. Definitions.

Terms not otherwise defined in this Addendum shall have the meaning given such terms in the Underlying Contract, or 42 CFR Part 423, as applicable.

B. Notifications.

All notifications to CMS required under this Addendum shall be submitted by Part D Sponsor to CMS by electronic mail to PartDSavingsModel@cms.hhs.gov. All notifications to Part D Sponsor required under this Addendum shall be submitted by CMS to Part D Sponsor by electronic mail either to the person(s) designated in the Approved Proposal or the Health Plan Management System as Part D Sponsor's primary point of contact, or via a Health Plan Management System broadcast email.

C. Compliance with Laws.

1. Part D Sponsor shall comply with the applicable terms of this Addendum, the Underlying Contract and all applicable statutes, regulations, and guidance, including without limitation (a) federal criminal laws; (b) the federal False Claims Act (31 U.S.C. § 3729 et seq.); (c) the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the federal civil monetary penalties law (42 U.S.C. § 1320a-7a); (e) the federal physician self-referral law (42 U.S.C. § 1395nn), and (f) applicable State laws.

2. This Addendum does not provide any waivers of the fraud and abuse laws. Part D Sponsor must comply with all applicable fraud and abuse laws, except as such laws may be waived pursuant to Section 1115A(d)(1) of the Act specifically for the Model.

D. Execution in Counterpart.

This Addendum and any amendments hereto may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. In the event that any signature is delivered by facsimile transmission or by e-mail delivery of a PDF data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such facsimile or PDF signature page were an original thereof.

E. Star Ratings.

CMS may adjust the rules for calculating the Star Ratings for MA Organizations and Part D Sponsors participating in the Model to protect against a statistically significant negative impact to the Part C or Part D Star Ratings for MA Organizations and Part D Sponsors that have MA-PDs and stand-alone PDPs not participating in the Model when the impact is directly attributable to participation in the Model.

In witness whereof, the parties hereby execute this Addendum. This document has been electronically signed by:

FOR Part D Sponsor

Juan Serrano

Contracting Official Name

9/9/2022 2:58:03 PM

Date

TRIPLE S ADVANTAGE, INC.

Organization

PO Box 11320
San Juan, PR 00922

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

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9/22/2022 10:52:58 AM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

<ARRAH TABE-BEDWARD ESIG>

Not Available

Date

Arrah Tabe-Bedward
Deputy Director
Center for Medicare and
Medicaid Innovation

Attachments:
Appendix 1 (Waivers of Part D Program Requirements)
Appendix 2 (Part D Rewards and Incentives Programs)

Appendix 1:
Waivers of Part D Program Requirements

A. Pursuant to Section 1115A(d)(1) of the Act, in its sole discretion, CMS waives the Medicare Part D statutory and regulatory requirements enumerated in this Appendix 1 for purposes of the Model. These waivers are granted only to the extent necessary to implement the Model. CMS may modify or rescind any or all of these waivers at any time, in its sole discretion.

B. Waivers for Part D Sponsors that are Model Participants. The waivers identified in this Section B are for Part D sponsors participating in the Model. Each waiver in this Section B is (1) each contingent on compliance with the terms and conditions of this Addendum, the Approved Proposal, and documents incorporated therein; (2) is granted to the Part D Plan Sponsor only as to the Model PBPs and only to the extent necessary to implement the Model in accordance with the Addendum and documents incorporated therein; and (3) is granted only for the term of this Addendum

1. Special Rule for Supplemental Benefits. The following requirement of section 1860D-14A(c)(2) of the Act and 42 CFR § 423.2325(e): "where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug." This will allow supplemental benefits to apply to the discounted price after the manufacturer coverage gap discount is applied to a Model Drug;

2. Low Income Cost Sharing Subsidy Calculation. 42 CFR § 423.329(d)(1) to the extent necessary calculate the low income cost-sharing subsidy for a Model Drug based on the cost sharing of the formulary tier(s) for the Model Drug without regard to any Model-Specific Supplemental Benefits for such drug.

3. Uniformity and Accessibility of Benefits and Cost Sharing. Section 1860D–2(a) of the Act; and 42 CFR §§ 423.104(b)(2) and 423.265(c) to the extent necessary to permit Part D sponsors to offer Model-specific supplemental benefits and Part D RI to non-LIS enrollees only, subject to the terms of the Model. Model-specific supplemental benefits consist of cost-sharing on Model drugs as described at Article 3, Section C(2)(a) of this addendum, and Part D RI includes any program offer under this Model in compliance with Appendix 2.

4. Tiering Exceptions. 42 CFR §423.578(a) to the extent necessary to permit Part D sponsors to exclude from their tiering exceptions process for Model PBPs any requests to apply Model-Specific Supplemental Benefits to any applicable drug that is, or contains, a drug classified as insulin in American Hospital Formulary Service (AHFS) Drug Information or the DRUGDEX Information System compendia.

5. Prohibition on Mid-year Benefit Enhancements. Requirements under Section 1860D-11, to the extent necessary solely to permit Part D sponsors to add Plan Selected Model Drugs at any time during the plan year, consistent with existing Part D formulary requirements.

C. Waiver for Part D sponsors. The waivers identified in this Section C are for Part D sponsors, inclusive of Part D Sponsors not participating in the Model and is granted only for the duration of the Model.

1. Star Ratings for Part D plans. 42 CFR §§ 423.182-423.186 and 42 C.F.R. 422.162-422.166 to the extent necessary to permit CMS to adjust the rules for calculating the Star Ratings for Part D sponsors participating in the PDSS Model to protect against a statistically significant negative impact to the Part C and Part D Star Ratings for MA-PDs and stand-alone PDPs that are not participating in the Model when the impact is directly attributable to participation in the Model;

2. Part D Bid and Payment Data. Section 1860D-15(f) of the Act is waived to the extent necessary to permit CMS to use Part D bid and payment data for purposes of conducting and evaluating the Model.

Appendix 2:
Part D Rewards and Incentives Programs

Part D Sponsor may, subject to certain conditions and CMS approval, implement a Part D RI Program. Part D Sponsor shall implement any Part D RI Program under the Part D Senior Savings Model during the term of the Addendum only in accordance with the terms of this Addendum, including this Appendix 2, and the Approved Proposal.

A. Part D Rewards and Incentives Programs Structure and Content

1. If Part D Sponsor is implementing a Part D RI Program under the Model, the parties acknowledge that Part D Sponsor has submitted as part of its application for participation in the Part D Senior Savings Model, a proposal to offer one or more Part D RI Programs to Targeted Enrollees.

2. Part D Sponsor shall identify Targeted Enrollees for the Part D RI Program without discrimination and using objective criteria that comply with the terms of the Addendum, including this Appendix 2, and are specified in the Approved Proposal or are otherwise approved in writing, in advance by CMS. Such objective criteria must identify the subset of enrollees who would receive the greatest health care value from receiving the benefits or participating in the activities associated with the particular reward or incentive in the Part D RI Program and must include that the enrollee have Diabetes or Pre-diabetes.

3. Part D Sponsor acknowledges that for each Part D RI Program the Approved Proposal contains the following:

(3.a) The goals of the Part D RI Program;

(3.b) The list of Model PBPs in which the Part D RI Program will be implemented;

(3.c) The nature and scope of the Part D RI Program, including the criteria for identifying Targeted Enrollees and the beneficiary engagement methodology;

(3.d) The eligibility criteria that must be met for an individual Targeted Enrollee to qualify to receive the reward or incentive, including the healthcare activity that must

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be completed for the reward or incentive to be available, and, if eligibility includes an adherence metric, the specific criteria for measuring adherence and the evidence base to support the clinical appropriateness of the adherence criteria;

(3.e) The type and per unit value of each reward or incentive and the method for providing the reward or incentive to eligible Targeted Enrollees. Part D Sponsor must reasonably establish value for each healthcare-related service or activity for which Part D sponsor is providing rewards and incentives;

(3.f) The maximum number and frequency of the rewards and incentives that may be obtained by an eligible Targeted Enrollee per year; and;

(3.g) The evidence base and theory of change used to develop the reward or incentive and the expected outcomes of the Part D RI Program(s).

4. Part D Sponsor shall:

(4.a) Provide the rewards and incentives only to eligible Targeted Enrollees and only in accordance with the Approved Proposal and this Addendum;

(4.b) Comply with the standards for rewards and incentives as outlined in the Medicare Managed Care Manual Ch. 4 § 100 issued and effective April 22, 2016 at available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf except as waived or otherwise modified by the Addendum, including Appendix 1 or this Appendix 2;

(4.c) Not provide any reward or incentive if its value exceeds the value of the expected impact on enrollee behavior or the expected benefit of the healthcare service or activity on which receipt of the reward or incentive is based, except that (notwithstanding the Rewards and Incentives provisions in the Medicare Managed Care Manual Ch. 4 § 100), the value of the individual reward or incentive may exceed the cost of the health-related service or activity itself, so long as the cost of the health-related service or activity is less than the expected benefit of the health care item or service on which receipt of the reward is based;

(4.d) Ensure that Part D RI Programs are complete by the end of a plan year. Part D RI programs may allow the enrollee to carry over unspent value of rewards and incentives from one contract year to the next for the enrollee's use, but Part D Sponsor must not require additional actions by the enrollee in the next plan year to receive that reward or incentive;

(4.e) Ensure that rewards and incentives are tangible items that align with the purpose of the Part D RI program and must directly benefit the enrollee; and,

(4.f) Limit the provision of rewards and incentives to each enrollee to a maximum annual aggregate amount of $600.00 for all rewards and incentives in this Model and the MA-VBID Model, and include the per unit value of each reward and incentive it offers to a Targeted Enrollee under the MA-VBID Model when determining whether a reward or incentive to such Targeted Enrollee would exceed the annual aggregate amount on the total value of rewards and incentives that Part D Sponsor can provide to a Targeted Enrollee under this Model.

5. Part D Sponsor shall ensure that any rewards and incentives in its Part D RI Programs are furnished in accordance with the goals of the program set forth in the Approved Proposal, which must reward or incentivize one or more of the following:

(5.a) Participation of Targeted Enrollees in a disease state management programs specifically for individuals with Pre-diabetes or Diabetes.

(5.b) Participation in a Part D Sponsor's medication therapy management (MTM) program that includes a focus on a Pre-diabetes or Diabetes.

(5.c) Receipt by the Targeted Enrollee of preventative health services, such as receiving Part D covered vaccines.

(5.d) Participation in educational activities designed to enable Targeted Enrollees to better understand their Part D plan benefit, costs, and clinically appropriate coverage alternatives, including biosimilars and generics.

6. In offering any reward or incentive for participation in an MTM program, Part D Sponsor shall comply with existing CMS requirements for MTM programs, as set forth in 42 CFR § 423.153.

7. In offering any reward or incentive for participation in preventive health services, Part D Sponsor may design a program with the overall goal of improving medication adherence, however Part D Sponsor shall not condition any such reward or incentive solely on prescription fills or clinical outcomes, and shall not furnish any such reward or incentive for a service that is not clinically indicated for the beneficiary

8. In implementing and operating its Part D RI Program, Part D Sponsor shall not:

(8.a) Provide a reward or incentive to a Medicare beneficiary who is not enrolled in a Model PBP.

(8.b) Provide a reward or incentive to an enrollee in a Model PBP who does not have Diabetes or Pre-diabetes.

(8.c) Provide a reward or incentive to an enrollee in a Model PBP in connection with the same healthcare activity or service that the enrollee completed to be eligible for a reward or incentive under the MA-VBID Model.

(8.d) Structure a Part D RI Program to discourage clinically indicated medication use.

(8.e) Structure a Part D RI Program to discourage clinically indicated medication use.

(8.f) Use a Part D RI Program largely to market a PBP or encourage beneficiaries to remain with a specific plan.

(8.g) Use a Part D RI Program to, in any way, choose or solicit healthier enrollees over enrollees who the sponsors believe may be less healthy.

(8.h) Create a Part D RI Program that discriminates against enrollees based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty status, health status, or other prohibited basis.

(8.j) Provide rewards or incentives in the form of cash, cash equivalents, or other monetary rebates, or use rewards or incentives to decrease cost-sharing or plan premium.

(8.k) Identify Targeted Enrollees based on the identity of their pharmacy provider.

(8.l) Use a Part D RI Program that is designed to allow for rewards and incentives to be won based on probability;

(8.m) Use prescription fills or adherence as the sole basis for providing a reward or incentive.

(8.n) Use a Part D RI Program that is designed to allow for rewards and incentives to be won based on probability;

(8.o) Use prescription fills or adherence as the sole basis for providing a reward or incentive.

(8.p) Incentivize enrollees to use mail service pharmacies, preferred pharmacies, or any other specific network providers.

(8.q) Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a drug manufacturer. This includes, but is not limited to, the use of personnel affiliated with a drug manufacturer, or manufacturer-financed coupons or discounts provided to a beneficiary.

(8.r) Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a pharmacy or entity that owns or operates pharmacies. This includes use of personnel affiliated with a pharmacy, or pharmacy-financed coupons or other discounts provided to a beneficiary.

(8.s) Provide RI that can be used for the purchase of alcohol, tobacco, gambling, or firearms.

B. Record Retention and Reporting

1. In accordance with Article 4 of this Addendum, Part D Sponsor shall maintain the following records regarding each Part D RI Program (and may be required to report such records):

(1.a) The identity of each Targeted Enrollee, including enrollees identified with Diabetes or Pre-Diabetes, and the total number of Targeted Enrollees;

(1.b) The identity of each enrollee who received a reward and incentive, including enrollees identified with Diabetes or Pre-diabetes, and the total number of enrollees who received a reward and/or incentive;

(1.c) The Part D RI Program pursuant to which the enrollee received the reward or incentive;

(1.d) The nature and date(s) of the activities or other conduct engaged in by the enrollee and clinical information about the enrollee that enabled the enrollee to qualify for the reward or incentive;

(1.e) The nature and amount of the reward or incentive received by the enrollee;

(1.f) The cost of the healthcare activities or services with which eligibility for a reward or incentive is associated, the value of the expected impact on enrollee behavior, and the value of the benefit of the healthcare activity on which receipt of the reward or incentive is based;

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(1.g) Any trends over time in the number of Targeted Enrollees in the RI program, or the number of enrollees who received a reward and/or incentive; and,

(1.h) Any evaluations done by Part D Sponsor to assess the effectiveness of the RI Program.

2. Part D Sponsor shall submit reports to CMS, in a form and manner and by a deadline specified by CMS, regarding its implementation of each Part D RI Program. Part D Sponsor shall provide CMS with supplemental information upon request regarding its implementation of any Part D RI Program.

C. Compliance and Enforcement

1. Part D Sponsor shall have in place a protocol for monitoring the implementation and administration of each Part D RI Program. Part D Sponsor shall make this protocol available to CMS upon request.

2. CMS may terminate or suspend Part D Sponsor's implementation of any Part D RI Program, or take other remedial action in accordance with Article 5 of the Addendum, including without limitation if –

(2.a) Part D Sponsor fails to comply with the terms and conditions of the Addendum or this Appendix 2; or

(2.b) CMS determines that Part D Sponsor's implementation of such a program might compromise the integrity of the Model.

3. Without limiting the foregoing, the parties agree that if CMS determines that Part D Sponsor has failed to comply with the terms of Article 3 of this Addendum or this Appendix 2, CMS may prohibit Part D Sponsor from offering Part D RI Programs in one or more future plan years, regardless of whether Part D Sponsor has corrected or otherwise resolved the noncompliance.

SIGNATURE ATTESTATION

Contract ID: H5774
Contract Name: TRIPLE S ADVANTAGE, INC.

I understand that by signing and dating this form, I am acknowledging that I am an authorized representative of the above named organization and that I am the contracting official associated with the user ID used to log on to the Health Plan Management System (HPMS) to sign the 2023 Medicare contracting documents. I also acknowledge that in accordance with the HPMS Rule of Behavior, sharing user IDs is strictly prohibited.

This document has been electronically signed by:

Juan Serrano

Contracting Official Name

9/9/2022 2:58:03 PM

Date

TRIPLE S ADVANTAGE, INC.

Organization

PO Box 11320
San Juan, PR 00922

Address

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Contrato Número
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ADDENDUM TO MEDICAREMANAGED CARE CONTRACT FOR PARTICIPATION IN THE MEDICARE ADVANTAGE VALUE-BASED INSURANCE DESIGN (VBID) MODEL

The Centers for Medicare & Medicaid Services ("**CMS**") and TRIPLE S ADVANTAGE, INC., a Medicare Advantage organization("**MA Organization**") agree to amend the contract H5774, including all attachments, addenda, and amendments thereto (the "**Underlying Contract**"), governing MA Organization's operation of a Part C plan described in Section 1851(a)(2)(A) of the Social Security Act ("**Act**"), and, if applicable, a Voluntary Medicare Prescription Drug Plan pursuant to Sections 1860D-1 through 1860D-43 (with the exception of Sections 1860D-22(a) and 1860D-31) of the Act to include this Addendum to provide for MA Organization's participation in the Medicare Advantage Value-Based Insurance Design Model ("**VBID Model**" or "**Model**").

