CONTRACT NUMBER: 2019-000049M

AMENDMENT TO THE CONTRACT BETWEEN
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES)
and
FIRST MEDICAL HEALTH PLAN, INC.
to
ADMINISTER THE PROVISION OF PHYSICAL
AND BEHAVIORAL HEALTH SERVICES UNDER THE GOVERNMENT HEALTH PLAN

THIS AMENDMENT TO THE CONTRACT BETWEEN ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES) AND FIRST MEDICAL HEALTH PLAN, INC., FOR THE PROVISION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES UNDER THE GOVERNMENT HEALTH PLAN (the "Amendment") is by and between **First Medical Health Plan, Inc.** ("the Contractor"), a managed care organization duly organized and authorized to do business under the laws of the Commonwealth of Puerto Rico, with employer identification number 66-0537624 and represented by its Administrative Vice President, José A. Pagán Torres, of legal age, married, resident of Cidra, Puerto Rico, and the **Puerto Rico Health Insurance Administration** (Administración de Seguros de Salud de Puerto Rico, hereinafter referred to as "**ASES**" or "**the Administration**"), a public corporation of the Commonwealth of Puerto Rico, with employer identification number 66-0500678, represented by its Executive Director, Jorge E. Galva Rodríguez, JD, MHA, of legal age, married and resident of Vega Alta, Puerto Rico.

WHEREAS, the Contractor and ASES executed a Contract for the provision of Physical Health and Behavioral Health Services under the Government Health Plan for the Commonwealth of Puerto Rico, on September 21, 2018, (hereinafter referred to as the "Contract");

WHEREAS, the Contract provides, pursuant to Article 55, that the Parties may amend such Contract by mutual written consent;

WHEREAS, all provisions of the Contract will remain in full force and effect as described therein, except as otherwise provided in this Amendment.

NOW, THEREFORE, and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to clarify and/or amend the Contract as follows:

I. AMENDMENTS

1. **The definition for "Sub-capitated" in Article 2 shall be deleted in its entirety.**

2. **The definition for "Encounter" in Article 2 shall be amended and replaced in its entirety as follows:**

   Encounter: A distinct set of services provided to an Enrollee in a Telehealth, Telemedicine, Teledentistry, or face-to-face setting on the dates that the services were delivered and properly documented on the appropriate health record, regardless of whether the Provider is paid on a

Fee-for-Service, Capitated, salary, or alternative payment methodology basis. Encounters with more than one (1) Provider, and multiple Encounters with the same Provider, that take place on the same day in the same location will constitute a single Encounter, except when the Enrollee, after the first Encounter, suffers an illness or injury requiring an additional diagnosis or treatment.

3. **The following definitions in Article 2 shall be inserted as follows:**

Aids Drug Assistance Program: state and territory-administered program authorized under Part B that provides FDA-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare.

High Cost High Needs Pre-Registry: Process to be followed by the Contractor, as set forth in Attachment 28, detailing the changes regarding all of HCHN conditions identified.

Subcapitation Arrangement: An arrangement where an entity paid through capitation contracts with other providers to reimburse for their services on a capitated basis, sharing a portion of the original capitated amount.

Teledentistry: The use of telehealth systems and methodologies to deliver dental services to patients in remote locations, as further defined by the American Dental Association ("ADA") and inclusive of any of the ADA's Code on Dental Procedures and Nomenclature ("CDT") codes specific to teledentistry.

Telehealth: The use of electronic information and telecommunications technologies, including but not limited to telephonic communications, the internet, videoconferencing, and remote patient monitoring, to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration, as further defined by the American Medical Association ("AMA") and inclusive of any of the AMA's Current Procedural Terminology ("CPT") Codes or other nomenclature accepted by HIPAA transactions specific to telehealth.

Telemedicine: The clinical use of telehealth systems and methodologies by Providers to diagnose, evaluate and treat patients in remote locations, as further defined by the American Medical Association ("AMA") and inclusive of any of the AMA's Current Procedural Terminology ("CPT") Codes specific to Telemedicine.

4. **Immediately following Section 7.1.5, a new Section 7.1.6 shall be inserted stating as follows:**

7.1.6 The availability of health care services through Telehealth, Telemedicine, and Teledentistry is a matter of public policy that must be developed and made operational by the Contractor and Providers. As a general principle, ASES will treat Telemedicine and telehealth services on equal footing as in-person services, providing for the required adjustment in reimbursement when appropriate and for the establishment of necessary oversight by the Contractor. Subject to the foregoing, the Contractor shall allow Providers to conduct patient re-assessments and provide clinically appropriate care via the use of Telemedicine and Teledentistry, in accordance with Puerto Rico law and any applicable federal requirements governing such activity.

