APPENDIX C (5)
Medicare Platino Norms

MMM

Certification

Platino General Information 2025

This communication is to inform MAOs the standards and other requirements that must be included in the 2025 Medicare Platino contract and the product design for the Platino Population. It is important to mention that Medicare Platino is only for dual eligible beneficiaries from Vital Plan; MAOs cannot subscribe other beneficiaries under these products.

The model for the 2025 Medicare Platino products continues to be a preferred network model. In addition, the product must ensure that transition of care will not require referrals within the medical group network, including specialists, if the specialist is contracted by the medical group.

MAOs may develop and present a maximum of six (6) products and six (6) Plan Benefit Packages (PBP) for Medicare Platino procurement. ASES will charge an administrative fee of twenty-five thousand dollars ($25,000) for each product submitted.

Requirements are as follows:

I - CARE COORDINATION

A. SPECIAL CONDITIONS

1. MAOs shall provide ASES with the implemented strategy for identification of populations with special health care needs, any ongoing special conditions of Enrollees that require a treatment plan and regular care monitoring by appropriate Providers. The conditions ASES classifies as special coverage and that do not require referral are:

    a) HIV/AIDS
    b) Tuberculosis
    c) Leprosy
    d) Systemic Lupus Erythematosus (SLE)

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e) Cystic Fibrosis
f) Cancer
g) Hemophilia
h) ESRD=> Levels 3, 4 and 5
i) Multiple Sclerosis & Amyotrophic Lateral Sclerosis (ALS)
j) Scleroderma
k) Pulmonary Hypertension
l) Aplastic Anemia
m) Rheumatoid Arthritis
n) Autism
o) Skin cancer: carcinoma IN SITU
p) Skin cancer: Invasive Melanoma or squamous cells with evidence of metastasis.
q) Adults with Phenylketonuria
r) Chronic Hepatitis C
s) Congestive Heart Failure (CHF) Class III and IV - NHHA in a potential candidate for heart transplant
t) Primary Ciliary Dyskinecia (PCD) / Immotile Ciliary Syndrome/ Syndrome de Kartagener
u) Inflammatory Bowel Disease (IBD): Chron's disease; Ulcerative Colitis and Microscopic Colitis.
v) Post-Transplant

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2. Once diagnosis has been established. Treatment, and its related services, for special conditions listed above do not need a referral from the Primary Care Physician (PCP).

3. The Contractor may use the Default Enrollment (previously known seamless conversion) Option for Newly Medicare Eligible Individuals, as detailed in §40.1.4, Chapter 2 of the Medicare Managed Care Manual. This option shall be available for newly eligible individuals for Medicare.

B. REFERRALS

1. When a patient is referred to a specialist by a PCP and prescribes a medication, no countersignature of the prescription will be required from the PCP, as established by CMS.

2. If MAOs have contracted with Primary Medical Groups (PMGs), who have directly contracted preferred provider specialists, a referral from the PCP is not necessary when both are part of the same PMG. However, the specialists will be required to inform the PCP about the medical services referred.

3. Patients can see specialists such as a Gynecologist/Obstetrician and Urologist, among others, without a referral from their PCP. Referrals for laboratory, diagnostic tests and others shall be governed by standard number two (2) of the referral section.

4. No referral is required for services related to pathological laboratories.

5. MAO's must inform and train all providers about the referral procedures and ensure that they understand the process to guarantee health care coordination between primary care provider and specialists.

C. PHARMACY

1. Bioequivalent drugs are mandatory.

2. Erectile Dysfunction (ED) drugs are not included in the Medicare Platino coverage. This prohibition is extended to marketing materials, and other activities for Medicare Platino Population.

II - PAY FOR PERFORMANCE AND OTHER INCENTIVES

ASES approves the use of incentive payments that complies with the following elements:

1. Credible use of medical standards that support quality improvement and reduce adverse effects on patient care.

2. Incentive payments to physicians and other providers must be related to quality initiatives supported by the Centers for Medicare and Medicaid Services (CMS).

3. Incentive payment arrangements cannot be used to reduce or limit the services that a patient needs or may need. For example, reduction of diagnostic tests, hospitalizations, treatments, and others.

4. Continuous supervision by a third party that is independent from hospitals, medical groups, and insurers, to evaluate that the services provided to patients are not affected.

5. Maintain transparency by clearly defining quality objectives. MAOs must notify patients of the implementation of the incentive programs and the physicians are accountable for proper care.

6. These incentives must not be used to penalize physicians that have patients with major health conditions that do not meet clinical guidelines.

7. MAOs must submit to the ASES Compliance Office a list of the incentives established by the MAOs with their description, within 30 days of signing the contract with ASES.

8. MAO's are required to establish quality incentives to never reduce events, as long as they are identified by CMS, this incentive cannot be aimed at reducing payment to Providers.