For purposes of this Addendum, unless otherwise noted, references to an "MA organization" or "MA plan" are deemed to include an "MA-PD sponsor" or an "MA-PD plan" respectively, to the extent MA Organization is offering a Part D benefit.

The VBID Model, conducted under the authority of Section 1115A of the Act, is an opportunity for CMS to test the impact on Medicare program costs and the quality of care of services furnished by MA organizations that agree to offer a Wellness and Health Care Planning Component and at least one of the following:

i. Additional Benefits, such as reduced cost sharing for Targeted Enrollees, based on the chronic health condition and/or socioeconomic status criteria proposed by MA Organization and approved by CMS;

ii. additional rewards and incentives to enrollees, including in the Part D benefit;

iii. new and innovative technologies for Targeted Enrollees for an FDA approved medical device or new technology that has a Medicare coverage determination (either national or local) where the MA plan seeks to cover it for an indication that differs from the Medicare coverage determination and the MA plan demonstrates the device is medically reasonable and necessary, as well as for new technologies that do not fit into an existing benefit category; or

iv. the Medicare hospice benefit ("**Hospice Benefit Component**"). The Parties hereby amend the Underlying Contract as follows:

Article I
Term and MA Plan Participation

A. This Addendum becomes effective on the date it is signed by CMS ("**Effective Date**") and will remain in effect through December 31, 2023, unless sooner terminated in accordance with Articles 5 or 6 of this Addendum. This contract covers Plan Year 2023 for the VBID Model, which will start on January 1, 2023 ("**Start Date**"). If MA Organization wishes to participate in the Model during a subsequent Plan Year, it must timely submit for CMS review a Model application for the relevant Plan Year in addition to its annual MA bid submission.

B. MA Organization must not include any of its plans of the following types in its participation in the VBID Model: Medicare-Medicaid Plans (MMPs) or other demonstration plans; Employer Group Waiver Plans (EGWPs) that are offered exclusively to employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations and that exclusively enroll members of group health plans; Medical Savings Account (MSA) Plans; Private Fee-For-Service (PFFS) Plans; cost plan offered under Section 1876 of the Act; or a Program of All-Inclusive Care for the Elderly (PACE).

Article II
Definitions

"Additional Benefits" means extra Medicare Advantage (MA) and Part D benefits (in addition to MA and Part D benefits required to be offered by the terms of the Underlying Agreement) offered by MA Organization under the Model and may be in the form of additional items and services and reductions in cost sharing. Additional Benefits includes reductions in Part D cost sharing targeted to LIS beneficiaries, which are referred to as "Part D Cost Sharing Reductions Based on SES." Additional Benefits do not include Hospice Care benefits or other benefits provided solely pursuant to Appendix 3 by an MA organization participating in the Hospice Benefit Component.
"Approved Proposal" means MA Organization's final approved application that reflects and is consistent with MA Organization's final approved bid and VBID Model benefit package(s), including by final corresponding bid submission approved by CMS. The Approved Proposal includes all updates based on CMS guidance, and reflects all corresponding bid submissions, allowing participation in the VBID Model in Plan Year 2023 for the VBID Components for which MA Organization is participating.

"Hospice Benefit Component" means the part of the VBID Model permitting MA Organization (pursuant to Article 3(F) of this Addendum) to (1) cover the Medicare Part A hospice benefit; (2) to develop and implement a Palliative Care strategy and Transitional Concurrent Care strategy, and (3) to offer Additional Hospice Benefits.

"Model Communications and Marketing Guidelines" mean the supplemental document provided by CMS outlining the communications and marketing requirements and any limitations on communications and marketing materials related to VBID Components for all enrollees in a VBID PBP.

"Model Monitoring Guidelines" mean the supplemental documents, provided by CMS, outlining the monitoring and reporting requirements for MA organizations participating in the VBID Model.

"Model Technical and Operational Guidance" means supplemental direction and instructions from CMS regarding technical and operational requirements for MA organizations participating in the VBID Model, including without limitation the Model Communication and Marketing Guidelines and Model Monitoring Guidelines.

"Part C RI Program" means Part C Rewards and Incentives Program and means a program that offers certain rewards and incentives that are connected to the Part C program.

"Part D Cost Sharing Reductions Based on SES" means Additional Benefits that take the form of reduced cost-sharing for covered Part D drugs that are offered to Targeted Enrollees on the basis of socioeconomic status (SES).

"Part D RI Program" stands for Part D Rewards and Incentives Program and means a program that offers certain rewards and incentives that are connected to the Part D Prescription Drug Benefit.

"PBP" stands for Plan Benefit Package and has the meaning set forth at 42 CFR § 422.162.

"Plan Year" has the same meaning as set for at 42 CFR § 422.2274.

"Rewards and Incentives Program" ("RI Program") means a Part C RI Program, a Part D RI Program, or both.

"Targeted Enrollee" means a Medicare beneficiary who is enrolled in one of MA Organization's VBID PBPs participating in the Model and targeted by MA Organization to receive interventions under one or more VBID Components, except the Hospice Benefit Component and the Wellness and Healthcare Planning Component. The standards and criteria used by MA Organization to identify Targeted Enrollees may vary depending on the VBID Component, and must be identified in the Approved Proposal. Certain Additional Hospice Benefits may be limited to certain enrollees who have elected hospice and, in some cases, meet other eligibility criteria in accordance with Appendix 3.

"VBID Component" means one or more of the following components of the VBID Model offered by MA Organization pursuant to its participation in the VBID Model: (i) required WHP Services; (ii) additional benefits furnished pursuant to Article 3(D) in the form of certain reduced cost-sharing obligations and certain additional items or services, including new and innovative technologies; (iii) the Hospice Benefit Component; and an RI Program.

"VBID PBP" has the meaning set forth in Article 3(B)(1).

"WHP Services" stands for Wellness and Health Care Planning Services and means advance care planning services and other services identified in the Approved Proposal for the WHP Services VBID Component. Such services may be in addition to the activities and performance required by 42 CFR § 422.128.

A list of definitions specific to the Hospice Benefit Component is included in Appendix 3 of this Addendum.

Article III
Functions to be Performed by MA Organization

A. BID AND BENEFIT PACKAGE SUBMISSION AND REVIEW

MA Organization certifies that its annual benefit and pricing proposal(s) for Parts C and D bids are consistent with the remainder of the Approved Proposal (unless otherwise authorized in writing by CMS) and in accordance with supplemental bid instructions issued by CMS for participants in the VBID Model.

B. IMPLEMENTATION OF VBID COMPONENTS

1. MA Organization shall implement the VBID Components in accordance with the Approved Proposal this Addendum (including all applicable Appendices.), and all applicable Model Technical and Operational Guidance. MA Organization may participate in the VBID Model only with the MA PBPs that CMS has approved for participation in the VBID Model and which are identified in the Approved Proposal(each, a**"VBID PBP"**).

2. MA Organization shall comply with all applicable laws governing its operation and offering of an MA plan, except as specifically waived in writing in accordance with

Section 1115A of the Act.

3. MA Organization shall provide a mechanism for eligible enrollees to opt out of Additional Benefits provided under the VBID Model at any time. If an enrollee opts out of Additional Benefits provided under the VBID Model or out of any VBID Component, MA Organization shall take the following actions:

a. Send a written acknowledgement to the enrollee of his or her request to opt out of the benefits provided under the VBID Model or out of the VBID Component;

b. Thereafter, provide the enrollee with coverage of benefits offered by MA Organization under the PBP without benefits, items or services provided solely under this Addendum for the VBID Model; and

c. Not treat the enrollee as a Targeted Enrollee for purposes of the applicable VBID Component.

If after opting out of the Additional Benefits provided under the VBID Model or out of a VBID Component, an enrollee who meets the criteria to be a Targeted Enrollee wishes to regain eligibility for or access to the Additional Benefits provided under the VBID Model or a VBID Component, MA Organization must honor that request and begin or resume providing Additional Benefits provided under the VBID Model or eligibility for or access to a VBID Component to the enrollee prospectively, consistent with the terms of this Addendum for a Targeted Enrollee.

4. MA Organization shall:

a. Implement the VBID Components in a manner that is consistent with the efficient and effective implementation of 42 CFR Parts 422 and 423 (as applicable) and Section 1115A of the Act;

b. Continually meet the applicable MA organization eligibility conditions of the Model, unless CMS has granted MA Organization an exception to participate in the Model;

c. Implement the VBID Components on the Start Date, consistent with the Approved Proposal and all applicable Model Technical and Operational Guidance;

d. Comply with the Model Monitoring Guidelines, including the timely submission of data to facilitate model monitoring;

e. Not take any action that threatens the health or safety of any enrollee; and

f. Ensure that MA Organization's participation in the VBID Model does not result in lower quality of care or any other adverse outcomes for Targeted Enrollees.

C. WELLNESS AND HEALTH CARE PLANNING

1. MA Organization's performance of the WHP Services described in this Article 3(C) is a condition of participating in the VBID Model and of any program waiver provided under the VBID Model.

2. MA Organization shall adopt and implement a plan to offer WHP Services to all enrollees in its VBID PBPs.

3. The plan to offer WHP Services to all enrollees in its VBID PBPs must include at a minimum:

a. The mechanisms to ensure that each enrollee is aware of the availability of WHP Services (e.g., descriptive language in the EOC or marketing materials regarding the opportunity to engage in advance care planning) and the manner in which the enrollee may receive WHP Services (e.g., Annual Wellness Visit, Health Risk Assessment, care management program, etc.); and

b. Ways that MA Organization is leveraging technology (e.g., Electronic Health Record, Electronic Medical Record, provider/patient portal) to communicate with enrollees about WHP Services and to document and track the use of WHP Services.

4. In accordance with the VBID Model Monitoring Guidelines, MA Organization shall monitor and track the implementation and effectiveness of WHP Services and provide such information to CMS upon request.

D. PROVISION OF ADDITIONAL BENEFITS

1. To the extent that the Approved Proposal involves the provision of Additional Benefits, consistent with the Approved Proposal and the scope of the waiver(s) identified in Appendix 1 of this Addendum, MA Organization must cover, and must provide to Targeted Enrollees that have not opted out Additional Benefit(s) in the form of:

a. Reduced cost sharing, which may include the elimination of cost-sharing, as follows:

i. Reducedcost-sharing for high-value services, as identified by MA Organization pursuant to the Approved Proposal.

ii. Reduced cost-sharing for high-value providers, as identified by MA Organization pursuant to the Approved Proposal.

iii. Reduced cost-sharing for covered Part D drugs.

iv. Reduced cost-sharing for new and innovative technologies or FDA-approved medical devices.

b. Additional items or services that comply with the requirements of 42 CFR Part 422 for supplemental benefits, except as those requirements are specifically waived under the Model, as follows:

i. Additional items or services, including new and innovative technologies or FDA-approved medical devices that meet the criteria for supplemental benefits in Part 422.

ii. Additional non-primarily health related supplemental benefits that have a reasonable expectation of improving or maintaining the health or overall function of the Targeted Enrollee with regard to the chronic health condition or socioeconomic status of the Targeted Enrollee population.

2. To the extent that the Approved Proposal includes the provision of Additional Benefits, MA Organization shall provide the Additional Benefits to Targeted Enrollees consistent with the Approved Proposal and as follows:

a. All Additional Benefits that are additional items and services must be provided as mandatory supplemental benefits in accordance with 42 CFR Part 422 and other applicable law, subject to the waivers in Appendix 1.

b. All Additional Benefits that are reductions in cost sharing for MA basic benefits (as defined in § 422.100(c)), or reductions in cost sharing for MA supplemental benefits or additional items and services that are treated as mandatory supplemental benefits under the Addendum, must be provided as mandatory supplemental benefits in accordance with 42 CFR Part 422 and other applicable law, subject to the waivers in Appendix 1.

c. All Additional Benefits that are reductions in Part D cost sharing, including Part D Cost Sharing Reductions Based on SES, must be provided as Part D supplemental benefits in accordance with 42 CFR Part 423 and other applicable law, subject to the waivers in Appendix 1.

3. If approved by CMS in the Approved Proposal to provide Additional Benefits based on a Targeted Enrollee utilizing services from a high-value provider(s), MA Organization must:

a. In determining the composition of a high-value provider network, adhere to the criteria and parameters for such providers in the Approved Proposal and the Value-Based Insurance Design Model Request for Applications for CY 2023, posted online at https://innovation.cms.gov/media/document/cy-2023-vbid-rfa, including the following:

i. MA Organization must use only the rationale and standards in the Approved Proposal to identify high-value providers;

ii. High-value providers may be of any Medicare provider type, including physicians and medical practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, and others except for pharmacies;

iii. MA Organization must ensure that high-value providers are identified in connection with the specific clinical condition(s) or other factors as used to identify Targeted Enrollees;

iv. MA Organization must not identify high-value providers based on cost or coding accuracy or intensity alone; and

v. High-value providers must be available and accessible to all Targeted Enrollees.

b. Not remove a provider from its roster of high-value providers during a contract year, unless the provider is terminated from the network, the provider requests exclusion from the high-value network or, with the concurrence of CMS, exclusion from the high-value network is warranted for the best interest of enrollees;

c. Clearly inform Targeted Enrollees which providers are considered high-value and the rationale for using high-value providers to encourage Targeted Enrollees to use high-value providers;

d. Notify Targeted Enrollees of the termination of a provider from its high-value provider network in accordance with the Model Communications and Marketing Guidelines; and

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e. Notify CMS of any change to the composition of a high-value provider network in the same manner as if the change were a significant change to the provider network under Chapter 4, Section 110.1.2 of the Medicare Managed Care Manual (see https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf), regardless of whether such changes are considered "significant" with respect to the network-at-large.

4. If MA Organization offers Additional Benefits to Targeted Enrollees pursuant to the Approved Proposal, MA Organization must not condition access to high-value providers or Additional Benefits on the enrollee meeting specific health measurements (e.g., conditioning lower cost-sharing on maintaining specific blood pressure ranges);

5. MA Organization shall identify Targeted Enrollees for Additional Benefits based on chronic health condition(s) and/or socioeconomic status as described in Article 3(D)(6) and 3(D)(7) and using criteria and methodologies in the Approved Proposal. MA Organization shall retain all necessary data to allow CMS to replicate and verify application of targeting criteria. CMS may reject or request changes to the criteria used to identify Targeted Enrollees if CMS determines that the rejection or change is necessary to ensure the integrity of the VBID Model or to avoid harm to an enrollee. CMS may also reject or request changes to the criteria if it determines that the criteria is not in the best interest of an enrollee.

6. The methodologies and criteria used by MA Organization to identify Targeted Enrollees must be in the Approved Proposal, be able to be replicated by CMS, be applied uniformly to all enrollees who meet the definedcriteria, be evidence-based, and be expected to materially impact the health of the targeted population. The Targeted Enrollee population may be identified based on (i) targeting by chronic health condition, as described below; (ii) targeting by socioeconomic status, as described below; or (iii) targeting by a combination of both chronic health condition(s) and socioeconomic status.

a. Targeting by Chronic Health Condition. When eligibility of enrollees is based on chronic health condition, MA Organization shall identify Targeted Enrollees by either:

i. a broad targeting methodology, such as targeting all enrollees with a specific chronic health condition; or

ii. a tailored methodology, such as targeting enrollees with a specific level of a condition, as defined by ICD-10 codes or other data.

b. Targeting by Socioeconomic Status. When eligibility of enrollees is based on socioeconomic status, MA Organization shall identify Targeted Enrollees by:

i. Low-income subsidy (LIS) status by subsidy level, as defined in the Plan Communication User Guide (PCUG) for Medicare Advantage and Prescription Drug Plans found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide. Where a specific subsidy level is not identified in the Approved Proposal, all LIS enrollees are Targeted Enrollees.

ii. For enrollees in a U.S. territory, dual eligibility for both Medicare and Medicaid, using CMS identification of a dual-eligibility status in MARx.

c. Targeting Based on Additional Other Factors. Upon approval by CMS, the MA Organization may identify Targeted Enrollees using other factors that are present in addition to the chronic health condition(s) and/or socioeconomic status, such as by requiring an LIS enrollee to also participate in a disease management program, or related program in order to be a Targeted Enrollee who is eligible for Additional Benefits described in Article 3(D)(1) and (D)(2).

7. MA Organization shall make reasonable efforts to identify, based on information known to MA Organization, Targeted Enrollees using the applicable criteria identified in this Article 3(D) and MA Organization's Approved Proposal.