5. **Immediately following Section 7.5.3.2.1.2, a new Section 7.5.3.2.1.3 shall be inserted stating as follows:**

7.5.3.2.1.3 The Contractor shall cover the immunization of all Enrollees against COVID-19. COVID-19 vaccine costs are not considered in the current premium. When a COVID-19 vaccine becomes available, ASES shall procure an actuarial analysis to calculate any necessary changes to PMPM Payment rates. Any changes to PMPM payment rates will be retroactively adjusted as of the date the Contractor began to cover the treatment.

6. **Immediately following Section 7.5.6.1.18, a new Section 7.5.6.1.19 shall be inserted stating as follows:**

7.5.6.1.19 The use of Veklury (remdesivir) as medically necessary for the treatment of hospitalized adult and pediatric Enrollees with suspected or laboratory-confirmed COVID-19, in accordance with FDA guidance. The costs of such drug and/or treatment shall be reimbursed by ASES separately from PMPM Payments.

7. **Section 7.5.12.3.1 shall be deleted in its entirety, and the remaining Section 7.5.12.3 shall be renumbered accordingly, including any references thereto.**

8. **Section 7.7.11.16 shall be amended and replaced in its entirety as follows:**

7.7.11.16 Required medication for the outpatient treatment of Hepatitis C is included under Special Coverage. Any costs incurred for required medication for the outpatient treatment of Hepatitis C shall be funded through separate payment by ASES to PBM. Medication for the outpatient treatment for AIDS-diagnosed Enrollees or HIV-positive Enrollees is also included under Special Coverage and are provided by ADAP. . . Protease inhibitors are excluded from the covered services are provided by CPTET Centers.

9. **Section 7.5.12.15.1 shall be amended and replaced in its entirety as follows:**

7.5.12.15.1 The Contractor shall select two (2) members of its staff to serve on a cross-functional committee, the Pharmacy Benefit Financial Committee, tasked with rebate maximization and/or evaluating recommendations regarding the FMC and LME from the P&T Committee and the PPA and PBM as applicable. The Pharmacy Benefit Financial Committee will also review the FMC and LME from time to time and evaluate additional recommendations on potential cost-saving pharmacy initiatives, including the evaluation of the utilization of high-cost specialty medications and orphan drugs and the exceptions process through which such drugs are approved, under the direction and approval of ASES. The Pharmacy Benefit Financial Committee will meet not later than thirty (30) days after the execution of this Amendment and monthly thereafter.

At the request of either party, ASES will conduct an actuarial evaluation of any new treatment, including but not limited to new: technology, medical or surgical procedure, physical or behavioral therapy, drugs, Part B drugs and orphan drugs (collectively, "New Treatment"), that are Medically Necessary and are not expressly excluded from the GHP. ASES will adjust the PMPM rates to reflect the above-referenced changes after the adjusted rates are approved by CMS.

10. Section 10.3.1.14 shall be amended and replaced in its entirety as follows:

10.3.1.14 Require the Provider to cooperate with the Contractor's quality improvement and Utilization Management activities, including those activities set forth in the HCIP, and any related reporting. Contractor is not permitted to grant any individual Provider an exception to the requirements under this Section;

11. Immediately following Section 10.3.2.1.6, a new Section 10.3.2.1.7 shall be inserted stating as follows:

10.3.2.1.7 Require PMGs reimbursed by Contractor under a Subcapitated Arrangement to certify that the PMG has passed through any increase of Subcapitated amounts to its affiliated physicians. ASES and Contractor shall track any complaints filed by PMG-affiliated physicians and conduct the appropriate investigation and diligence to ensure compliance with this section. The Contractor shall provide to ASES an attestation to certify compliance with this section. If PMGs refuse to certify the pass-through of the increase of Subcapitated amounts to its affiliated physicians, or otherwise fail to comply with this section's requirements, Contractor may escalate the issue to ASES and shall not be obligated to remit to impacted PMGs the increased amounts set forth under Section 10.5.1.5.3 until ASES has resolved the issue.