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III - PAYMENT TO PROVIDERS AND OTHERS

Non-compliance with the "Payment to Providers" rule could result in administrative penalties not less than $100.00 by invoice line up, and up to a maximum of$1,000.00 by invoice line, not paid or partially paid.

1. **Clean Claims - Payment within thirty (30) calendar days**

In accordance with 42 CFR 422.520 and as established in the Contract Between ASES and the MAOs, the contracts between the MAOs and Providers, must contain a prompt payment provision indicating that ninety-five percent (95%) of all clean claims must be paid by the MAOs, no later than thirty (30) days from the date of their receipt, and the one hundred percent (100%) of all clean claims must be paid by the MAO not later than fifty (50) days from the date of their receipt, including claims billed on paper or electronically. For the purposes of this Section, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim and the date of payment is the date of the check or other form of payment.

Any clean claim not paid within thirty (30) calendar days shall bear interest in favor of participating provider on the total unpaid amount of such claim, according to the prevailing legal interest rate fixed by the Puerto Rico Commissioner of Financial Institutions. Such interest shall be considered payable on the day following the terms hereof and it shall be paid together with the claim.

2. **Unclean Claims**

As established in the Contract between ASES and the MAOs, ninety percent (90%) of the unclean claims must be resolved and processed with payment by the MAOs, if applicable, not later than ninety (90) calendar days from the date of initial receipt; this includes claims billed on paper or electronically.

Nine percent (9%) of the unclean claims must be resolved and processed with payment by the MAOs, if applicable, not later than six (6) calendar months from the date of initial receipt; this includes claims billed on paper or electronically.

One percent (1%) of all unclean claims must be resolved and processed with payment by the MAOs, if applicable, not later than the year (12 months) from the date of initial receipt; this includes claims billed on paper or electronically.

3. **Clean Claim Definition**

Clean Claim are defined as one that can be processed without obtaining additional information from the provider of the service or from a third party.

It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

In certain instances, the information requested from the provider depends on, or is under the control of, the MAOs. In these cases, the MAOs shall process a claim although it does not contain required information that is accessible to or is under the MAOs control.

The MAOs shall not establish any administrative proceeding that impedes the Provider from submitting a clean claim. The MAOs must report to the providers the details of the requirements to consider a claim as a clean claim and cannot make changes to the rules without the prior consent of the providers, unless it is required by ASES, CMS or other Commonwealth or Federal law or regulation.

4. The MAOs may reach agreements to improve a provision but cannot be more restrictive than the provisions of this Section.

5. Whenever the MAOs determines that a claim was wrongfully paid, or an overpayment occurred, and the same happened because of a potential instance of fraud, it shall be informed to ASES's Compliance Office before proceeding with a possible recoupment process. The MAO shall send to ASES a written notice, stating the reasons for the recoupment, a list of claims wrongfully paid, and the amounts to be potentially recovered. Any report concluding that a recoupment may be required as a result of potential fraud must be clearly and unambiguously identified and demonstrated, a simple explanation will not suffice without documents to support it.

6. **Hospitalization services or extending for more than thirty (30) calendar days.**

In the event of hospitalizations or extended services that exceed thirty (30) calendar days, the provider may be bill and collect at least every thirty (30) calendar days for services rendered to the patient, these services will be paid according to the procedure in this section (Payment to Providers and Others)

7. **Refusals**

In the case where there is an intention to deny hospitals days or denied services to a provider, and the denial is not accepted by the provider or the issues are in appeals process, the MAO's cannot withhold until the case is finally adjudicated.

In the instances, if there are not agreements between parties, a third party,

external to the MAO's and the Providers and chosen by mutual agreement with competence in the case, will judge over the denial in the period no grated than thirty (30) calendar days. The Part adversely affected in the case in question will pay for the third party's service fees. Is there not agreement on the third party's selection, it will be appointed by ASES, and the parties will comply with the third party's decision.

The party who causes the error must pay the Third Party's service fees. If both parties have caused an error, the third parties shall determine the percentage attributable to each party, in which case payment of the Third Party must be in accordance with percentage of responsibility.

The MAO's cannot deny or make a recoupment wherever it has issued a document authorizing a health service, but then it determines that there was an error because the service is not covered or the patients is not insured of the entity, this provision does not apply in cause of fraud.

The MAO's cannot withhold the payment to the providers until the controversy is firm and final.

IV - REPORTING OBLIGATION

1. The MAOs shall submit all reports required by ASES in the format required by Contract and Normative Letters.

2. The MAOs must require Providers to comply with all reporting requirements contained in their Contract, as applicable, and particularly with the requirements to submit Encounter Data for all services provided, and report all instances of suspected Fraud, Waste, or Abuse.

3. ASES will consider granting extension requests by the MAO only if it's requested with at least twenty-four (24) hours before due date of the report.