8. MA Organization shall submit to CMS all targeting and engagement (e.g., data around outreach to Targeted Enrollees) data used to identify Targeted Enrollees in a form and manner and by a deadline specified by CMS in Model Technical and Operational Guidance.

9. MA Organization shall not require a Targeted Enrollee to receive, opt in, or otherwise register for benefits provided under the VBID Model, except as described in the Approved Proposal and in accordance with Article 3(D)(6)(c).

E. REWARDS AND INCENTIVES PROGRAMS

MA Organization shall implement any Part C RI Program and any Part D RI Program consistent with the Approved Proposal and this Addendum, including Appendix 2. Any changes to a RI Program are subject to written CMS review and approval.

F. HOSPICE BENEFIT COMPONENT

If approved by CMS to participate in the Hospice Benefit Component, MA Organization shall implement the Hospice Benefit Component consistent with the Approved Proposal and this Addendum, including Appendix 3. Any changes to an MA Organization's implementation of the Hospice Benefit Component are subject to written CMS review and approval.

G. COMMUNICATIONS, MARKETING, AND DISCLOSURES

1. In addition to the marketing requirements and prohibitions in 42 CFR Parts 422 and 423, in this Addendum and in the Underlying Contract, MA Organization shall comply with the Model Communications and Marketing Guidelines issued by CMS and available on the VBID Model website at https://innovation.cms.gov/initiatives/vbid/.

2. MA Organization shall convey information about its participation in the Model and benefits, and RI programs available for eligible Targeted Enrollees in approved VBID Components as described in the Approved Proposal to Targeted Enrollees consistent with CMS rules permitting marketing of covered benefits and RI Programs and the Model Communications and Marketing Guidelines.

3. If the eligibility for a VBID Component as a Targeted Enrollee (e.g., for a particular item or reward under the RI Program, for an Additional Benefit described in Article 3(D), or for benefits under the Hospice Benefit Component as described in Appendix 3) is not assured or cannot be determined before a Plan Year for a specific enrollee or enrollees, MA Organization shall provide a disclaimer on all materials describing VBID Component. Such disclaimer must clearly state that eligibility for VBID Components available under the VBID Model is not assured and will be determined by MA Organization after enrollment based on relevant criteria (e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program).

4. Evidence of Coverage and Plan Annual Notice of Change. MA Organization shall include in the Evidence of Coverage descriptions of all VBID Components, including WHP, but except RI Programs, offered by the VBID PBP along with language that ensures enrollees are aware of any conditional or targeting criteria. For Plan Year 2023, if MA Organization is new to the VBID Model, newly participating in certain VBID Components, discontinuing from the VBID Model, or discontinuing certain VBID Components, MA Organization shall include descriptions of the VBID Components, including WHP but except RI Programs, that are new for 2023 or being discontinued in 2023 in the Plan Annual Notice of Change for existing enrollees.

5. MA Organization shall submit to CMS any VBID Model-related enrollee communication and marketing materials designated in the Model Communications and Marketing Guidelines for review and approval, and shall not make use of such materials until they are approved by CMS.

6. In the event of a conflict between the marketing requirements in the Underlying Contract and the Model Communications and Marketing Guidelines such that MA Organization cannot comply with both, MA Organization must comply with the Model Communications and Marketing Guidelines.

H. NOTICE OF CHANGES TO CMS

Prior to the beginning of and throughout the 2023 Plan Year, MA Organization shall provide to CMS written notice of its intention to make any of the following changes, and of the method by which Targeted Enrollees will be notified of such changes, which MA organization shall not implement without obtaining prior written approval from CMS;

1. Changes to benefits, including the formulary, that are permitted under Parts 422 and 423, offered by a VBID PBP to the extent any benefits provided under the VBID Model are impacted.
2. Any change in circumstances which would constitute a material change to a fact or representation made in MA Organization's Approved Proposal. This includes not being able to implement or provide one or more of the benefits or RI Programs offered under the VBID Model.
3. Changes in the composition of a high-value provider network available as part of the VBID Model, as described in Article 3(D).
4. Such changes must be provided to CMS prior to the beginning of the 2023 Plan Year in accordance with process and timeline outlined in the Model Communications and Marketing Guidelines.

I. RELEASE OF INFORMATION

1. MA Organization shall obtain prior approval from CMS during the term of this Addendum and for six months thereafter for the publication or release of any press release, external report or statistical/analytical material or other similar material that references MA Organization's participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. When reviewing these materials, CMS intends to disapprove only those materials containing material misstatements of fact or conclusions based on improper methodology or inaccurate data, or that are inconsistent with the implementation of the VBID Model or other applicable laws, regulations or CMS instructions. CMS will make reasonable efforts to complete its review expeditiously. Any material describing MA Organization's participation in the VBID Model that is submitted to CMS for prior approval that is not disapproved in writing by CMS, or where CMS has requested additional time to review, within 30 calendar days after receipt by CMS will be deemed approved.

2. MA Organization agrees to include the following statement on the first page of all external reports and statistical/analytical material that are subject to this Article 3(I): "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

J. NON-DISCRIMINATION

MA Organization shall comply with all applicable law, including Section 1852(b)(1) of the Act, concerning discrimination against enrollees.

Article IV
Additional Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

MA Organization shall maintain books, records, documents, and other evidence relating to the VBID Model for a period of 10 (ten) years from the expiration or termination of this Addendum or from the date of completion of any Model-related monitoring, auditing, and evaluation, whichever is later. MA Organization shall provide access in accordance with the record retention provisions of the Underlying Contract.

B. DATA REPORTING AND COOPERATION WITH MONITORING AND EVALUATION

1. MA Organization shall cooperate with CMS's efforts to evaluate the effectiveness of each VBID Component implemented by MA Organization and shall participate in all VBID Model monitoring, auditing, evaluation, and learning and diffusion activities, excluding the Voluntary Health Equity Incubation Program. MA Organization may elect to participate in the Voluntary Health Equity Incubation Program.

2. CMS will issue Model Monitoring Guidelines, which will be designed to allow CMS to collect the necessary data to monitor the real-time impact of the Model and to perform the requisite model evaluation. Model Monitoring Guidelines will include instructions regarding the collection and reporting of data regarding the MA Organization's participation in the VBID Model.

3. MA Organization shall comply with the Model Monitoring Guidelines.

4. MA Organization shall comply with Model Technical and Operational Guidance, including but not limited to the reporting of Part D Prescription Drug Event (PDE) data and the calculation, application, and reporting of the Low Income Cost-Sharing Subsidy (LICS) with respect to Additional Benefits as applicable, including Part D Cost Sharing Reductions Based on SES.

Article V
Termination of Addendum or MA plan(s) Participation by CMS

A. CMS may terminate MA Organization's participation in the VBID Model, or terminate a particular MA plan from the VBID Model at any time, with or without advance notice if:

1. CMS terminates the VBID Model pursuant to Section 1115A(b)(3)(B) of the Act or otherwise;

2. CMS determines that MA Organization or a particular MA plan or its subcontractors and/or downstream entities (as defined at 42 CFR § 422.2):

a. Has failed to comply with any term of this Addendum or documents incorporated herein;

b. Has carried out this Addendum in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Parts 417, 422 or 423 or Section 1115A of the Act;

c. Has failed to continually meet the applicable MA Organization eligibility conditions, or does not have an exception to one or more eligibility conditions, of the VBID Model;

d. Has failed to implement or fully comply with the terms of a corrective action plan or an intermediate sanction imposed by CMS;

e. Has taken an action that threatens the health or safety of a beneficiary, or MA Organization's participation in the VBID Model is resulting in lower quality of care or any other adverse outcomes for beneficiaries;

f. Has submitted false data or made false representations, warranties, or certifications in connection with any aspect of the VBID Model;

g. Is subject to sanctions or other enforcement or corrective actions of an accrediting organization or federal, state or local government agency;

h. Is subject to investigation or action by HHS (including HHS-OIG and CMS) or the Department of Justice due to an allegation of fraud or significant misconduct, including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, being named as a defendant in a False Claims Act qui tam matter in which the government has intervened or similar action;

i. Assigns or purports to assign any of the rights or obligations under this Contract and Addendum voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or any other manner, without the prior written consent of CMS;

j. Experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists;

k. Has committed any act that would be cause for termination of the Underlying Contract or imposition of any penalty or sanction thereunder, regardless of whether such termination, penalty or sanction is actually imposed by CMS; or

l. Has engaged in prohibited discrimination against a Medicare beneficiary.

B. Prior to terminating MA Organization or a particular MA Plan pursuant to Section A of this Article, CMS may afford MA Organization an opportunity to develop and implement a corrective action plan acceptable to CMS to correct deficiencies in accordance with the procedures of 42 CFR § 422.510(c)(1).

C. In addition to any sanction or penalty authorized under 42 CFR §§ 422.750 and 423.750, CMS may rescind or make inapplicable on a prospective basis one or more waivers provided to MA Organization, or limit the benefits offered under the VBID Model that may be offered by MA Organization if CMS determines that an event identified in Paragraph A(2) of this Article has occurred.

Article VI
Termination and Surviving Obligations

A. As the term of this Addendum is from the Start Date through the 2023 Plan Year, if MA Organization does not wish for one or more of its VBID PBPs to participate in the VBID Model for the subsequent Plan Year, it must notify CMS in writing by the first Monday in June that precedes the start of that Plan Year.

B. If MA Organization does not wish to continue participation in the VBID Model for one or more MA plans, MA Organization shall notify each Targeted Enrollee who is eligible for benefits provided under the VBID Model. Such notice must be in writing and must inform the enrollee of any changes to their benefits for the next Plan Year. MA Organization must comply with the Model Communications and Marketing Guidelines to notify Targeted Enrollees of the change to benefits to be effective January 1 of the upcoming Plan Year. MA Organization shall submit to CMS the notification to enrollees for changing VBID Components in accordance with the Model Communications and Marketing Guidelines.

C. MA Organization shall ensure the timely transfer of any data or files to CMS necessary for evaluation, transition or close-out of MA Organization's model-related activities, and shall comply with all other CMS-specified close-out procedures and related Model Technical and Operational Guidance.

D. Upon any termination of this Addendum (other than pursuant to Article 5), MA Organization shall continue to provide coverage for items and services other than benefits that were offered under the VBID Model consistent with applicable law and the Underlying Contract as if this Addendum had never been executed. CMS may require MA Organization to make appropriate adjustment to its bid submission for a contract year to account for the absence of benefits that were offered under the VBID Model.

E. Termination of this Addendum by either party shall not affect the rights and obligations of the parties accrued prior to the effective date of the termination or expiration of this Addendum. The rights and duties set forth in this Article, Article 4, and Article 11 shall survive the termination or expiration of this Addendum. The termination of this Addendum does not relieve either party of any claims against it that arise under this Addendum before the Addendum is terminated, including the remedies of Article 5(B).

Article VII
Amendment

A. This Addendum may be amended at any time by written mutual consent.

B. CMS may amend this Addendum without the consent of MA Organization for good cause or as necessary to comply with applicable federal or state law, regulatory requirements, or accreditation standards. To the extent practicable, CMS shall provide MA Organization with 30 calendar days advance written notice of any such unilateral amendment, which notice shall specify the amendment's effective date. If MA Organization does not wish to be bound by the unilateral amendment, it may terminate this Addendum by providing CMS with 30 days advance written notice.

Article VIII
Order of Precedence & Relationship to Other Agreements

A. This Addendum does not supersede or modify Sections 1851 through 1859, and Sections 1860D-1 through 1860D-43 of the Act, or 42 CFR, Parts 422 or 423, except as specifically waived in Appendix 1 of this Addendum.

B. This Addendum specifies additional rights and obligations of the parties with respect to the VBID Model and does not relieve the parties from, or modify any rights and obligations with respect to, the operation of an MA coordinated care plan (and, if applicable, a Part D prescription drug plan as part of an MA-PD plan) in general or pursuant to the Underlying Contract.

C. If MA Organization also has an agreement to participate in the Part D Senior Savings Model (PDSS Model) and has proposed to offer rewards and incentives associated with the Part D benefit under such other model, the following additional requirements apply to MA Organization under this Model.

1. MA Organization shall not conduct an RI Program in a Model PBP that conditions eligibility for a reward or incentive on the Targeted Enrollee completing the same healthcare activity (or service) that the enrollee must complete for a reward or incentive to be available to that enrollee under this Model or the PDSS Model. Upon request, MA Organization shall provide documentation and data related to compliance with this requirement.
2. MA Organization shall limit the provision of rewards and incentives to each Targeted Enrollee to a maximum annual aggregate amount of $600.00 for all rewards and incentives under this Model and the PDSS Model and shall include the per unit value of each reward and incentive it offers to a Targeted Enrollee under the PDSS Model when determining whether a reward or incentive provided to such Targeted Enrollee would exceed the annual aggregate cap on the total value of rewards and incentives that MA Organization can provide to a Targeted Enrollee under this Model. Upon request, MA Organization shall provide documentation and data related to compliance with these requirements.

D. In the event of any conflict among the documents or other requirements that might govern the conduct of CMS and MA Organization in their administration of or participation in the VBID Model, such that MA Organization cannot comply with all documents and requirements, the order of priority to interpret the obligations of the parties shall be as follows:

1. This Addendum including Appendices;
2. The Underlying Contract to which this Addendum is attached, and other addenda;
3. Any Model Technical and Operational Guidance issued by CMS, including but not limited to guidance on communications or data collection; and
4. MA Organization's Approved Proposal.

E. The termination of this Addendum by either party shall not, by itself, relieve the parties from their obligations under the Underlying Contract and its other addenda, if any.

Article IX
Attestation of Compliance

MA Organization hereby attests that:

A. The VBID Components identified in each VBID PBP in the Health Plan Management System (HPMS) are consistent with the benefits detailed in MA Organization's Approved Proposal

B. Each bid pricing tool (BPT) submitted for each VBID PBP has been completed in a manner consistent with the actuarial assumptions and projections contained in the actuarial component of MA Organization's Approved Proposal and take into account all costs associated with MA Organization's implementation of the Approved Proposal as required in this Addendum.

C. MA Organization has not made changes to a VBID Model-participating PBP's benefit structure, formulary, network, or otherwise that discriminate against enrollees in the MA plan who are not eligible for benefits under the VBID Model.

Article X
Appeals and Limitation on Review

A. There is no administrative or judicial review under Sections 1869 or 1878 of the Act or otherwise for the following:

1. The selection of MA organizations or MA plans to participate in the VBID Model, including the decision by CMS to terminate this Addendum or to direct the termination of any plan's participation in the VBID Model;
2. The elements, parameters, scope, and duration of the VBID Model;
3. Determinations regarding budget neutrality under Section 1115A(b)(3);
4. The termination or modification of the design and implementation of a model under Section 1115A(b)(3)(B); or
5. Decisions about expansion of the duration and scope of a model under Section 1115A(c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

B. MA Organization may dispute such matters for which review is not precluded in accordance with the procedures of 42 CFR Part 422, Subpart N or § 422.756, as appropriate.

Article XI
Severability

In the event that one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Addendum, and this Addendum shall be construed as if such invalid, illegal or unenforceable provisions had never been contained herein, unless the deletion of such provision or provisions would result in such a material change so as to cause completion of the transactions contemplated herein to be unreasonable.

Article XII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this Addendum shall have the meaning given such terms in the Underlying Contract, or 42 CFR Parts 422 or 423, as applicable.

B. NOTICES

All notifications required under this Addendum shall be submitted by MA Organization to CMS by electronic mail to VBID@cms.hhs.gov, and by CMS to MA Organization by electronic mail to the person designated in the Approved Application Proposal as MA Organization's primary point of contact, or via a Health Plan Management System broadcast email.

C. COMPLIANCE WITH LAWS

1. MA Organization shall comply with the applicable terms of this Addendum, the Underlying Contract and all applicable statutes, regulations, and guidance, including without limitation (a) federal criminal laws; (b) the federal False Claims Act (31 U.S.C. § 3729 et seq.); (c) the federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)); (d) the federal civil monetary penalties law (42 U.S.C. § 1320a-7a); (e) the federal physician self-referral law (42 U.S.C. § 1395nn); and (f) applicable State laws.

2. This Addendum does not provide any waivers of the fraud and abuse laws. MA Organization must comply with all applicable fraud and abuse laws, except as such laws may be waived pursuant to Section 1115A(d)(1) of the Act specifically for the VBID Model.

D. STAR RATINGS

CMS may adjust the rules for calculating the Star Ratings for MA organizations participating in the VBID Model to protect against a statistically significant negative impact to the Part C or Part D Star Ratings for MA organizations that are not participating in the Model when the impact is directly attributable to participation in the Model.

