APPENDIX D

Actuarial Certification

Bid Reports 2024

Bid Submission Status Report

Report Date: 6/6/2023 2:57:31 PM EDT

Contract Number	Organization Name	Plan ID	Segment ID	Version	User ID/Name	Submission Confirmation Number	Submission Date/Time
H4007	HUMANA HEALTH PLANS OF PUERTO RICO, INC.	016	N/A	7	kvtl/ASHLEY KLINK	1886	06/04/2023 14:07:38
H4007	HUMANA HEALTH PLANS OF PUERTO RICO, INC.	018	N/A	2	kvtl/ASHLEY KLINK	1886	06/04/2023 14:07:38
H4007	HUMANA HEALTH PLANS OF PUERTO RICO, INC.	019	N/A	2	kvtl/ASHLEY KLINK	1886	06/04/2023 14:07:38
H4007	HUMANA HEALTH PLANS OF PUERTO RICO, INC.	026	N/A	2	kvtl/ASHLEY KLINK	1886	06/04/2023 14:07:39
H4007	HUMANA HEALTH PLANS OF PUERTO RICO, INC.	027	N/A	2	kvtl/ASHLEY KLINK	1886	06/04/2023 14:07:39
H4007	HUMANA HEALTH PLANS OF PUERTO RICO, INC.	030	N/A	2	kvtl/ASHLEY KLINK	1886	06/04/2023 14:07:39

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Final and Confidential — Not for Public Disclosure

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ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

May 17, 2023

Subject: Calendar Year 2024 Platino Certification Report

Dear Edna:

The Administración de Seguros de Salud (ASES) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rates for the Medicare Platino Program (Platino). The Platino program is a dual-eligible special needs plan (D-SNP) that provides "wrap-around" coverage for Medicaid state plan services not covered by Medicare. The "wrap-around" services consist mainly of prescribed drugs and dental services.

The Platino program is jointly funded by Puerto Rico and the Federal government. The Federal funds are limited to those available under the Enhanced Allotment Plan (EAP) drawn down at the Federal Match Assistance Percentage. Once the funds in the EAP grants are exhausted during the Federal Fiscal Year, any additional expenditure must be covered with local Puerto Rico funds.

According to Actuarial Standard of Practice (ASOP) 49, actuarially sound is being defined by Mercer as follows: Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, cost of capital and government mandated assessments, fees, and taxes.[1]

In certifying to the actuarial soundness of the premium of $50 PMPM for Calendar Year (CY) 2024, Mercer also reviewed the comments in the letter from the Long Term Care Medicaid Subcommittee of the American Academy of Actuaries sent to the Centers for Medicare & Medicaid Services (CMS)

[1] Please see page two of the ASOP No. 49, Medicaid Managed Care Capitation Rate Development and Certification, from the Actuarial Standards Board, https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

regarding "Proposed Rule, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs" dated March 7, 2022.[2]

The Platino program is not operated under a Financial Alignment Initiative (FAI) program where there is one three-way contract between CMS, the state Medicaid agency, and the applicable Medicare-Medicaid plan. For that reason, Mercer did not determine actuarial soundness based on the combined Medical Loss Ratio for Medicare and Medicaid services.

Under the D-SNP program, there is a Medicaid Advantage contract between the Medicare Advantage Organization (MAO) and CMS and a separate capitated contract between the MAO and ASES. As such, the determination of actuarial soundness is based on the separate contract between the MAOs and ASES under the provisions of 42 CFR § 438.4(a).

The increase from $35 PMPM in CY 2023 to $50 PMPM represents an increase of 43% in premium. The estimated premium impact from CY 2023 to CY 2024 by MAO based on CY 2022 enrollment as of December 31, 2022, can be found in the table below.

Table 1: CY 2023 to CY 2024 Budget Impact

MAO	Member Months	CY 2023 Premium at $35 PMPM	CY 2024 Premium at $50 PMPM	Difference
Humana	148,506	$5,198,000	$7,425,000	$2,227,000
MCS Advantage	1,237,307	$43,306,000	$61,865,000	$18,559,000
MMM Healthcare, INC	1,575,223	$55,133,000	$78,761,000	$23,628,000
Triple-S Advantage	493,055	$17,257,000	$24,653,000	$7,396,000
Total	3,454,091	$120,894,000	$172,704,000	$51,810,000

The certified rates for each MAO and product can be found in Appendix A.