Additional time will only be authorized in rare and unusual circumstances documented by the MAO. The request must be submitted by the Division Director responsible for the report of the Compliance Officer liable. If the extension is granted grants and the report is submitted before the extended deadline, the report(s) will be considered timely and not subject to penalty. The extension will not exceed more than ten (10) calendar days.

4. If the delivery date for a report falls on a weekend or federal holiday, the report will be accepted for receipt on the next business day. Puerto Rico Holidays will be considered valid dates to submit reports and information required by contract or requested by the ASES.

V - REQUIRED PROVISIONS IN PROVIDER CONTRACT

1. The Medicare Platino Program, administered by ASES, is a Medicaid product. Every

MAO contracted by ASES for the Vital Plan must ensure that their providers, hospitals, and ancillary providers offer services in both Platino and Vital Plan. If a MAO is not contracted by ASES for the Vital Plan, it shall be the MAO's responsibility to ensure that health care services are provided as needed by the beneficiary and as contracted with ASES.

VI - OTHER PROVISIONS

1. People aged 60 and over will be able to choose a Geriatrician as their PCP.

2. Every MAO must establish procedures that guarantee that PCPs will be informed of all services provided to their patients. For this reason, communication standards among Providers should include a requirement for specialists to send the beneficiary's PCP a report on the patient's health condition.

3. Every MAO contracted by ASES to offer services for the Platino population must comply with the requirements established in 42 CFR 455. The integrity guides will be included in the contract with the MAOs. ASES will perform tests and/or audits to ensure compliance.

4. MAOs must require that no charge will apply to Platino beneficiaries for provision of certifications required for the Puerto Rico Medicaid Program.

5. Every MAO shall ensure that all providers and beneficiaries understand the process regarding how beneficiaries can ask for coverage determinations, exceptions to rules, and perform an appeal if the MAO does not cover a medication or service or if beneficiaries cannot afford a medication or service.

6. Every MAO shall ensure that marketing activities are following the Guidelines for Marketing Activities establishes by ASES.

7. If the MAO plans to introduce a PBP with a limited-service area or an area divided by regions, please note that marketing materials should not be promoted by segment or region. The marketing materials to be submitted for ASES approval must include information applicable to all regions (i.e. 1SB, **1** EOC per. PBP).

8. ASES will not approve any changes outside the dates established by CMS, for which reason it is recommend that MAOs' products and co-pays be submitted correctly within the dates established by CMS in the Call Letter 2024.

   Should there be any change because of an administrative decision by ASES or the publication of a normative letter, ASES will be responsible to coordinate with CMS and request approvals to allow the MAO's implement the change. This rule also applies to Value-Added Items and Services (VAIS) which must be in place for the entire contract

year (refer to 80.1). In addition, ASES will not allow any changes to the certifications submitted as part of the contract unless required by ASES and/or CMS as part of bid adjustments. ASES will not accept changes to the certifications after the contract signature with CMS.

9. Utilization Guides to be used for clinical audits must be submitted to ASES and prepared from nationally recognized entities. The MAO's must submit, as part of the required information, licenses for use and a training certification for the personnel that will be using them. These guides must be submitted to the Executive Division within 30 days after contract signature.

10. The MAO must be following the CMS' Marketing Guidelines and ASES Normative Letter 17-08-II(Amendment) that establishes the marketing material standards to be adhered to approval the announcement or promotional material by ASES.

11. The MAO's are responsible for ensuring that not only its marketing activities, but also the marketing activities of its Subcontractors and Providers, meet the above requirements.

12. ASES will establish sanctions or civil monetary penalties against any MAO that does not comply with these norms. The sanctions or monetary penalties for noncompliance will be forty thousand ($40,000.00) dollars for each event of non-compliance. If the MAO incurs in the same non-compliance of the norms that resulted in a previous imposition of sanctions, ASES has the discretion of imposing to the MAO a sanction or monetary penalty of eighty thousand ($80,000.00) dollars for each reoccurring event of non-compliance. ASES may impose additional intermediate sanctions or civil monetary penalties in the contract to be executed between ASES and the MAOs for the latter's non-compliance with any of the terms and conditions of the contract.

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Normative Letter

If necessary, ASES will issue Normative Letters to clarify any doubts with the procedure to be followed by this letter, including terms and interest payments.

The Parties may not change the conditions imposed by ASES in the 2025 Platinum Standards, any doubts in the implementation thereof shall be the full responsibility of ASES to interpret them.

Medicare Advantage companies are responsible of publishing this Normative Letter to beneficiaries and providers.

I, **Ricardo Rivera Cardona**, **President**, hereby certify that **MMM Healthcare, LLC**, will follow the guidelines established in the **Platino General Information 2025, received on May 29, 2024.**

President

06/07/24
Date