In witness whereof, the parties hereby execute this contract. This document has been electronically signed by:

FOR MA ORGANIZATION

Juan Serrano

Contracting Official Name

9/9/2022 2:58:03 PM

Date

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número

TRIPLE S ADVANTAGE, INC.

Organization

PO Box 11320
San Juan, PR 00922

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/22/2022 10:52:58 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

<AMY LARRICK CHAVEZ-VALDEZ ESIG>

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

Not Available

Date

<ARRAH TABE-BEDWARD ESIG>

Arrah Tabe-Bedward
Deputy Director
Center for Medicare and
Medicaid Innovation

<DATE STAMP>

Date

Appendix 1: Program Waivers
Appendix 2: Rewards and Incentives Programs
Appendix 3: Hospice Benefit Component
Appendix 4: HIPAA-Covered Data Disclosure Request Form

Appendix 1:
Program Waivers

A. Pursuant to Section 1115A(d)(1) of the Act, in its sole discretion, CMS waives the following requirements for MA Organization participating in the VBID Model only to the extent necessary to implement MA Organization's Approved Proposal in accordance with the Addendum. CMS may modify or rescind any or all of these waivers at any time, in its sole discretion.

1. Uniformity and Accessibility of Benefits and Cost Sharing: Targeted Enrollees shall be identified as described in Article 3 of the Addendum. The following are waived to the extent necessary to permit MA organizations to offer certain benefits and reduced or eliminated cost sharing to Targeted Enrollees, rather than to all enrollees in the MA plan(s) participating in the VBID Model, subject to the terms of the Model:

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 U.S.C §§ 1395w-22(d)(1)(A) and 1395w-24(c)]; 42 CFR §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2),

b. 422.254(b)(2), 422.262(c)(1);

c. Section 1860D-2(a) of the Act [42 USC § 1395w-102(a)]; and

d. 42 CFR §§ 423.104(b)(2), 423.265(c).

2. Provision of Non-Primarily Health Related Supplemental Benefits: Targeted Enrollees shall be identified as described in Article 3. of the Addendum. Non-primarily health related supplemental benefits must have a reasonable expectation of improving or maintaining the health or overall function of the Targeted Enrollee with regard to the chronic health condition or socioeconomic status of the Targeted Enrollee population. The following are waived to the extent necessary to allow MA organizations to offer to certain Targeted Enrollees (who do not meet the definition "chronically ill enrollee" in Section 1852(a)(3)(D) of the Act or 42 CFR 422.102(f)(1)(ii)) additional "non-primarily health related" supplemental benefits the terms of the Model:

a. Section 1852(a)(3)(D)(i), (ii)(I), and (iii) of the Act [42 U.S.C. § 1395w– 22(a)(3)(D)(i), (ii)(I), and (iii)];

b. 42 CFR 422.100(c)(2)(ii)(A) and 422.102(f)(2)(i), (ii), and (iii).

3. Increased Flexibility for Rewards and Incentives: The following are waived to the extent necessary to allow participating MA organizations to offer RI Programs, subject to the terms of the Model, that: are available only to Targeted Enrollees, as identified in Article 3, and Appendix 2; are based on the anticipated benefit (rather than the value) of the associated healthcare item or service; are subject to an annual limit of $600.00 per enrollee for all rewards received by the enrollee; are available before the entire activity has been completed; or are permitted in connection with Part D benefits:

a. 42 CFR §§ 422.134(b) as a whole, and 422.134(c)(1)(iv), (c)(1)(v), and (d)(1)(i) to the extent the availability and eligibility for rewards and incentives is broader than permitted in the Model; and

b. 42 CFR § 422.134(c)(2)(i), related to RI associated with Part D benefits;

c. 42 CFR § 422.134(d)(2)(ii), related to the prohibition on offering a reward that has a value that exceeds the value of the target activity; and

d. d. 42 CFR § 422.134(g)(1), related to the offering of RI to Targeted Enrollees.

4. Stars Ratings for MA Organizations Participating in the VBID Model: The following may be waived to the extent necessary to permit CMS to adjust the rules for calculating the Star Ratings for MA organizations participating in the VBID Model and protect against a statistically significant negative impact to the Part C or Part D Star Ratings for MA organizations that are not participating in the Model when the impact is directly attributable to participation in the Model:

a. 42 CFR 422.162 through 422.166 (Part C Star Ratings for participating MA organizations); and

b. 42 CFR 423.182 through 423.186 (Part D Star Ratings for participating MA-PDs).

5. Part D: The following are waived to the extent necessary for participating MA organizations that are not otherwise authorized to offer Part D supplemental benefits to offer cost sharing reductions consistent with the terms of the Model, and for participating MA organizations to include as administrative costs in the Part D portion of their bids the value of the reduction in the statutory maximum cost sharing for a targeted LIS enrollee and to report such amounts on PDE data consistent with CMS instructions in VBID Model Technical and Operational Guidance:

a. 42 CFR 423.104; and

b. Part 423, Subparts F and G.

B. The waivers in paragraph A above, and the waivers included in Appendix 3 (Hospice Benefit Component), are (1) each contingent on compliance with the terms and conditions of this Addendum and documents incorporated therein; (2) granted only to the extent necessary to implement MA Organization's Approved Proposal and Participation in the Model; (3) granted only to MA Organization as to those MA PBPs (or MA plans) for which CMS has approved a Proposal; and (4) granted only for the term of this Addendum.

Appendix 2:
Rewards and Incentives Programs

MA Organization may, subject to certain conditions and CMS approval, provide a RI Program to Targeted Enrollees. MA Organization shall implement any RI Program under the VBID Model during the term of the Addendum in accordance with the terms of this Addendum, this Appendix 2, and the Approved Proposal.

A. RI Programs:

1. If MA Organization is implementing a Part C RI Program and/or Part D RI Program under the Model, the parties acknowledge that MA Organization has submitted as part of its application for participation in the VBID Model, a proposal to offer one or more RI Programs to Targeted Enrollees.

2. MA Organization shall identify Targeted Enrollees for a Part C RI Program and/or Part D RI Program under the Model without discrimination and using objective criteria that comply with the terms of the Addendum, including this Appendix 2 and are specified in the Approved Proposal or are otherwise approved in writing, in advance by CMS. Such objective criteria must identify either (i) all enrollees or (ii) a subset of enrollees who would receive the greatest health care value from receiving the benefits or participating in the activities associated with a particular reward or incentive in the Part C RI Program and/or Part D RI Program

3. The parties acknowledge that that the Approved Proposal contains the following:

a. The list of Model PBPs in which the Part C and/or D RI Programs will be implemented.

b. The nature and scope of each RI Program, including the criteria for identifying Targeted Enrollees, and the beneficiary engagement methodology;

c. The eligibility criteria that must be met for an individual Targeted Enrollee to qualify to receive the reward or incentive, including the associated healthcare activity that must be completed for the reward or incentive to be available, and, if eligibility includes an adherence metric, the specific criteria for measuring adherence and the evidence base to support the clinical appropriateness of the adherence criteria;

d. The type and per unit value of each reward and incentive and the method for providing the reward or incentive to eligible Targeted Enrollees.

e. The maximum number and frequency of the reward or incentive that may be obtained by a Targeted Enrollee for participation in an RI Program.

f. The evidence base and theory of change used to develop the reward or incentive and the intended goals of the RI Program.

4. MA Organization may implement a RI Program that is specific to participation in a disease management program, transition of care program, or similar programs that are evidence-based and approved by CMS.

5. MA Organization shall:

a. Provide the rewards and incentives only to eligible Targeted Enrollees and only in accordance with the Approved Proposal and this Addendum.

b. Comply with the standards for reward programs in 42 CFR § 422.134 and as outlined in Chapter 4, Sections 100 through 100.6 of the Medicare Managed Care Manual (posted at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf), issued and effective 04-22-2016, for both its Part C RI Program and its Part D RI Program, except as waived or otherwise modified in the Addendum, Appendix 1, or this Appendix 2;

c. Not provide any reward or incentive if its value exceeds the value of the expected impact on enrollee behavior or the expected benefit of the health-related service or activity on which receipt of the reward or incentive is based, except that (notwithstanding 42 CFR § 422.134(d)(2)(ii) the value of the individual reward or incentive may exceed the cost of the health-related service or activity itself, so long as the cost of the health-related service or activity is equal to or less than the expected benefit of the health-related service or activity on which receipt of the incentive or reward is based;

d. Limit the provision of rewards and incentives to each Targeted Enrollee to a maximum annual aggregate amount of $600.00 for all rewards and incentives, in this Model and the PDSS Model, and include the per unit value of each reward and incentive it furnishes to a Targeted Enrollee under the PDSS Model when determining whether a reward or incentive to such Targeted Enrollee would exceed the annual aggregate amount on the total value of rewards and incentives that MA Organization can provide to a Targeted Enrollee under this Model;

e. Ensure that rewards or incentives are tangible items that align with the purpose of the RI Program and that must directly benefit the Targeted Enrollee;

f. Furnish an earned reward or incentive by the end of the Plan Year; Model RI programs may allow the enrollee to carry over any unspent value of rewards or incentives from one plan year to the next for the enrollee's use, but MA Organization must not require additional actions by the enrollee in the next plan year to receive that reward or incentive; and

g. Not provide a reward or incentive under any RI Program operated under this Model to a Targeted Enrollee in connection with the same healthcare activity or service

that the Targeted Enrollee completed to be eligible for any reward or incentive under the PDSS Model.

6. MA Organization shall not:

a. Provide a RI in connection with the Part D benefit to a Medicare beneficiary who is not enrolled in a Model PBP, except as permitted by 42 CFR § 423.128(d)(3);

b. Provide RI in the form of cash, cash equivalents, or other monetary rebates or in the form of decreased cost-sharing or plan premiums;

c. Provide RI that can be used for gambling or the purchase of alcohol, tobacco, or firearms;

d. Use an RI Program largely to market a PBP or encourage beneficiaries to remain with a specific plan;

e. Use an RI Program to, in any way, choose or solicit enrollees based on health status

f. Create an RI Program that discriminates against enrollees based on race, national origin, limited English proficiency, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, frailty status, health status, or other prohibited basis; or

g. Use an RI Program that allows RI to be won based on probability or that does not meet the standards described in 42 CFR § 422.134(d), excluding § 422.134(d)(2)(ii).

B. Part C RI Programs

Except to the extent that certain provisions are identified as waived in Appendix 1, MA Organization shall comply with 42 CFR § 422.134 in connection with its Part C RI Program. Notwithstanding any other provision of this Addendum or its appendices, MA Organization shall comply with all relevant fraud and abuse laws, including the anti-kickback statute and civil money penalty prohibiting inducements to beneficiaries, except as explicitly provided in any separately documented waiver issued pursuant to Section 1115A(d)(1) specifically for the VBID Model. Any such waiver will apply solely to the VBID Model and may differ in scope or design from waivers granted for other programs and models.

C. Part D RI Program Requirements

1. MA Organization shall implement a Part D RI Program only in connection with a PBP for which MA Organization has executed a Part D Addendum such that the PBP is an MA-PD plan.

2. Except to the extent that certain provisions are identified as waived in Appendix 1, MA Organization shall implement any Part D RI Program in compliance with the terms of 42 CFR § 422.134 (as if such regulation applied to Part D plans). Notwithstanding any other provision of this Addendum or its appendices, MA Organization shall comply with all relevant fraud and abuse laws, including the anti-kickback statute and civil money penalty prohibiting inducements to beneficiaries, except as explicitly provided in any separately documented waiver issued pursuant to Section 1115A(d)(1) of the Act specifically for the VBID Model. Any such waiver will apply solely to the VBID Model and may differ in scope or design from waivers granted for other programs and models.

3. If MA Organization offers a Part D RI Program, the rewards and incentives in any such Part D RI Program must be furnished to reward or incent one of the following:

a. Participation in a MA plan medication therapy management program **(MTMP)**;

b. Participation in receipt of covered Part D vaccines and other drug therapies that focus on preventive health;

c. Participation in a program that allows enrollees to better understand their Part D plan benefit, costs, and therapeutic-equivalent coverage alternatives, including biosimilars and generics; and/or

d. Participation in a program designed for enrollees who have specific conditions or enrollees who would otherwise benefit from participation in disease state management programs.

4. In offering any reward or incentive for participation in an MTMP, MA Organization shall comply with existing CMS requirements for MTMPs, as set forth 42 CFR § 423.153.

5. In offering any reward or incentive for participation in preventive health services, MA Organization may design a program with the overall goal of improving medication adherence; however, MA Organization shall not condition any RI in such RI Program on clinical outcomes, and shall not furnish any such reward or incentive solely for a service that is not clinically indicated for the enrollee.

6. In offering any Part D RI, MA Organization shall reasonably establish value for the successful medication adherence or formulary compliance for which they offer rewards and incentives.

7. In implementing and operating its Part D RI Program, the MA Organization shall not:

a. Use prescription fills or adherence as the sole basis for providing a reward or incentive.

b. Incentivize enrollees to use mail service pharmacies, preferred pharmacies or any other specific network providers.

c. Structure a Part D RI Program to discourage clinically indicated medication use, or otherwise reward enrollees not taking any, or taking few, Part D covered drugs or vaccines.

d. Identify Targeted Enrollees based on the identity of their pharmacy provider.

e. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a drug manufacturer. This includes, but is not limited to, the use of personnel affiliated with a drug manufacturer, manufacturer-financed coupons or discounts provided to a beneficiary, or manufacturer supplied education materials.

f. Receive or use funding, in-kind resources, or any kind of remuneration provided directly or indirectly by a pharmacy or entity that owns or operates pharmacies. This includes use of personnel affiliated with a pharmacy, pharmacy-financed coupons or other discounts provided to a beneficiary, or pharmacy supplied education materials.

D. Record Retention

1. In accordance with Article 4 of this Addendum (Additional Record Retention and Reporting Requirements), MA Organization shall maintain the following records regarding all RI Programs under this Model (and may be required to report such records):

a. The identity of each Targeted Enrollee and the total number of Targeted Enrollees;

b. The identity of each enrollee who received a reward or incentive, and the total number of enrollees who received a reward and/or incentive;

c. Information regarding which Part C RI Program, Part D RI Program, or both, that enabled the enrollee to receive the reward or incentive;

d. The nature and date(s) of the activities or other conduct engaged in by the enrollee and clinical information about the enrollee that enabled the enrollee to qualify for the reward or incentive;

e. The nature and amount of the reward or incentive received by the enrollee;

f. The cost of the healthcare activities or services with which eligibility for a reward or incentive is associated, the value of the expected impact on enrollee behavior, and the value of the expected benefit of such healthcare activities and services;

g. Any trends over time in the number of Targeted Enrollees in the RI Program, or the number of enrollees who received a reward and/or incentive; and

h. Any evaluations done by MA Organization to assess the effectiveness of the RI Program.

2. MA Organization shall submit semi-annual reports to CMS, in a form and manner and by a deadline specified by CMS, regarding its implementation of any Part C RI Program or Part D RI Program. MA Organization shall provide CMS with supplemental information upon request regarding its implementation of any Part C RI Program or Part D RI Program.

E. Compliance and Enforcement

1. MA Organization shall have in place a protocol for monitoring the implementation and administration of each approved Part C RI Program and Part D RI Program. MA Organization shall make this protocol available to CMS upon request.

2. In accordance with Article 5 of the Addendum (Termination of Addendum or MA Plan(s) Participation by CMS), CMS may terminate or suspend MA Organization's implementation of any Part C RI Program or Part D RI Program, or take other remedial action, if -

a. MA Organization fails to comply with the terms and conditions of the Addendum or this Appendix 2; or

b. CMS determines that MA Organization's implementation of such a program might compromise the integrity of the Model.

3. If CMS determines that MA Organization has failed to comply with the terms of Article 3(D) of the Addendum or this Appendix 2, CMS may prohibit MA Organization from participating in the VBID Component regarding RI Programs, regardless of whether MA Organization has corrected or otherwise resolved the noncompliance.

Appendix 3:
Hospice Benefit Component

MA Organization may, subject to the terms and conditions of the VBID Model and this Addendum and Appendix 3 and CMS's approval of its Proposal, cover the Medicare hospice benefit as part of the participating PBP's benefits in combination with offering Palliative Care outside the hospice benefit for enrollees with serious illness, and providing individualized Transitional Concurrent Care during a hospice benefit period, described in Section 1812(a)(4) and (d) of the Act. MA Organization shall implement the Hospice Benefit Component under the VBID Model during the term of the Addendum only in accordance with the terms of this Addendum, including this Appendix 3, and the Approved Proposal.

MA Organization must comply with all applicable laws and regulations governing the Medicare hospice benefit, except those laws and regulations that are waived pursuant to Section 1115A(d)(1) of the Act specifically for the Model as identified in Appendix 1 and this Appendix 3.