Program History

The Platino program began on January 1, 2006, after the passage of the Medicare Modernization Act. It allows dual eligible individuals residing in a MAO service area to enroll with a Medicare Advantage plan with prescription drug coverage. The Platino program was originally intended to assist dual eligible individuals with the cost of prescription drug benefits, but it now also includes wrap-around services. Wrap-around services in general are a "non-covered benefit under the MAO supplementary benefit coverage and included as covered services in the Medicaid state plan." A list of the covered services in the Platino program can be found in Appendix B.

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[2] https://www.actuary.org/sites/default/files/2022-03/American_Academy_of_Actuaries_DSNP_Proposed_Rule_Comment_Letter_03072022.pdf

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Rate Setting Overview

The base data was the 2022 and 2023 Medicare Advantage Part C and Part D bids submitted to the CMS.

We reviewed the bid submissions from the following MAOs:

- Humana Health Plans of Puerto Rico, INC. (Humana)
- MCS Advantage, INC. (MCS)
- Medicare y Mucho Mas Healthcare, LLC. (MMM)
- Triple S Advantage, INC. (Triple S)

Mercer reviewed the Medicaid projected cost not in the MAO bids and projected them forward to CY 2024 since the CY 2024 Medicare MA bids are not available currently. Mercer assumed a 10.7% one-year annualized trend to project the CY 2023 Medicaid projected cost not in the MAO bids to CY 2024. One of the barriers to integrating Medicare and Medicaid D-SNP coverage is that investments in Medicaid coverage for services not covered by Medicare generates savings that accrue to Medicare services and not Medicaid.[3] Since Puerto Rico's D-SNP program does not operate under an FAI arrangement, Medicaid is not able to share in the savings and efficiencies. Considering this, each of the MAOs have agreed Medicare savings and other sources of funds will be used as an additional revenue source to supplement the Platino premium paid by ASES. The MAO contracts with ASES shall be executed to reflect this arrangement. This ensures the ASES premium plus the additional funding from the MAOs are sufficient to cover the wrap-around service costs. This satisfies the actuarial soundness requirement under ASOP 49 whereby "Medicaid capitation rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation rates and **other revenue sources** provide for all reasonable, appropriate and attainable costs."

Program Changes

There were benefit changes assumed for CY 2024 compared to CY 2023. The trend assumption of 10.7% accounts for this difference in benefits. This is reflected in the wrap-around benefit costs found in Appendix A. The MAOs will still contribute the difference between the wrap-around benefit costs and the premium provided by ASES.

Rate Structure

There is only one rate cell for Platino enrollees. All MAOs receive the same rate.

Risk Adjustment

The Platino rates are not risk adjusted.

[3] https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0

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Other Rating Considerations

There are no other risk-sharing, incentive arrangement, or withhold arrangements between ASES and the MAOs.

Projected Non-Benefit Costs

Mercer has not made an explicit adjustment for the administration or underwriting gain component. Mercer assumed the administration and underwriting gain component provided from Medicare would be sufficient and any incremental expenses from this wrap-around coverage would be negligible.

Rate Certification and Caveats

This certification assumes items in the Medicaid state plan or waiver, as well as the MAO contracts, have been approved by CMS. Mercer's certification is contingent on ASES updating the MAO contracts to require the MAOs to fund the difference between the rate paid by ASES and the total cost of Medicaid wrap-around services for the Platino program.

In preparing the attached rates, Mercer has used and relied upon enrollment, eligibility, MAO-submitted bids, and other information supplied by ASES and its vendors. ASES and its vendors are solely responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended rate-setting purpose. However, if the data and information are incomplete, inaccurate, the values shown in this report may differ significantly from values obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates or simplifications of calculations to facilitate the modeling of future events in an efficient and cost effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness, or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate, or unattainable when they were made.

Mercer certifies that the contracted rates for the January 1, 2024, through December 31, 2024, rating period, including any risk sharing mechanisms, incentive arrangements, or other payments, were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the MAO contracts. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other

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party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MAO costs will differ from these projections. Mercer has developed these rates on behalf of ASES to demonstrate compliance with the CMS requirements under 42 CFR § 438.4 and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MAOs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MAOs for any purpose. Mercer recommends that any MAO considering contracting with ASES should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with ASES.

ASES understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends ASES secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This certification report assumes the reader is familiar with the Platino program, Medicaid eligibility rules and actuarial rating techniques. It has been prepared exclusively for ASES and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

ASES agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The certification report will be deemed final and acceptable to ASES if no communication on this matter is received by Mercer within such 30-day period.

If you have any questions, or would like to discuss this information further, please contact An Danh or Chris Guzman.