A. Hospice Benefit Component Definitions

"Additional Hospice Benefits" means benefits offered by MA Organization, including additional items, services and reductions in cost sharing, that are targeted to enrollees based on Hospice Election and may be further targeted to those Hospice Enrollees who choose an in-network Hospice Provider AND/OR on the basis of (i) one or more chronic health conditions, (ii) socioeconomic status, or (iii) a combination of both chronic health condition(s) and socioeconomic status. Additional Hospice Benefits includes reductions in Part D cost sharing under Defined Standard plans, which are also referred to as "Part D Cost Sharing Reductions Based on SES" that are targeted to enrollees based on Hospice election.

"Business Associate" ("BA") has the meaning provided at 45 CFR § 160.103.

"Covered Entity" ("CE") has the meaning provided at 45 CFR § 160.103.

"Health Care Operations" has the meaning provided at 45 CFR § 164.501.

"Hospice Care" means a comprehensive set of items and services (described at Section 1861(dd)(1) of the Act) that are identified and coordinated by an interdisciplinary care team to provide for the physical, psychosocial, spiritual, and emotional needs of a Terminally Ill (as defined below) patient and/or family members, as delineated in a specific patient plan of care (42 CFR § 418.3). These items and services include core and non-core services. With the exception of physician services, substantially all core services must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. Core services (42 CFR § 418.64) include physician, nursing, medical social services, counseling, bereavement, and spiritual services. Nursing services, physician services, and drugs and biologicals must be made routinely available on a 24-hour basis seven days per week. In addition to the hospice core services, the following services must be provided by a Hospice Provider, either directly or under arrangements with other providers, to meet the needs of the patient and family as part of non-core services: Physical and occupational therapy and speech-language pathology services; hospice aide services; homemaker services; volunteers; medical supplies (including drugs and biologicals) and use of medical appliances related to the terminal illness and related conditions; and short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management (42 CFR §§ 418.70-418.78; 418.100)).

"Hospice Election" means the voluntary decision made by eligible individuals in accordance with 42 CFR § 418.24 (as amended from time to time) to receive Hospice Care.

"Hospice Enrollee" means an enrollee who meets the statutory definition of "terminally ill" as defined below, and has voluntarily elected to receive Hospice Care through a Hospice Election.

"Hospice Provider" means a public agency or private organization or subdivision of either of these that is primarily engaged in providing Hospice Care in accordance with 42 CFR §418.3; MA Organization may only provide hospice services through a Hospice Provider that has a participation agreement with Medicare and meets the applicable requirements of title XVIII and part A of title XI of the Social Security Act, in accordance with 42 CFR 422.204(b)(3).

"Mature-Year PBP" means a plan benefit package that (i) is participating in the Hospice Benefit Component for the second or third year in CY 2023 and has largely maintained its service area from its most recent year of participation in the model or (ii) has been determined to be a Mature-Year PBP through a process identified in Model Technical and Operational Guidance.

"Palliative Care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice (42 CFR § 418.3).

"Targeted Hospice Enrollee" means a Medicare beneficiary who is enrolled in one of MA Organization's VBID PBPs participating in the Hospice Benefit Component and targeted by MA Organization to receive Additional Hospice Benefits. The standards and criteria used by the MA Organization to identify Targeted Hospice Enrollees must be one or more of the criteria specified in Article 3(D) of the Addendum and identified in the Approved Proposal.

"Terminally Ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course (42 CFR § 418.3).

"Transitional Concurrent Care" means clinically appropriate continuing care needs related to the treatment of Hospice Enrollees' terminal conditions.

B. Hospice Benefit Component Structure and Content

1. With regard to an MA organization that is implementing the Hospice Benefit Component under the Model pursuant to the Addendum, the parties acknowledge that MA Organization has submitted as part of its application for participation in the VBID Model, a proposal to offer the Hospice Benefit Component and that CMS has approved that proposal.

2. Provision of the Full Scope of Medicare Hospice Benefits.

MA Organization shall:

a. Provide the full scope of Hospice Care, as set forth in Section 1861(dd) of the Act and all implementing regulations at 42 CFR Part 418 to all Hospice Enrollees in VBID PBPs participating in the Hospice Benefit Component;

b. Provide Hospice Care in accordance with each enrollee's choice to elect or revoke the hospice benefit in accordance with Section 1812(d) of the Act and 42 CFR §§ 418.24 and 418.28; and

c. Treat Hospice Care as a basic benefit for purposes of compliance with regulations in 42 CFR Part 422, except for regulations that have been waived.

3. Palliative Care Strategy.

MA Organization shall:

a. Consistent with the Approved Proposal, develop and implement a strategy regarding access to and delivery of Palliative Care for enrollees with serious illness who are either not eligible for or who have chosen not to (or not yet chosen to) receive hospice services.

b. In accordance with the Model Monitoring Guidelines, identify to CMS any costs related to the provision of Palliative Care that are in the basic bid.

4. Transitional Concurrent Care Strategy.

MA Organization shall:

a. Consistent with the Approved Proposal, develop and implement a strategy for the provision of Transitional Concurrent Care only by in-network Hospice Providers and other in-network providers that is clinically appropriate and reflective of Hospice Enrollees' and caregivers' needs as identified in the plan and goals of care and does not duplicate the services covered in the Medicare hospice benefit.

b. In accordance with the Model Monitoring Guidelines, MA Organization shall report to CMS the costs related to the provision of Transitional Concurrent Care during the Plan Year and a comparison of actual experienced costs to the costs projected in the Approved Proposal.

5. Coverage of Hospice Care Furnished by In-Network and Out-of-Network Providers

a. MA Organization must provide access to a network of high-quality Hospice Providers that are certified by Medicare to provide hospice care. MA Organization must cover all Hospice Care furnished by either in-network Hospice Providers or out-of-network (non-contracted) Hospice Providers to a Hospice Enrollee who is enrolled

in the VBID PBP that is participating in the Hospice Benefit Component.

b. In ensuring beneficiary access to a network of Hospice Providers, MA Organization shall:

i. Offer access to in-network Hospice Providers, by contracting with at least one Hospice Provider for the service area regardless of whether MA Organization has a Mature-Year PBP, as well as covering Hospice Care furnished by out-of-network Hospice Providers. Where there are no existing contractual arrangements between a participating MA Organization and a Hospice Provider in the service area, MA Organization must reach out to local Hospice Providers to discuss the Model and billing processes to minimize confusion and maximize efficiencies, even if the parties do not ultimately contract with each other.

ii. Provide clinically appropriate pre-hospice consultation services to enrollees consistent with the Approved Proposal. In implementing any type of pre-hospice consultation service, such services must be provided by specially trained staff who are accessible by phone and other means available 365 days a year, 24 hours a day, and 7 days a week. Specially trained staff must provide information to aid in enrollees' understanding of their care choices (including Hospice Care, Palliative Care, Transitional Concurrent Care, and Additional Hospice Benefits) and Hospice Provider options in a way that is clear, immediately available, culturally competent, and knowledgeable about the Hospice Benefit Component. The pre-hospice consultation services must be optional for enrollees to use and cannot be required as a condition for accessing Hospice Care.

iii. For Hospice Enrollees that utilize an out-of-network Hospice Provider, cover Hospice Care provided by the out-of-network Hospice Provider and make payments at the same amount that the Hospice Provider would receive from Original Medicare for Hospice Care. MA Organization shall ensure that Hospice Enrollees are not balanced billed.

iv. Clearly and explicitly inform the Hospice Enrollee that payments for covered Hospice Care will be made by MA Organization to out-of-network Hospice Providers that have participation agreements with Medicare.

v. Clearly and explicitly inform the Hospice Enrollee regarding any difference in out-of-pocket costs, Transitional Concurrent Care, or Additional Hospice Benefits associated with using an out-of-network rather than in-network Hospice Provider.

vi. Make timely and reasonable payments for covered Hospice Care provided by a Hospice Provider that does not contract with MA Organization in accordance with 42 CFR § 422.520.

vii. Count toward the maximum out-of-pocket (MOOP) limit (required pursuant to 42 CFR § 422.100(f) or 422.100(d), as applicable) those amounts for which the Hospice Enrollee is responsible for Hospice Care and other basic benefits (as defined in 42 CFR § 422.100(c)), regardless whether the items and services are also Palliative Care or Transitional Concurrent Care.

viii. Consistent with 42 CFR 422.105(a), treat any enrollee referral by an in-network Hospice Provider (even one who has not consulted with MA Organization about its policy for in-network referrals) to an out-of-network provider (non-hospice provider) as an in-network referral for purposes of determining enrollee cost sharing amounts if the member correctly identified himself or herself as a member of that plan to the contracted provider before receiving the covered item or service, unless the contracted provider can show that the enrollee was notified prior to receiving the item or service that the item or service is covered only if further action is taken by the enrollee.

ix. Comply with all unwaived requirements of 42 CFR Part 422, Subpart E, in connection with Hospice Providers.

c. If MA Organization chooses not to participate in a future year, MA Organization must continue to cover, through discharge or revocation from Hospice Care, disenrollment from the VBID PBP, or death, Hospice Care furnished to Hospice Enrollees whose Hospice Election started during the time in which the Hospice Enrollee was in a Hospice Benefit Component VBID PBP. If a Hospice Enrollee elects to change enrollment from the Hospice Benefit Component VBID PBP, MA Organization must continue providing payment for all services, including both hospice and non-hospice care, until the enrollee's coverage with the Hospice Benefit Component VBID PBP ends, which generally would be at the end of the month in which the enrollee made the enrollment change request.

6. In ensuring enrollee access to a network of Hospice Providers, MA Organization shall not:

a. Charge higher cost sharing for Hospice Care provided in-network or out-of-network than the cost sharing levels permitted under Medicare as set forth in Section 1813 of the Act (42 U.S.C. § 1395e).

b. Impose any additional coinsurance or deductibles, as compared to what an enrollee would pay if not enrolled in the Model, for Hospice Care furnished to Hospice Enrollees during the period of a Hospice Election, regardless of the setting of the services.

c. Require prior authorization or implement other utilization management protocols in connection with the coverage or provision of Hospice Care, unless approved by CMS.MA Organizations may implement appropriate program integrity safeguards, specifically prepayment or post payment review strategies, that align with policies described in Model Technical and Operational Guidance. Other prepayment or postpayment review strategies require prior written CMS approval.

7. If MA Organization has Mature-Year PBPs, MA Organization must have an adequate network of hospice providers. Specifically, adequacy of the Hospice Provider network will be evaluated as follows:

a. Minimum Number of Providers. MA Organization must have the minimum number, as identified by CMS consistent with Model Technical and Operational Guidance, issued before the execution of this Addendum, of Hospice Providers in network. CMS agrees to calculate the minimum number of providers and determine MA Organization's status as offering a Mature-Year PBP in accordance with such Model Technical and Operational Guidance. MA Organization must be in compliance with the minimum number of provider requirement by January 1, 2023 and throughout Plan Year 2023. MA Organization may submit an exception request regarding the requirement for a minimum number of providers, which will be evaluated and may be approved as described in Model Technical and Operational Guidance.

b. Comprehensive Strategy for Access. MA Organization must implement the comprehensive strategy for network access described in the Approved Proposal.

8. If MA Organization has Mature-Year PBPs, it is required to monitor and maintain an adequate network of Hospice Providers throughout Plan Year 2023, consistent with 42 CFR 422.112. In addition, MA Organization must:

a. Notify CMS of any Hospice Provider terminations that go beyond individual or limited provider terminations that occur during the routine course of plan operations; affect, or have the potential to affect, ten percent or more of MA Organization's Hospice Enrollees within a Mature-Year PBP; or would affect MA Organization's ability to meet the minimum number of providers criterion in any part of its service area(s).

b. Comply with 42 CFR 422.111(e) and make a good faith effort to provide written notice of a termination of a contracted Hospice Provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

9. Additional Hospice Benefits for Targeted Hospice Enrollees

a. The following may be permissible Additional Hospice Benefits:

i. additional items or services that meet the criteria for MA supplemental benefits in 42 CFR Part 422;

ii. reductions in cost sharing, which includes reduction in cost-sharing to zero, for covered or non-covered services, items, drugs (including Part D drugs provided outside Hospice Care) and biologicals that a Targeted Hospice Enrollee receives during the period of Hospice Care or following a discharge from Hospice Care; and

iii. additional non-primarily health related items or services that meet the requirements of 42 CFR § 422.102(f), except the provisions that have been waived, provided that the non-primarily health related items or services have a reasonable expectation of maintaining or slowing the progressive decline of the health or overall function of the enrollee

b. To the extent that the Approved Proposal involves the provision of Additional Hospice Benefits, MA Organization shall provide the Additional Hospice Benefits to Targeted Hospice Enrollees consistent with the Approved Proposal and as follows:

i. All Additional Hospice Benefits that are additional items and services must be provided as mandatory supplemental benefits in accordance with 42 CFR Part 422 and other applicable law subject to the waivers in Appendix 1.

ii. All Additional Hospice Benefits that are reductions in cost sharing for MA basic benefits (as defined in § 422.100(c)), reductions in cost sharing for Hospice Care or Transitional Concurrent Care, or reductions in cost sharing for MA supplemental benefits or additional items and services that are treated as mandatory supplemental benefits under the Addendum must be provided as mandatory supplemental benefits in accordance with 42 CFR Part 422 and other applicable law, subject to the waivers in Appendix 1.

iii. All Additional Hospice Benefits that are reductions in Part D cost sharing, including Part D Cost Sharing Reductions Based on SES must be provided as Part D supplemental benefits in accordance with 42 CFR Part 423 and other applicable law, subject to the waivers in Appendix 1.

iv. All Additional Hospice Benefits must be provided in accordance with the provisions in Article 3(D) of the Addendum.

c. To the extent that the Approved Proposal involves the provision of Additional Hospice Benefits, MA Organization must clearly identify the Additional Hospice Benefits in accordance with the Model Communications and Marketing Guidelines.

10. Quality Improvement Organization (QIO) Review of Terminations of Hospice Services.

a. A Hospice Enrollee whose hospice services have been terminated by either the Hospice Provider or MA Organization shall have the right to review of that termination of services by a QIO. A Hospice Enrollee who is dissatisfied with a QIO's expedited determination may request an expedited reconsideration by the QIO, applying the same standards described in 42 CFR § 422.626 for terminations of other provider services, consistent with Section B(10)(g) of this Appendix 3. MA Organization shall submit to and cooperate with these reviews of terminations of hospice services in the Hospice Benefit Component of the Model.

b. MA Organization agrees that its role and responsibilities in connection with the termination of hospice services for a Hospice Enrollee shall be subject to review by the QIO for the service area of the applicable participating PBP.

c. The provisions of 42 CFR § 405.1200, requiring certain notices from a hospice provider, have not been waived and continue to apply to a Hospice Enrollee's receipt of Hospice Care and the termination of hospice services by a Hospice Provider.

i. Termination of hospice services defined. In addition to the description at 42 CFR § 405.1200(a)(2), termination of hospice services includes the discharge of a Hospice Enrollee from covered Hospice Care or discontinuation of Hospice Care when the enrollee has been authorized by MA Organization, either directly or by delegation, to receive Hospice Care from a Hospice Provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end.

ii. Advance written notification of termination. Prior to any termination of hospice services and consistent with 42 CFR § 405.1200, the Hospice Provider must deliver valid advance written notice of any termination of Hospice Care to the Hospice Enrollee of MA Organization's or the Hospice Provider's decision to terminate Hospice Care.

iii. Financial liability for failure to deliver valid notice. MA Organization shall be financially liable for continued hospice services for the Hospice Enrollee if the Hospice Enrollee is not provided a valid notice of the termination of hospice services no later than two days before the proposed end of the hospice services. MA Organization is financially liable for continued services until 2 days after the Hospice Enrollee receives valid notice. MA Organization is not liable if the Hospice Enrollee agrees with the termination of hospice services earlier than 2 days after receiving the notice described in this Section B(10)(c).

d. MA Organization shall submit to, participate in, and cooperate with the review of the termination of hospice services for a Hospice Enrollee that is performed by the QIO.

i. When an enrollee fails to make a timely request to a QIO for the review of the termination of hospice services, MA Organization shall provide the option for an enrollee to request an expedited reconsideration by MA Organization using the process described in 42 CFR § 422.584. For purposes of this Model, the procedures specified in 42 CFR § 422.626(a)(2) and (3) shall be used and applied to untimely requests for QIO review of termination of hospice services for a Hospice Enrollee.

ii. When a QIO notifies MA Organization that a Hospice Enrollee has requested a fast-track review by the QIO of a termination of hospice services, MA Organization must send a detailed notice to the enrollee as soon as possible and no later than close of business of the day of the QIO's notification, consistent with and meeting the timing and content standards specified in 42 CFR § 422.626(e)(1) for reviews of terminations of other provider services, and notwithstanding the requirements that would otherwise apply under § 405.1202(f)(1). References to the "IRE" in § 422.626 shall mean the "QIO" for that area for purposes of applying this Section B(10). If a Hospice Provider sends a detailed notice to the enrollee in accordance with 42 CFR § 405.1202(f)(1), MA Organization is not required to send a duplicative notice to the enrollee so long as the detailed notice from the provider includes the information that the MA Organization is required to send.

iii. Upon notification by the QIO that a Hospice Enrollee has requested a fast-track review by the QIO of the termination of hospice services, the MA Organization must supply to the QIO any and all information, including a copy of the notice sent to the enrollee that the QIO needs for its review. The MA Organization must supply this information as soon as possible, but no later than by close of business of the day that the QIO notifies the MA Organization that a request has been received from the enrollee. The MA Organization must make the information available by phone (with a written record made of what is transmitted in this manner) and/or in writing, as requested by the QIO. The MA Organization is not required to send duplicative information and records to the QIO if this function has been delegated to or otherwise completed by the Hospice Provider and the information and records from the Hospice Provider includes the information that the MA Organization is required to send.

e. Upon an enrollee's request, MA Organization must provide the enrollee a copy of, or access to, any documentation sent to the QIO by MA Organization, including records of any information provided by telephone. MA Organization may charge the enrollee a reasonable amount to cover the costs of duplicating the information for the enrollee and/or delivering the documentation to the enrollee. MA Organization must accommodate such a request by no later than close of business of the first day after the day the material is requested. MA Organization is not required to send duplicative information and records to the enrollee if this function has been delegated to or otherwise completed by the Hospice Provider and the information and records from the Hospice Provider includes all documentation sent to the QIO.

f. Coverage by MA Organization of Hospice Care from the Hospice Provider continues until the date and time designated on the termination notice described in Section B(10)(c) of this Appendix 3 unless the enrollee requests review by the QIO and the QIO reverses the decision to terminate hospice services

i. If the QIO's decision is delayed because MA Organization did not timely supply necessary information or records as required by this Appendix 3, MA Organization is liable for the costs of any additional coverage required by the delayed QIO decision.

ii. If the QIO finds that the enrollee did not receive valid notice, coverage of Hospice Provider services by MA Organization continues until at least two days after valid notice has been received. Continuation of coverage is not required if the QIO determines that coverage could pose a threat to the enrollee's health or safety.

iii. If the QIO reverses the termination of Hospice Services, MA Organization must ensure that the Hospice Enrollee is provided with a new advance written notice of any subsequent decision to terminate hospice services consistent with Section B(10) of this Appendix 3.

g. Reconsideration of review decisions. MA Organization shall submit to, participate in, and cooperate with a reconsideration review conducted by a QIO when a Hospice Enrollee requests within 60 days that the QIO conduct a reconsideration review of the QIO's initial decision regarding the termination of hospice services. CMS and MA organizations agree not to invoke § 405.1204(b)(1) (regarding expedited reconsideration of a QIO determination), and to instead permit Hospice Enrollees to request reconsideration reviews within 60 days of receiving notice that the QIO upheld the participating MA Organization's decision, consistent with the timeframes and standards in § 422.626(g) for reviews of terminations of other provider services. The Hospice Provider and MA Organization may, but are not required to, submit evidence to be considered by the QIO in the QIO's reconsideration of its initial decision. MA Organization shall cover Hospice Care consistent with the QIO's decision on the reconsideration. If on reconsideration the QIO determines that coverage of hospice services should terminate on a given date, MA Organization shall cover Hospice Care until that date. If the QIO's decision is reversed on appeal, MA Organization must reimburse the enrollee, consistent with the appealed decision, for the costs of any covered services for which the enrollee has already paid MA Organization or provider.

h. MA Organization is financially responsible for coverage of hospice services as provided in this Section B(10) regardless of whether it has delegated responsibility for decisions authorizing coverage or termination of hospice services.

C. Hospice Capitation Amount

1. Payment Structure of the Hospice Benefit Component.

For Plan Year 2023, MA organizations participating in the Hospice Benefit Component will continue to be paid consistent with current law (and the Underlying Contract) for their enrollees who do not elect hospice. In VBID PBPs that offer the Hospice Benefit Component in both Plan Years 2022 and 2023, MA organizations participating in the VBID Model will continue to be paid consistent with current law (and the Underlying Contract) for their hospice enrollees whose hospice election started prior to January 1, 2022. In VBID PBPs that offer the Hospice Benefit Component in Plan Year 2023 only, MA organizations participating in the VBID Model will continue to be paid consistent with current law (and the Underlying Contract) for their hospice enrollees whose hospice election started prior to January 1, 2023. For other Hospice Enrollees in an MA organization's VBID PBPs that are offering the Hospice Benefit Component, CMS will pay the MA organization, for each Hospice Enrollee, using the following methodology:

a. For the first month of Hospice Election, consistent with 42 CFR § 422.320(c), the basic benefit capitation rate will only be paid if as of the first day of the month, an enrollee is not under Hospice Election status.

b. For all calendar months that an enrollee elects Hospice Care, including the first month of Hospice Election, MA Organization will receive the following payments from CMS for each Hospice Enrollee:

i. The monthly Hospice Capitation Amount as specified in Section C(2) of this Appendix 3;

ii. Consistent with 42 CFR § 422.320(c)(2), the beneficiary rebate amount as described in 42 CFR§ 422.304(a); and

iii. Consistent with 42 CFR § 422.320(c), the monthly prescription drug payment described in 42 CFR § 423.315 (for MA-PDs).

2. Hospice Capitation Amount.

The Hospice Capitation Amount means the monthly county capitation rate published by CMS that reflects the amount for coverage for a Hospice Enrollee in an MA Organization's VBID PBP that is offering the Hospice Benefit Component. The Hospice Capitation Amount payment varies by a monthly rating factor.

CMS published the Hospice Capitation Amount rates for the 2023 Plan Year here: https://innovation.cms.gov/innovation-models/vbid.

3. Monthly Rating Factor.

The Hospice Capitation Amount payment for the first month varies based on the number of days of Hospice Care occurring in the first calendar month of a hospice stay (which is the period of time between a Hospice Election and discharge from Hospice Care), split into the following three tiers: 1-6 days, 7-15 days, and 16 or more days of Hospice Care delivered in the first calendar month of the hospice stay. The monthly rating factor for each tier is: 0.3400, 0.6400 and 1.0030 respectively if any VBID PBPs in the county did not participate in the Hospice Benefit Component in Plan Year 2022. The monthly rating factor for each tier is: 0.3500, 0.6587, and 1.0324 if any VBID PBPs in the county participated in the Hospice Benefit Component in Plan Year 2022.

The Hospice Capitation Amount does not vary for the second and/or additional calendar months of a hospice stay; the monthly rating factor for additional calendar months beyond the first calendar month is 1.0.

4. Timing of Hospice Capitation Amount Payments.

CMS shall pay the Hospice Capitation Amount for the first calendar month of a Hospice Enrollee's hospice stay in a lump-sum retrospectively to MA Organization on a quarterly basis, if the Hospice Election did not occur on the first of the calendar month. If the Hospice Election occurred on the first of the calendar month, CMS shall make an advance monthly payment for the Hospice Capitation Amount and retrospectively adjust the Hospice Capitation Amount to reflect the monthly rating factor in its lump-sum payment on an annual basis to MA Organization.

For Hospice Enrollees with hospice stays that include additional calendar months beyond the first calendar month, CMS shall make monthly prospective payments of the Hospice Capitation Amount for coverage of services for a Hospice Enrollee for a month.

5. Adjustment of Payments.

CMS shall adjust payments retroactively to take into account any difference between the actual number of Hospice Enrollees in MA Organization's VBID PBPs that are offering the Hospice Benefit Component and the number of which it based an advance monthly payment consistent with 42 CFR 422.308(f). The period of time and manner in which adjustments are calculated and processed will be determined at CMS's sole discretion.

D. Record Retention

1. In accordance with Article 4 of this Addendum (Additional Record Retention and Reporting Requirements), MA Organization shall maintain books records, documents, and other evidence relating to the Hospice Benefit Component Model for a period of 10 (ten) years from the expiration or termination of this Addendum or from the date of completion of any Model-related monitoring, auditing, and evaluation, whichever is later. MA Organization shall and provide access in accordance with the record retention provisions of the Underlying Contract.

2. MA Organization shall submit reports to CMS, in a form and manner and by a deadline specified by CMS in Model Technical and Operational Guidance, regarding its implementation of Hospice Benefit Component. MA Organization shall provide CMS with supplemental information upon request regarding its implementation of the Hospice Benefit Component.

E. Compliance and Enforcement

1. MA Organization shall have in place a protocol for monitoring the implementation and administration of the Hospice Benefit Component . and ensuring compliance with this Appendix 3 (and the implementation of the Approved Proposal). MA Organization shall make the protocol available to CMS upon request.

2. CMS may terminate or suspend MA Organization's implementation of Hospice Benefit Component, or take other remedial action in accordance with 42 CFR part 422 or Article 5 of the Addendum, including without limitation if –

a. MA Organization fails to comply with the terms and conditions of underlying Contract, the Addendum or this Appendix 3; or

b. CMS determines that MA Organization's implementation of the Hospice Benefit Component might compromise the integrity of the Model.

3. CMS reserves the right to investigate MA Organization and downstream entities if there is evidence that indicates that the organization's participation in the Model is adversely impacting enrollee quality of care, and to exercise all available remedies in appropriate instances, including potential termination of MA Organization or any of its downstream entities from the Model test.

4. Without limiting the foregoing, the parties agree that if CMS determines that MA Organization has failed to comply with the terms of Article 3 of this Addendum or this Appendix 3, CMS may prohibit MA Organization from offering the Hospice Benefit Component in one or more future Plan Years, regardless of whether MA Organization has corrected or otherwise resolved the noncompliance.

F. Hospice Benefit Component Programmatic Waivers

Pursuant to Section 1115A(d)(1) of the Act, CMS waives the following programmatic requirements for MA Organizations participating in the Hospice Benefit Component. These waivers are granted only to the extent necessary to implement MA Organization's Approved Proposal in accordance with the Addendum and this Appendix 3. CMS may modify or rescind any or all of these waivers at any time, in its sole discretion.

1. Coverage of Medicare Hospice Benefit: Section 1852(a)(1) of the Act and 42 CFR 422.100(a) and 422.101, to the extent necessary, to remove the exclusion of Hospice Care from the scope of coverage of Part A and Part B benefits that MA organizations must cover so that MA organizations participating in the Hospice Benefit Component of the VBID Model may cover the Medicare hospice benefit consistent with the scope of coverage under Part A and consistent with the terms of this Model. Sections 1851(i) and 1853(h)(2) of the Act, with regard to payment to Hospice Providers by the Medicare Fee-For-Service program for Hospice Care covered under Part A and furnished to enrollees in MA plans, are waived to the extent necessary for such payment to instead be made by CMS to a participating MA organization and by a participating MA organization to the Hospice Provider

2. Hospice Capitation Rate Payment: 42 CFR 422.320 with respect to payment to the extent necessary to permit payment to participating MA organizations as provided under the Hospice Benefit Component and this Appendix 3.

3. Transitional Concurrent Care Costs and the Basic Bid: Section 1854(a)(6) of the Act, and provisions in 42 CFR Part 422, Subpart F that limit the basic bid to benefits covered under Original Medicare to the extent necessary to permit the basic bid to include the costs of Transitional Concurrent Care by MA organizations participating in this component of the VBID Model as a Part A or Part B benefit that is covered by the participating MA organizations only when furnished through in-network providers to Hospice Enrollees.

4. Transitional Concurrent Care: Sections 1812(d)(2)(A)(ii)(I) and 1852(a)(1) of the Act, and implementing regulations, to the extent necessary, with respect to Hospice Enrollee's waiver of payment for treatment of the individual's condition(s) with respect to which the diagnosis of terminal illness has been made, so that, as described in Appendix 2, Section B(4) and as required as part of the Model, Transitional Concurrent Care may be treated as a Part A and B benefit that is covered by MA Organization only when furnished through in-network providers to Hospice Enrollees.

5. Uniformity and Accessibility of Benefits: To be waived to the extent necessary to permit organizations to offer additional mandatory Additional Hospice Benefits to the Targeted Hospice Enrollee population, rather than to all enrollees, in the VBID PBPs participating in the Hospice Benefit Component as described in 3.G of this Appendix 3. The Targeted Hospice Enrollee population must be identified based on Hospice Election and may be further targeted to those Hospice Enrollees who choose an in-network Hospice Provider AND/OR (i) one or more chronic health conditions, or (ii) socioeconomic status or (iii) a combination of both these health conditions and socioeconomic statuses.

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 U.S.C. §§ 1395w-22(d)(1)(A) and 1395w-24(c)]

b. 42 CFR. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2), 422.254(b)(2), and 422.262(c)(1); and

c. Section 1860D–2(a) of the Act [42 U.S.C. § 1395w-102(a)]; and 42 CFR. §§ 423.104(b)(2), and 423.265(c).

6. Uniform Cost-Sharing: To be waived to the extent necessary to offer certain reductions in cost sharing to ,Targeted Hospice Enrollees in the VBID PBPs participating in the Hospice Benefit Component as described in Section B(9) of this Appendix 3. The targeted enrollee population may be identified based on Hospice Election, which may be further targeted to those hospice enrollees who choose an in-network hospice provider, AND/OR (i) one or more chronic health conditions, (ii) socioeconomic status or (iii) a combination of both these health conditions and socioeconomic statuses.

a. Sections 1852(d)(1)(A) and 1854(c) of the Act [42 U.S.C §§ 1395w-22(d)(1)(A) and 1395w-24(c)]

b. 42 CFR. §§ 422.2 (definition of an MA plan), 422.100(d)(2), 422.102(a)(2), 422.254(b)(2), 422.262(c)(1); and Section 1860D–2(a) of the Act [42 U.S.C § 1395w-

102(a)]; and

c. 42 CFR. §§ 423.104(b)(2) and 423.265(c).

7. Requirements for Supplemental Benefits to Permit Coverage by a Participating MA Plan of Non Primarily Health Related Supplemental Benefits: To be waived to the extent necessary to allow MA Organization to offer to the Targeted Enrollee population, but not to all enrollees, in the VBID PBPs participating in the Hospice Benefit Component certain additional "non-primarily health related" supplemental benefits. Such supplemental benefits must have a reasonable expectation of maintaining or slowing the progressive decline of the health or overall function of the enrollee with regard to the chronic health condition or socioeconomic status of the Targeted Enrollee population during Hospice Election. The Targeted Enrollee population may be identified based on Hospice Election (which may be further targeted to those enrollees who choose an in-network Hospice Provider) AND (i) one or more chronic health conditions, (ii) socioeconomic status, or (iii) a combination of both these health condition and socioeconomic statuses. In using one or more chronic health conditions to identify eligible enrollees, an applicant may propose for CMS consideration and approval a targeted population that does not meet the statutory definition of "chronically ill enrollee" in Section 1852(a)(3)(D)(iii) of the Act.

a. Section 1852(a)(3)(D)(i), (ii)(I), and (iii) of the Act [42 U.S.C § 1395w– 22(a)(3)(D)(i), (ii)(I), and (iii)] and any implementing regulations.

b. Provisions of 42 CFR §§ 422.100(c)(2)(ii)(A) and 422.102(f)(2)(i), (ii), and (iii) that limit eligibility for special supplemental benefits for the chronically ill to enrollees who meet the definition of "chronically ill enrollee."

8. Application of the Hospice Inpatient Cap and Hospice Aggregate Cap: Section 1814(i)(2 of the Act and 42 CFR §§ 418.302(f) and 418.309, to exclude from the calculation of hospice's inpatient cap and the hospice aggregate cap those enrollees in an MA organization's VBID PBP(s) providing the Hospice Benefit Component.

9. QIO Review of Terminations of Hospice Services: All obligations, standards, requirements and duties imposed on and rights of beneficiaries, including the timeframe on which and the manner and form by which a beneficiary may request review by a QIO, are not waived and shall continue to apply to a Hospice Enrollee. Unless explicitly waived, obligations on Hospice Providers in 42 CFR §§ 405.1200 through 405.1204 remain in effect. The regulations at 42 CFR §§ 405.1200 through 422.1204 are waived only to the extent necessary to permit the MA organizations and applicable QIOs to comply with the appeals process detailed in Section B(10) of this Appendix 3 for reviews of termination of hospice services under the Hospice Benefit Component of the Model

a. The provision of 42 CFR § 405.1202(b)(4) regarding QIO review when a beneficiary does not file a timely request for review by a QIO of a termination of hospice services is waived.

b. The provision of 42 CFR § 405.1202(e)(7) that makes the provider liable for the cost of the hospice services being continued when the provider fails to furnish information to the QIO to support the termination of services, is waived.

c. The provision of 42 CFR § 405.1202(c) that relates to provider liability for the cost of hospice services in certain situations, is waived.

d. 42 CFR § 405.1204(b) through (f), regarding expedited reconsiderations by a Qualified Independent Contractor of a QIO's review of a termination of hospice services, is waived. The right of a Hospice Enrollee to seek review of a QIO's determination regarding the termination of hospice services in § 405.1204(a) is not waived but that review is as described in Section B(10) of this Appendix 3.