Sincerely,

An Danh, FSA, MAAA
Principal

Chris Guzman, ASA, MAAA
Principal

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Appendix A: Medicare Platino 2024

Contract No.	MAO	Product	Wrap-around Benefit Costs	Contribution from MAOs	Premium
2024-000001	Triple S Advantage, Inc.	H5774 Plan 024	$165.09	$115.09	$ 50.00
		H5774 Plan 025	$183.29	$133.29	$ 50.00
		H5774 Plan 026	$116.60	$66.60	$ 50.00
		H5774 Plan 028	$139.79	$89.79	$ 50.00
		H5774 Plan 035	$183.29	$133.29	$ 50.00
		H5774 Plan 036	$138.56	$88.56	$ 50.00
2024-000002	MMM Healthcare, LLC	H4003 Plan 017	$155.87	$105.87	$ 50.00
		H4003 Plan 047	$139.90	$89.90	$ 50.00
		H4003 Plan 049	$147.47	$97.47	$ 50.00
		H4003 Plan 058	$140.08	$90.08	$ 50.00
		H4004 Plan 048	$138.58	$88.58	$ 50.00
		H4004 Plan 062	$132.64	$82.64	$ 50.00
2024-000003	MCS Advantage, Inc.	H5577 Plan 002	$120.73	$70.73	$ 50.00
		H5577 Plan 017	$138.35	$88.35	$ 50.00
		H5577 Plan 029	$124.27	$74.27	$ 50.00
		H5577 Plan 037	$131.94	$81.94	$ 50.00
		H5577 Plan 041	$129.24	$79.24	$ 50.00
		H5577 Plan 046	$138.35	$88.35	$ 50.00
2024-000004	Humana Health Plans of PR, Inc.	H4007 Plan 016	$141.82	$91.82	$ 50.00
		H4007 Plan 018	$139.56	$89.56	$ 50.00
		H4007 Plan 019	$135.03	$85.03	$ 50.00
		H4007 Plan 022	$129.58	$79.58	$ 50.00
		H4007 Plan 026	$146.88	$96.88	$ 50.00
		H4007 Plan 027	$147.04	$97.04	$ 50.00

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Appendix B: Covered Services

COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN (Limited to the State Plan Covered Services)*
INPATIENT HOSPITAL SERVICES *Co- Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part A. ***Covers Hospitalization care.*** Covers hospital services, including semi-private rooms, meals, general nursing, and drugs as part of your inpatient treatment, and other hospital services and supplies. This includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. **Costs in Original Medicare:** Part B Medicare is responsible for the costs of that inpatient stay.	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year. Coverage includes: • Isolation room for medical reasons. • Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized. • Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy. Blood: Blood, plasma and their derivatives without limitations, to include irradiated and autologous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per

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	authorization of a certified hematologist and Prothrombin Activated Complex (Auto flex and Feiba) per authorization of a certified hematologist.
INPATIENT HOSPITAL FOR MENTAL HEALTH DISEASES *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part A Covers Hospital Inpatient Mental Health. Covers your room, meals, and nursing care. Medicare limited 190 days lifetime limit in psychiatric hospital.	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.
INPATIENT SUBSTANCE USE DISORDER *Co- Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part A. ***Covers* Inpatient Substances Abuse.** Covers medically necessary inpatient substance abuse treatment services can be covered in Medicare certified hospital. Services provided in facilities that are not Medicare certified are not covered by Medicare.	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
OUTPATIENT SUBSTANCE USE DISORDER *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part B **Covers Partial Hospitalization.** Partial hospitalization programs (PHPs) are structured to provide intensive psychiatric care	Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit

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through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are discharged from an inpatient hospital treatment program, and the PHP is in lieu of continued inpatient treatment; or those patients who, in the absence of partial hospitalization, would be at reasonable risk of requiring inpatient hospitalization. According to current practice guidelines, the treatment goals should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.	coverage and included as covered services on Medicaid state plan. Access to a semi-private room (bed available twenty-four (24) hours a day, every Calendar Day of the year.
OUTPATIENT MENTAL HEALTHCARE /130- $0.00 & PROFESSIONAL SERVICES	*Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00***
Medicare Part B **Cover Mental Health Services and Visits**. Covers with these types of health professionals (deductibles and coinsurance may apply): Psychiatrist or other doctor, Clinical psychologist, Clinical social worker, Clinical nurse specialist, Nurse practitioner and Physician assistant. One depression screening per year. The screening must be done in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals. Part B also covers outpatient mental health services for treatment of inappropriate alcohol and drug use.	All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.