10. Part D Waivers: The following are waived to the extent necessary for participating MA organizations that are not otherwise authorized to offer Part D supplemental benefits to offer cost sharing reductions consistent with the terms of the Model, and for participating MA organizations to include as administrative costs in the Part D portion of their bids the value of the reduction in the statutory maximum cost sharing for a Targeted Hospice Enrollee and to report such amounts on PDE data consistent with CMS instructions in VBID Model Technical and Operational Guidance:

a. 42 CFR 423.104; and

b. Part 423, Subparts F and G.

G. Data Sharing and Reports

1. General

a. Subject to the limitations discussed in this Addendum, and in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") regulations and the regulations in 42 CFR Part 2 regarding confidentiality of substance use disorder patient records, at any time deemed necessary by CMS, CMS will offer an MA organization participating in the Hospice Benefit Component an opportunity to request certain data and reports as described in Section G(2) of this Appendix 3 and Appendix 4 of this Addendum.

b. Data and reports provided to MA Organization under the preceding paragraph will omit substance use disorder data for any Hospice Enrollees who have not opted into substance use disorder data sharing, as described in Section G(3) of this Appendix 3.

2. Provision of Certain Data.

a. CMS believes that the Health Care Operations work of MA Organization, a HIPAA CE, would benefit from the receipt of certain beneficiary-identifiable claims data and reports as described in Section G(2)(c) of this Appendix 3. CMS will therefore offer to MA Organization an opportunity to request specific Beneficiary-identifiable data by completing and submitting the HIPAA-Covered Data Disclosure Request Form (Appendix 4). All requests for Beneficiary-identifiable claims data and reports will be granted or denied at CMS's sole discretion based on CMS's available resources, technological capabilities, and data policies, the limitations in this Addendum, and applicable law.

b. In offering this Beneficiary-identifiable data, CMS does not represent that MA Organization has met all applicable HIPAA requirements for requesting data under 45 CFR § 164.506(c)(4). MA Organization should consult with its own counsel to make those determinations prior to requesting this data from CMS.

c. The following specific Beneficiary-identifiable data will be made available on request, subject to the terms of this Appendix 3 and in accordance with applicable law, to MA Organization:

i. Beneficiary Level Hospice Month 1 Payment Report: The Beneficiary Level Hospice Month 1 Payment Report provides a beneficiary-level itemization of quarterly plan-level manual adjustments made by CMS, through the Automated Plan Payment System, to reflect Hospice Capitation Amount payments for Hospice Enrollees' first month of Hospice Care. This report will provide a cumulative history and accounting of all quarterly manual adjustments paid to MA Organization for the plan year and an accounting of the Hospice Enrollees for whom the first month Hospice Capitation Amount payments are being made retroactively.

ii. Hospice Utilization Report for Plan Years 2022 and/or 2023 Hospice Enrollee Detailed Claims Data: Individually identifiable Medicare FFS claims data for hospice services provided to MA Organization's Hospice Enrollees during hospice stays that occurred during MA Organization's time period participating in the Hospice Benefit Component with election period starts in Plan Years 2022 or 2023, as applicable. These files will be made available on request and in accordance with applicable law to the MA Organization at least quarterly and at most on a monthly basis at CMS's sole discretion based on CMS's available resources.

iii. Hospice Historical Utilization Report for Plan Years 2019-2021 and the first six months of 2022 Hospice Enrollee Detailed Claims Data: Individually identifiable Medicare FFS claims data for services provided to MA Organization's Hospice Enrollees in applicable VBID PBPs with an election period that started in Plan Years 2019, 2020, 2021 and 2022 through live discharge from Hospice Care, up until the first of the next month following discharge (data for 2022 is limited to the first six months of 2022). Individually identifiable Medicare FFS claims data for deceased and disenrolled enrollees would be included, provided they were members of MA Organization's VBID participating PBPs (or crosswalked PBPs) at the time of Hospice Election.

d. The following reports will be made available to MA Organization upon request and in accordance with applicable law:

i. Hospice Provider Report: Information about Hospice Providers within the service area(s) of MA Organization's VBID Participating PBPs. This would include mailing and physical address, phone number, e-mail (if available in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)), fax number (if available), National Provider Identifier (NPI) and Taxpayer Identification Number (TIN).

e. The parties mutually agree that, except for data covered by Section G(2)(o) of this Appendix 3, CMS retains all ownership rights to the data files described in the HIPAA-Covered Data Disclosure Request Form (Appendix 4), and MA Organization does not obtain any right, title, or interest in any of the data furnished by CMS.

f. MA Organization represents, and in furnishing the data files specified in Appendix 4 CMS relies upon such representation, that such data files will be used solely for the purposes described in this Appendix 3 and that the data requested by MA Organization is the minimum necessary to achieve those purposes. The MA Organization shall not disclose, use or reuse the data except as specified in this Appendix 3 or except as CMS shall authorize in writing or as otherwise required by law. MA Organization further agrees not to sell, rent, lease, loan, or otherwise grant access to any other party or person of the data covered by this Appendix 3.

g. MA Organization represents that it intends to use and hereby agrees to use the requested data and reports described in Section G(2)(c) of this Appendix 3 for the Health Care Operations described in paragraphs (1) and (2) of the definition of "health care operations" in 45 CFR §164.501, related to implementation of the Hospice

Benefit Component of the Model. Information derived from the CMS files specified in Appendix 4 may be shared and used in accordance with applicable law within the legal confines of MA Organization and in a manner consistent with Section G(2)(h) of this Apendix 3 to enable MA Organization to improve care integration and conduct quality improvement activities.

h. MA Organization may reuse or further disclose original or derivative data in accordance with applicable law without prior written authorization from CMS for clinical treatment, care management and coordination, quality improvement activities, review of competence or qualifications of health care professionals, review of need for reinsurance of risk relating to claims for health care of enrollees who elect hospice, and provider incentive design and implementation, but shall not disseminate individually identifiable original or derived information from the files specified in the HIPAA-Covered Data Disclosure Request Form to anyone who is not a HIPAA CE provider in a treatment relationship with the subject Hospice Enrollee(s) or a HIPAA BA of such a CE provider. MA Organization may reuse or further disclose original or derivative data in accordance with applicable law for any other reasons not listed in this paragraph with prior written authorization from CMS. When using or disclosing PHI or personally identifiable information ("PII"), obtained from files specified in Appendix 4, MA Organization must make "reasonable efforts to limit" the information to the "minimum necessary" to accomplish the intended purpose of the use, disclosure or request. MA Organization shall further limit its disclosure of such information to the types of disclosures that CMS itself would be permitted make under the "routine uses" in the applicable systems of records listed in Appendix 4.

Subject to the limits specified above and elsewhere in this Addendum and applicable law, MA Organization may link individually identifiable information specified in Appendix 4 (including directly or indirectly identifiable data) or derivative data to other sources of individually-identifiable health information, such as other records available to MA Organization. MA Organization may disseminate such data that has been linked to other sources of individually identifiable health information provided such data has been de-identified in accordance with HIPAA requirements in 45 CFR § 164.514(b).

i. MA Organization must establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards should provide a level and scope of security that is not less than the level and scope of security requirements established for federal agencies by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix I--Responsibilities for Protecting and Managing Federal Information Resources (https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A130/a130revised.pdf) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf); and, NIST Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (https://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r5.pdf).

j. MA Organization acknowledges that the use of unsecured telecommunications, including the Internet, to transmit directly or indirectly individually identifiable information from the files specified in Appendix 4 or any such derivative data files is strictly prohibited. Further, MA Organization agrees that the data specified in Appendix 4 must not be physically moved, transmitted or disclosed in any way from or by the site of the custodian indicated in Appendix 4 other than as provided in this Appendix 3 without written approval from CMS, unless such movement, transmission or disclosure is required by law.

k. MA Organization shall grant access to the data and/or the facility(ies) in which the data is maintained to the authorized representatives of CMS or HHS Office of Inspector General, including at the site of the custodian indicated in Appendix 4, for the purpose of inspecting to confirm compliance with the terms of this Appendix 3.

l. MA Organization agrees that any use of CMS data in the creation of any document concerning the purpose specified in this Appendix 3 and Appendix 4 must adhere to CMS' current cell size suppression policy. This policy stipulates that no cell (e.g., admittances, discharges, patients, services) representing 10 or fewer Beneficiaries may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell representing 10 or fewer beneficiaries.

m. MA Organization shall report any breach of PHI or PII from or derived from the CMS data files, loss of these data or improper use or disclosure of such data to the CMS Action Desk by telephone at (410) 786-2850 or by email notification at cms_it_service_desk@cms.hhs.gov within one hour. Furthermore, MA Organization shall cooperate fully in any federal incident security process that results from such improper use or disclosure.

n. The parties mutually agree that the individual named in Appendix 4 is designated as Custodian of the CMS data files on behalf of MA Organization and will be responsible for the observance of all conditions of use and disclosure of such data and any derivative data files, and for the establishment and maintenance of security arrangements as specified in this Addendum to prevent unauthorized use or disclosure. Furthermore, such Custodian is responsible for contractually binding any downstream recipients of such data to the terms and conditions in this Appendix 3 as a condition of receiving such data. MA Organization shall notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

o. Data disclosed to MA Organization pursuant to this Appendix 3 and Appendix 4 may be retained by MA Organization until the conclusion or termination of the Underlying Contract or the conclusion or termination of MA Organization's participation in the Model, whichever occurs first. MA Organization is permitted to retain any individually identifiable health information from such data files or derivative data files after that point if MA Organization is a HIPAA CE and the data has been incorporated into the subject Hospice Enrollees' records that are part of a designated record set under HIPAA. Furthermore, any HIPAA CE to whom MA Organization provides such data in the course of carrying out the Model may also retain such data if the recipient entity is a HIPAA CE or BA and the data is incorporated into the subject Hospice Enrollees' records that are part of a designated record set under HIPAA. MA Organization shall destroy all other data and send written certification of the destruction of the data files and/or any derivative data files to CMS within 30 days following the conclusion or termination of the Underlying Contract or of the conclusion or termination of MA Organization's participation in the Model, whichever occurs later, except as CMS shall authorize in writing or as otherwise required by law. Except for disclosures for treatment purposes, MA Organization shall bind any downstream recipients to these terms and conditions as a condition of disclosing such data to downstream entities and permitting them to retain such records under this paragraph. These retention provisions survive the conclusion or termination of this Addendum, the Underlying Contract, or MA Organization's participation in the Model.

3. Beneficiary Substance Use Disorder Data Opt-In

a. MA Organization may inform each Hospice Enrollee, in compliance with applicable law: (a) that he or she may elect to allow MA Organization to receive Beneficiary-identifiable data regarding his or her utilization of substance use disorder services; (b) of the mechanism by which the Beneficiary can make this election; and (c) that 1-800-MEDICARE will answer any questions regarding sharing of data regarding utilization of substance use disorder services.

b. A Hospice Enrollee may opt in to substance use disorder data sharing only by submitting a CMS-approved substance use disorder opt in form to MA Organization. MA Organization shall promptly send the opt-in form to CMS.

Appendix 4
HIPAA-Covered Data Disclosure Request Form

A. Data Disclosure Request and Attestation

MA Organization requests the CMS data from one or more of the files selected below and makes the following assertions regarding its ability to meet the HIPAA requirements for receiving such data:

MA Organization is (select one):

- o A HIPAA Covered Entity (CE) as defined in 45 CFR § 160.103
- o The BA of a HIPAA CE as defined in 45 CFR § 160.103.
- o Other (neither a HIPAA CE nor a BA of a HIPAA CE): Please provide a description of the intended user.

MA Organization is seeking protected health information (PHI), as defined in 45 CFR § 160.103 (select one):

- o For its own use.
- o On behalf of a CE for which MA Organization is a BA
- o Other: Please attach a description of the intended purpose (e.g., for "research" purposes, for "public health" purposes, etc.).

MA Organization requests (select all that apply):

o Beneficiary Level Hospice Month 1 Payment Report: The Beneficiary Level Hospice Month 1 Payment Report provides a beneficiary level itemization of quarterly plan level manual adjustments made by CMS, through the Automated Plan Payment System, to reflect Hospice Capitation Amount payments for Hospice Enrollees' first month of Hospice Care. This report will provide a cumulative history and accounting of all quarterly manual adjustments paid to MA Organization for the plan year and an accounting of the Hospice Enrollees for whom the first month Hospice Capitation Amount payments are being made retroactively.

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o Hospice Utilization Report for Plan Years 2022 and 2023 Hospice Enrollee Detailed Claims Data: Individually identifiable Medicare FFS claims data for hospice services provided to MA Organization's Hospice Enrollees during hospice stays that occurred during MA Organization's time period participating in the Hospice Benefit Component with election period starts in Plan Years 2022 and/or 2023, as applicable. These files will be made available on request and in accordance with applicable law to MA Organization at least quarterly and at most on a monthly basis at CMS' sole discretion based on CMS' available resources.

o Hospice Historical Utilization Report for Plan Years 2019-2021 and first six months of 2022 Hospice Enrollee Detailed Claims Data: Individually identifiable Medicare FFS claims data for services provided to MA Organization's Hospice Enrollees in applicable VBID PBPs with an election period that started in Plan Years 2019, 2020, 2021 and 2022 through live discharge from Hospice Care, up until the first of the next month following discharge (data for 2022 is limited to the first six months of 2022). Individually identifiable Medicare FFS claims data for deceased and disenrolled enrollees would be included for health care operations, provided they were members of MA Organization's VBID participating PBPs (or crosswalked PBPs) at the time of hospice election.

o Hospice Provider Report: Information about Hospice Providers within the service area of MA Organization's VBID Participating PBPs. This would include mailing and physical address, phone number, e-mail (if available in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)), fax number (if available), National Provider Identifier (NPI) and Taxpayer Identification Number (TIN).

o Other: Please attach a detailed description of the data requested.

This data and reports will be created from the following CMS data files (System(s) of Records Notice(s)):

o NPPES (09-70-0555)

o PECOS (09-70-0532)

o EDB (09-70-0502)

o IDR (09-70-0571), including FISS (09-70-0503), MCS (09-70-0501) and DDPS (09-70-0553)

o MARx System (09-70-0588)

The MA Organization intends to use the requested data to carry out (select one):

o "Health care operations" that fall within the first and second paragraphs of the definition of that phrase under the HIPAA Privacy Rule (45 CFR § 164.501).

o Other: Please attach a description of the intended purpose (e.g., for payment purposes, for "research" purposes, for "public health" purposes, etc.).

The data requested is (select one):

o The "minimum necessary" (as defined at 45 CFR § 164.502) to carry out the health care operations activities described above.

o Other: Please attach a description of how (if applicable) the data requested exceeds what is needed to carry out the work described above.

MA Organization's data custodian for the requested data is:

_____
(name)

_____
(phone number)

_____
(email address)

MA Organization's Alternate Data Custodian for the requested data is:

_____
(name)

_____
(phone number)

_____
(email address)

By:_____ Date: _____

_____
Name of authorized signatory

_____
Title

B. Data Specification Worksheet

The Data Specification Worksheet below only applies to the Hospice Historical Utilization Report for Plan Years 2019-2021 and the first six months of 2022 Hospice Enrollee Detailed Claims Data. For the Hospice Utilization Report for Plan Years 2022 and 2023 Hospice Enrollee Detailed Claims Data, only Part A hospice claims will be included.

Data Element Source	Data Element	Data Element Description
Part A Claims	ClaimNo	A unique identification number assigned to the claim.
Part A Claims	Provider Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, OSCAR Provider Number, or CCN. This number verifies that a practitioner has been Medicare certified for a particular type of service.