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• Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where you get the services. • Family counseling, if the main purpose is to help with your treatment. • Testing to find out if you're getting the services you need and if your current treatment is helping you. • Psychiatric evaluation. • Medication management. • Certain prescription drugs that aren't usually "self-administered" (drugs you would normally take on your own), like some injections. • Diagnostic tests. • Partial hospitalization. • A one-time "Welcome to Medicare" preventive visit. This visit includes a review of your potential risk factors for depression. • A yearly "Wellness" visit. This is a good time to talk to your doctor or other health care provider about changes in your mental health so they can evaluate your changes year to year.	
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
LABORATORY AND HIGH-TECH LABORATORIES *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120-$0.00 /130- $0.00***	
Medicare Part B **Covers *Clinical Diagnostic Laboratory Services.*** Covers that are ordered by your doctor or practitioner. Laboratory tests include certain blood tests, urinalysis, tests on	Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.

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tissue specimens, and some screening tests. They must be provided by a laboratory that meets Medicare requirements. **Medicare doesn't cover most Health Certificates**	
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
FAMILY PLANNING *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare doesn't cover Family Planning	Family Planning services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: education and counseling; pregnancy testing; infertility assessment; sterilization services in accordance with 42 CFR 441.200 subpart F; laboratory services; cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC); at least one of every class and category of FDA-approved contraceptive; at least one of every class and category of FDA-approved contraceptive method; and other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations: • Contra-indication with drugs that the Enrollee is already taking, and no other

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	methods covered/available that can be used by the Enrollee. • History of adverse reaction by the Enrollee to the contraceptive methods covered. • History of adverse reaction by the Enrollee to the contraceptive medications that are covered.
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
TOBACCO CESSATION Co-Payment Code ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part B (Medical Insurance) covers up to 8 face-to-face visits in a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner.	Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and non-prescription aids as indicated by a physician.
MATERNITY SERVICES Co-Payment Code ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Maternity Services Medicare Part A and B Covers Prenatal and Maternity Care. Covers medically necessary services and Inpatient services Abortions are only covered when the life of the mother would be in danger if the fetus is carried to term.	Maternity services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Abortions when the pregnancy is a result of rape or incest as certified by a physician. Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term as certified by a physician.

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COVERAGE ORIGINAL MEDICARE	*PLATINO WRAP STATE PLAN*
MEDICAL AND SURGICAL *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130-$0.00***	
Medicare Part B **Covers Ambulatory Surgery**. Covers the facility and professional service fees related to approve surgical procedures provided in an ambulatory surgical center.	Medical and Surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form included as Appendix (O) (18) of the Contract.
VISION* SERVICES** *Co-Payment Code* ***100-$0.00 / 110-$1.00 /120- $1.50 /130- $2.00	
Medicare Part B - Medicare does not normally cover routine vision services, such as eyeglasses and eye exams. **Covers Glaucoma Tests** every 12 months under certain circumstances. For people with diabetes: It covers eye exam to check for diabetes retinopathy.	Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when **medically necessary** will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lens have to be preauthorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre-authorization will be covered.
DENTAL SERVICES PREVENTIVE & RESTORATIVE *Co-Payment Code*	

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Preventive (Child)*100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00* **Preventive (Adult)*100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00*** **Restorative *100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare doesn't cover most dental care, Part A can pay for inpatient hospital care to have emergency or complicated dental procedures, even though the dental care isn't covered	Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. The following are the benefits included in the GHP; • All preventative and corrective services for children under age twenty-one (21) mandated by the EPSDT requirement • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy; • Preventive dental services for Adults; • Restorative dental services for Adults; • One (1) comprehensive oral exam per year; • One (1) periodical exam every six months; • One (1) defined problem-limited oral exam; • One (1) full series of intra oral radiographies, including bite, every three (3) years. • One (1) initial periapical intra-oral radiography; • Up to five (5) additional periapical/intra-oral radiographies per year; • One (1) single film-bite radiography per year; • One (1) two-film bite radiography per year; • One (1) panoramic radiography every three (3) years; • One (1) adult cleanse every six (6) months; • One (1) child cleanse every six (6) months; • One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old;

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	• Fissure sealants for life for Enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies; • Amalgam restoration; • Resin restorations; • Root Canal; • Palliative treatment; and • Oral Surgery • Sedation and anesthesia services for beneficiaries with physical or mental handicaps in compliance with local laws. • Periodontal Scaling and root planning up to 4 cuadrants per beneficiary. • Interim removable partial dentures (upper and lower). • Hospital visits. • All limitations may be exceeded based on medical necessity and approved thorough prior pre authorization or exemption process.
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
HEARING EXAMS *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	

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Medicare Part B Covers Diagnostic Hearing and balance exams if the physician or other health care provider orders these tests to see if you need medical treatment. Medicare covers audio logic diagnostic testing provided by an audiologist when a physician or non-physician practitioner (nurse practitioner, clinical nurse specialist, or physician's assistant) orders the evaluation for the purpose of informing the physician's diagnostic medical evaluation or determining appropriate medical or surgical treatment of a hearing deficit or related medical problem Medicare doesn't cover, hearing aids, or exams for fitting hearing aids.	Hearing related services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Hearing aids for beneficiaries over 20 years old are excluded from coverage.
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
PREVENTIVE* SERVICES** *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00	
Immunizations Medicare Part B **Covers Normally covers one Immunizations** shot per: Influenza (Flu); Hepatitis B; and Pneumococcal shots. Also cover tetanus and rabies shots when expose or at-risk episode. Vaccines coverage according to the Medicare Benefit Package/ Recommended all vaccines by ACIP and DOH for adults population.	Immunization services non-covered by; 1- Medicare Part B. 2- MAO Part D drug formulary. 3- MAO supplementary plan benefits. Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan.
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY *Co-Payment Code* ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00***	
Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services. Medicare law no longer limits how much Medicare pays for your medically necessary outpatient therapy services in one	Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.

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calendar year. However, your therapist will need to add information to your therapy claims and your medical record if your therapy services reach these amounts in 2023:

CY 2023 this KX modifier threshold amount is:

- $2,230 for PT and SLP services combined, and
- $2,230 for OT services.

Once your therapy services reach these amounts, your therapist will need to add a special code to your therapy claim. By adding this code, your therapist confirms that:

Your therapy services are reasonable and necessary

Your medical record includes information to explain why the services are medically necessary

A Medicare contractor may also review your medical records to be sure your therapy services were medically necessary. This review may happen if your therapy services reach these amounts in 2023:

$3,000 for PT and SLP services combined

$3,000 for OT services

Your therapist or therapy provider must give you a written notice before providing services that aren't medically necessary. This includes therapy services that are generally covered but aren't medically reasonable and necessary for you at the time. This notice is called an "Advance Beneficiary Notice of Non Coverage" (ADN). The ADN lets you choose whether or not you want the therapy

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services. If you choose to get the medically unnecessary services, you agree to pay for them.	
COVERAGE ORIGINAL MEDICARE	***PLATINO WRAP STATE PLAN***
PRESCRIPTION DRUGS	
Co-Payment Code ***100-$0.00 / 110-$1.00 /120- $2.00 /130- $3.00*** ***Preferred (Adult)*******	
Co-Payment Code ***100-$0.00 / 110-$3.00 /120- $4.00 /130- $6.00*** ***Non-Preferred (Adult)*******	
Co-Payment Code ***100-$0.00 / 110-$0.00 /120- $0.00 /130- $0.00*** ***Outpatient Substance Abuse***	
Drugs and biologicals are covered only if all of the following are met: they meet the definition of drugs or biologicals; they are not the type that are usually self-administered; they meet all of the general requirements for coverage of items as incident to a physician's services; they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; they are not excluded as immunizations; and they have not been determined by the FDA to be less than effective.	Prescription drugs non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State plan The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings: • All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution. • Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary, the drug will be covered under Wrap-

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	Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category. Wrap around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.

[1]Medicare Platino cannot establish copayments higher than the ones specified in the Wrap Around table.

Platino wrap services are subject to the maximum co-payments in the table with exemptions and zero co-payments for Medicaid/CHIP beneficiaries and certain services as follows:

Medicaid/CHIP Beneficiaries

- **American Indians and Alaskan Natives (AI/AN)**
- **Institutionalized Individuals; and**
- **Individuals receiving Hospice Care.**

Services

- **Emergency services, including ambulatory, hospital and post-stabilization services as defined in federal regulations 1932(b)(2) of the Act and 42 CFR 438.114(a);**
- **Family Planning services and supplies;**
- **Pregnancy related services and counseling and drugs for cessation of tobacco use;**
- **Provider-preventable services as defined in 42 CFR 447.26(b); and**
- **Non-emergency visit to a hospital emergency room may be waived by calling the MCO call center and receiving a code to waiver co-pay.**

Notes: 1. Wrap around table is subject to change in 01/01/2024.

2. N/A= Medicare fulfill or exceeds PSG benefit

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