Part A Claims	Beneficiary MBI	A Medicare Beneficiary Identifier assigned to a beneficiary.
Part A Claims	Claim Type code	Signifies the type of claim being submitted through the Medicare or Medicaid programs. Claim type codes are: 10=HHA claim 20=Non swing bed SNF claim 30=Swing bed SNF claim 40=Outpatient claim 50=Hospice claim 60=Inpatient claim 61=Inpatient "Full-Encounter" claim
Part A Claims	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
Part A Claims	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
Part A Claims	Claim Bill Facility Type Code	The first digit of the type of bill (TOB1) is used to identify the type of facility that provided care to the beneficiary (e.g., hospital or SNF). Claim Facility Type Codes are: 1=Hospital 2=SNF 3=HHA 4=Religious non-medical (hospital) 5=Religious non-medical (extended care) 6=Intermediate care 7=Clinic or hospital-based renal dialysis facility 8=Specialty facility or Ambulatory Surgical Center (ASC) surgery 9=Reserved
Part A Claims	Claim Bill Classification Code	The second digit of the type of bill (TOB2) is used to indicate with greater specificity where the service was provided (e.g., a department within a hospital).
Part A Claims	Principal Diagnosis Code	The International Classification of Diseases (ICD)-9/10 diagnosis code identifies the beneficiary's principal illness or disability.
Part A Claims	Admitting Diagnosis Code	The ICD-9/10 diagnosis code identifies the illness or disability for which the beneficiary was admitted. Reported to IP, OP and SNF.
Part A Claims	Diagnosis Code	The diagnosis code array in the 1st-25th position identifying the condition(s) for which the beneficiary is receiving care.
Part A Claims	Procedure Code	The code array (1-25) that indicates the procedure performed during the period covered by the institutional claim. Reported to IP, OP and SNF.
Part A Claims	Procedure Date	The date on which the 1st-25th procedure was performed. Reported to IP, OP and SNF.
Part A Claims(cont.)	Claim Medicare Non payment Reason Code	Indicates the reason payment on an institutional claim is denied.
Part A Claims(cont.)	Claim Payment Ammount	Amount that Medicare paid on the claim.
Part A Claims(cont.)	Claim NCH Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the beneficiary's health insurance bills, this code indicates the responsible primary payer.
Part A Claims(cont.)	Federal Information Processing Standards FIPS State Code	Identifies the state where the facility providing services is located.
Part A Claims(cont.)	Beneficiary Patient Status Code	Indicates the patient's discharge status as of the Claim Through Date. For example, it may indicate where a patient was discharged to (e.g., home, another facility) or the circumstances of a discharge (e.g., against medical advice, or patient death).
Part A Claims(cont.)	Diagnosis Related Group Code	Indicates the diagnostic related group to which a hospital claim belongs for prospective payment purposes. Reported for IP.
Part A Claims(cont.)	Claim Outpatient Service Type Code	Indicates the type and priority of outpatient service. Reported for OP.
Part A Claims(cont.)	Claim Outpatient Service Type Code	Claim Outpatient Service Type Codes are:
Part A Claims(cont.)	Claim Outpatient Service Type Code	0=Blank
Part A Claims(cont.)	Claim Outpatient Service Type Code	1=Emergency
Part A Claims(cont.)	Claim Outpatient Service Type Code	2=Urgent
Part A Claims(cont.)	Claim Outpatient Service Type Code	3=Elective
Part A Claims(cont.)	Claim Outpatient Service Type Code	5-8=Reserved
Part A Claims(cont.)	Claim Outpatient Service Type Code	9=Unknown
Part A Claims(cont.)	Facility Provider NPI Number	Identifies the facility associated with the claim. Each facility is assigned its own unique NPI.
Part A Claims(cont.)	Operating Provider NPI Number	Identifies the operating provider associated with the claim. Each provider is assigned its own unique NPI.

Part A Claims(cont.)	Attending Provider NPI Number	Identifies the attending provider associated with the claim. Each provider is assigned its own unique NPI.
Part A Claims(cont.)	Other Provider NPI Number	Identifies the other providers associated with the claim. Each provider is assigned its own unique NPI.
Part A Claims(cont.)	Claim Admission Type Code	Indicates the type and priority of inpatient services. Reported for IP and SNF.
Part A Claims(cont.)	Claim Admission Type Code	Claim Admission Type Codes are:
Part A Claims(cont.)	Claim Admission Type Code	0=Blank
Part A Claims (cont.)	Claim Admission Type Code	1=Emergency
Part A Claims (cont.)	Claim Admission Type Code (cont.)	2=Urgent
Part A Claims (cont.)	Claim Admission Type Code	3=Elective
Part A Claims (cont.)	Claim Admission Type Code	4=Newborn
Part A Claims (cont.)	Claim Admission Type Code	5=Trauma Center
Part A Claims (cont.)	Claim Admission Type Code	6-8=Reserved
Part A Claims (cont.)	Claim Admission Type Code	9=Unknown
Part A Claims (cont.)	Claim Source Inpatient Admission Code	Indicates the source of the beneficiary's referral for admission or visit (e.g., a physician or another facility). Reported for IP and SNF.
Part A Claims (cont.)		Find Admission Source Codes here: https://www.resdac.org/cms-data/variables/claim-source-inpatient-admission-code-ffs
Part A Claims (cont.)	Claim Bill Frequency Code	The third digit of the type of bill (TOB3) code. It indicates the sequence of the claim in the beneficiary's current episode of care (e.g., interim or voided).
Part A Claims (cont.)		Find Claim Frequency Codes here: http://www.resdac.org/cms-data/variables/Claim-Frequency-Code.
Part A Claims (cont.)	Claim Query Code	Indicates the type of claim record being processed with respect to payment (e.g., debit/credit indicator or interim/final indicator).
Part A Claims (cont.)	Claim Query Code	Claim Query Codes are:
Part A Claims (cont.)	Claim Query Code	0=Credit adjustment
Part A Claims (cont.)	Claim Query Code	1=Interim bill
Part A Claims (cont.)	Claim Query Code	2=HHA benefits exhausted
Part A Claims (cont.)	Claim Query Code	3=Final bill
Part A Claims (cont.)	Claim Query Code	4=Discharge notice
Part A Claims (cont.)	Claim Query Code	5=Debit adjustment
Part A Claims Revenue Center Details	ClaimNo	A unique identification number assigned to the claim.
Part A Claims Revenue Center Details	Claim Line Number	A sequential number that identifies a specific claim line
Part A Claims Revenue Center Details	Beneficiary MBI	A Medicare Beneficiary Identifier assigned to a beneficiary.
Part A Claims Revenue Center Details	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
Part A Claims Revenue Center Details	Claim Type Code	Claim type codes are:
Part A Claims Revenue Center Details	Claim Type Code	10=HHA claim

Part A Claims Revenue Center Details	Claim Type Code	20=Non swing bed SNF claim
Part A Claims Revenue Center Details	Claim Type Code	30=Swing bed SNF claim
Part A Claims Revenue Center Details	Claim Type Code	40=Outpatient claim
Part A Claims Revenue Center Details	Claim Type Code	50=Hospice claim
Part A Claims Revenue Center Details	Claim Type Code	60=Inpatient claim
Part A Claims Revenue Center Details	Claim Type Code	61=Inpatient "Full-Encounter" claim
Part A Claims Revenue Center Details	Claim Line From Date	The date the service associated with the line item began.
Part A Claims Revenue Center Details	Claim Line Thru Date	The date the service associated with the line item ended.
Part A Claims Revenue Center Details	Product Revenue Center Code	The number a provider assigns to the cost center to which a particular charge is billed (e.g., accommodations or supplies).
Part A Claims Revenue Center Details	Claim Line Institutional Revenue Center Date	The date that applies to the service associated with the Revenue Center code.
Part A Claims Revenue Center Details (cont.)	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
Part A Claims Revenue Center Details (cont.)	Provider Number	A facility's Medicare/Medicaid identification number. It is also known as a Medicare/Medicaid Provider Number, or CCN. This number verifies that a provider has been Medicare certified for a particular type of service.
Part A Claims Revenue Center Details	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
Part A Claims Revenue Center Details	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
Part A Claims Revenue Center Details	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
Part A Claims Revenue Center Details	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
Part A Claims Revenue Center Details	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part A Claims Revenue Center Details	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part A Claims Revenue Center Details	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part A Claims Revenue Center Details	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part A Claims Revenue Center Details	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B Physicians	ClaimNo	A unique identification number assigned to the claim.
Part B Physicians	Claim Line Number	A sequential number that identifies a specific claim line
Part B Physicians	Beneficiary MBI	A Medicare Beneficiary Identifier assigned to a beneficiary.
Part B Physicians	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
Part B Physicians	Claim Type Code	Claim type codes are:
Part B Physicians	Claim Type Code	10=HHA claim
Part B Physicians	Claim Type Code	20=Non swing bed SNF claim

Part B Physicians	Claim Type Code	30=Swing bed SNF claim
Part B Physicians	Claim Type Code	40=Outpatient claim
Part B Physicians	Claim Type Code	50=Hospice claim
Part B Physicians	Claim Type Code	60=Inpatient claim
Part B Physicians	Claim Type Code	61=Inpatient "Full-Encounter" claim
Part B Physicians	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
Part B Physicians	Provider Type Code	Identifies the type of Provider Identifier.
Part B Physicians	Rendering Provider FIPS State Code	Identifies the state that the provider providing the service is located in.
Part B Physicians	Claim Rendering Federal Provider Specialty Code	Indicates the CMS specialty code associated with the provider of services. CMS used this number to price the service on the line-item.
Part B Physicians	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.
Part B Physicians (cont.)	Claim Line From Date	The date the service associated with the line item began.
Part B Physicians	Claim Line Thru Date	The date the service associated with the line item ended.
Part B Physicians (cont.)	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
Part B Physicians	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
Part B Physicians	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer. This field is also known as the Line Beneficiary Primary Payer Code.
Part B Physicians	Principal Diagnosis Code	The ICD-9/10 diagnosis code identifying the beneficiary's principal illness or disability.
Part B Physicians	Claim Provider Tax Number	The SSN or Employee Identification Number (EIN) of the provider of the indicated service. This number identifies who receives payment for the indicated service.
Part B Physicians	Rendering Provider NPI Number	A number that identifies the provider rendering the indicated service on the claim line. Each provider is assigned its own unique NPI.
Part B Physicians	Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.
Part B Physicians	Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.
Part B Physicians	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.
Part B Physicians	Claim Line Service Unit Quantity	The number of dosage units of medication that were dispensed in this fill.
Part B Physicians	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B Physicians	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B Physicians	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B Physicians	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B Physicians	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B Physicians	Claim Line Diagnosis Code	The code indicating the diagnosis supporting this line item procedure/service on the non-institutional claim
Part B DMEs	ClaimNo	A unique identification number assigned to the claim.
Part B DMEs	Claim Line Number	A sequential number that identifies a specific claim line
Part B DMEs	Beneficiary MBI	A Medicare Beneficiary Identifier assigned to a beneficiary.
Part B DMEs	Claim Type Code	Signifies the type of claim being submitted through the Medicare or Medicaid programs.
Part B DMEs	Claim Type Code	Claim type codes are:
Part B DMEs	Claim Type Code	10=HHA claim
Part B DMEs	Claim Type Code	20=Non swing bed SNF claim
Part B DMEs (cont.)	Claim Type Code (cont.)	30=Swing bed SNF claim
Part B DMEs	Claim Type Code	40=Outpatient claim
Part B DMEs	Claim Type Code	50=Hospice claim

Part B DMEs	Claim Type Code	60=Inpatient claim
Part B DMEs (cont.)		61=Inpatient "Full-Encounter" claim
Part B DMEs	Claim From Date	The first day on the billing statement that covers services rendered to the beneficiary.
Part B DMEs	Claim Thru Date	The last day on the billing statement that covers services rendered to the beneficiary.
Part B DMEs	Claim Federal Type Service Code	Indicates the type of service (e.g., consultation, surgery) provided to the beneficiary. Types of Service Codes are defined in the Medicare Carrier Manual.
Part B DMEs	Claim Place of Service Code	Indicates the place where the indicated service was provided (e.g., ambulance, school). Places of service are defined in the Medicare Carrier Manual.
Part B DMEs	Claim Line From Date	The date the service associated with the line item began.
Part B DMEs	Claim Line Thru Date	The date the service associated with the line item ended.
Part B DMEs	HCPCS Code	The HCPCS code representing the procedure, supply, product, and/or service provided to the beneficiary.
Part B DMEs	HCPCS First Modifier Code	The first code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B DMEs	HCPCS Second Modifier Code	The second code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B DMEs	HCPCS Third Modifier Code	The third code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B DMEs	HCPCS Fourth Modifier Code	The fourth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B DMEs	HCPCS Fifth Modifier Code	The fifth code to modify the HCPCS procedure code associated with the claim-line. This provides more specific procedure identification for the line item service.
Part B DMEs	Claim Line Diagnosis Code	The code indicating the diagnosis supporting this line item procedure/service on the non-institutional claim
Part B DMEs	Claim Line Covered Paid Amount	The amount Medicare reimbursed the provider for covered services associated with the claim-line.
Part B DMEs	Claim Primary Payer Code	If a payer other than Medicare has primary responsibility for payment of the service indicated on the claim line, this code indicates the primary payer.
Part B DMEs	Supplier NPI Number	The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.
Part B DMEs	Claim Carrier Payment Denial Code	Indicates to whom payment was made (e.g., physician, beneficiary), or if the claim was denied.
Part B DMEs	Claim Carrier Payment Denial Code	Find Carrier Payment Denial Codes here: https://www.resdac.org/cms-data/variables/carrier-claim-payment-denial-code
Part B DMEs	Claim Line Processing Indicator Code	Indicates whether the service indicated on the claim line was allowed or the reason it was denied.
Part B DMEs	Claim Line Allowed Charges Amount	The amount Medicare approved for payment to the provider.

H5774 EMR

Medicare Advantage Attestation of Benefit Plan
TRIPLE S ADVANTAGE, INC.
H5774
Date: 09/09/2022

I attest that I have examined the Plan Benefit Packages (PBPs) identified below and that the benefits identified in the PBPs are those that the above-stated organization will make available to eligible beneficiaries in the approved service area during program year 2023. I further attest that we have reviewed the bid pricing tools (BPTs) with the certifying actuary and have determined them to be consistent with the PBPs being attested to here.

I attest that I have examined the employer/union-only group waiver (""800 series"") PBPs identified below and that these PBPs are those that the above-stated organization will make available only to eligible employer/union-sponsored group plan beneficiaries in the approved service area during program year 2023. I further attest we have reviewed any MA bid pricing tools (BPTs) associated with these PBPs (no Part D bids are required for 2023 "800 series" PBPs) with the certifying actuary and have determined them to be consistent with any MA PBPs being attested to here.

I attest that our MA plan(s) are implementing Part B step therapy under the direction of its P&T committee consistent with CMS regulatory and sub-regulatory guidance.

I further attest that these benefits will be offered in accordance with all applicable Medicare program authorizing statutes and regulations and program guidance that CMS has issued to date and will issue during the remainder of 2022 and 2023, including but not limited to, the 2023 Solicitations for New Contract Applicants, the Medicare Prescription Drug Benefit Manual, the Medicare Managed Care Manual, and the CMS memoranda issued through the Health Plan Management System (HPMS).

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
003	0	7	Basic (HMO)	HMO	Renewal	0.00	N/A	08/31/2022	01/01/2023
005	0	8	Real (HMO)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
022	0	8	Contigo Plus (HMO C-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
024	0	8	Platino Plus (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
025	0	8	Platino Ultra (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
026	0	8	Platino Advance (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
027	0	8	Magno (HMO-POS)	HMOPOS	Renewal	0.00	0.00	08/31/2022	01/01/2023
028	0	8	Platino Blindao (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
031	0	8	Brillante (HMO-POS)	HMOPOS	Renewal	0.00	0.00	08/31/2022	01/01/2023
035	0	8	Platino Alcance (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
036	0	8	Platino Titan (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
037	0	8	AhorroMax (HMO)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
038	0	7	Enlace Plus (HMO)	HMO	Renewal	0.00	0.00	08/31/2022	01/01/2023
802	0	6	Royal A (HMO)	HMO	Renewal	0.00	N/A	08/31/2022	01/01/2023
806	0	6	Royal B (HMO)	HMO	Renewal	0.00	32.70	08/31/2022	01/01/2023
808	0	6	Royal C (HMO)	HMO	Renewal	0.00	32.70	08/31/2022	01/01/2023
809	0	7	Royal D (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
810	0	6	Royal E (HMO)	HMO	Renewal	0.00	32.70	08/31/2022	01/01/2023
811	0	6	Royal Plus A (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
812	0	6	Employer BD 1 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
814	0	7	Employer BD 3 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
816	0	6	Employer BD 5 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
818	0	6	Employer BD 7 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
820	0	6	Employer BD 8 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
821	0	6	Employer BD 9 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
822	0	6	Employer BD10 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
823	0	6	Employer BD11 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
824	0	6	Employer BD12 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023
825	0	6	Employer BD13 (HMO-POS)	HMOPOS	Renewal	0.00	32.70	08/31/2022	01/01/2023

Juan Serrano
Contracting Official Name

9/9/2022 2:58:03 PM
Date

TRIPLE S ADVANTAGE, INC.
Organization

PO Box 11320
San Juan, PR 00922
Address

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
23-002

H5774