12. Section 10.5.1.5.1 shall be amended and replaced in its entirety as follows:

10.5.1.5.1 Claims submitted for professional services that are listed in the current Medicare Part B fee schedule, as established under Section 1848(b) of the Social Security Act, and as applicable to Puerto Rico for 2020 (70% MFS), shall be reimbursed by the Contractor at not less than seventy percent (70%) of the payment that would apply to covered services and benefits, if they were furnished under Medicare Part B, disregarding services that are paid through Subcapitation Arrangements. Any claims subject to reimbursement in accordance with this Section 10.5.1.5.1 that have been reimbursed at less than seventy percent (70%) of the corresponding rates on the Medicare Part B fee schedule shall be re-adjudicated for payment in compliance with this Section. In the event the MCO and the provider have a contracted rate greater than the 70% at the time of this Amendment, the MCO may (i) maintain the current rate contracted with the provider for the effectiveness of that agreement, or (ii) contract a different rate as long as such rate is 70% MFS or higher. The Contractor shall comply with all data collection and reporting requests from ASES, in the manner and frequency set forth by ASES, to validate the Contractor's compliance with this Section.

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13. Immediately following Section 10.5.1.5.2, new Sections 10.5.1.5.3, 10.5.1.5.4, and 10.5.1.5.5 shall be inserted stating as follows:

10.5.1.5.3 Contractor must increase payments to PMGs under a Subcapitated Arrangement from July 1, 2020. Contractor must remit the full increased amount to impacted PMGs. Subcapitation Arrangements shall not be subject to the requirements set forth in Section 10.5.1.5.1 and 10.5.1.5.2.

10.5.1.5.4 Contractors shall collaborate with ASES in good faith to adopt a DRG reimbursement methodology for hospitals within the timeframe specified by ASES. In addition, Contractors shall engage in good faith with the Provider community and ASES to identify providers and services that should be subject to future implementation of alternative payment methodologies (APMs) that align with Medicare APMs and/or the Health Care Payment Learning and Action Network (LAN) framework for classifying APMs to derive value and improved outcomes for the Plan Vital population. The Contractor shall identify dedicated staff to engage in these efforts and participate in meetings convened by ASES. ASES will adjust the PMPM rates to reflect the changes after said rates are approved by CMS.

10.5.1.5.5 Contractor shall make directed payments to qualifying short-term acute care hospitals in the amount and frequency set forth by ASES. Contractor shall make those payments as soon as ASES disburses such payments to the Contractor. Such directed payments shall reflect a uniform dollar increase per All Patient Refined Diagnosis Related Groups (APR-DRG) case-mix adjusted discharges for qualifying public and private short-term acute care hospitals. Such increases shall be funded through payments disbursed by ASES to Contractor as lump sum amounts payable throughout the year, quarterly or with the frequency mandated by ASES, and separate from PMPM Payments. Contractor shall cooperate in any efforts made by ASES to reconcile projected and actual APR-DRG case-mix adjusted discharges, including but not limited to complying with all data collection and reporting requests from ASES, in the manner and frequency set forth by ASES, and any required, post-reconciliation recoupment of directed payments previously made to qualifying short-term acute care hospitals.

14. Section 10.6.2 shall be amended and replaced in its entirety as follows:

10.6.2 The Contractor shall ensure that PMGs subject to a Subcapitation Arrangement with the Contractor are not responsible for the difference between current fee for service reimbursements for which the PMG is At Risk and increases in reimbursement amounts necessary to meet new minimum reimbursement thresholds, established at Section 10.5.1.5.1, unless a new Subcapitation Arrangement is negotiated between and agreed upon by the Contractor and the PMG to account for said increase.

15. Section 12.5.1 shall be amended and replaced in its entirety as follows:

12.5.1 The HCIP consists of four (4) initiatives subject to performance indicators specified in the Health Care Improvement Program Manual ("HCIP Manual"), Attachment 19 to this Contract. The initiatives and accompanying performance indicators and measurement periods for the Contract Term are further defined in the HCIP Manual.

12.5.1.1 High Cost Conditions Initiative;

12.5.1.2 Chronic Conditions Initiative;

12.5.1.3 Healthy People Initiative; and

12.5.1.4 Emergency Room High Utilizers Initiative

16. Immediately following Section 12.8.4 a new Section 12.9 shall be inserted stating as follows:

12.9 **Comprehensive Oversight and Monitoring Plan (COMP)**

12.9.1 The Comprehensive Oversight and Monitoring Plan ("COMP") as developed and implemented by ASES pursuant to federal requirements, sets forth clinical, operational and financial performance metrics and benchmarks to evaluate the efficiency, type and volume of care provided to Enrollees by all MCOs. As part of this oversight effort, Contractor shall timely comply with all ASES requests for COMP reporting and data collection as well as operational reviews, corrective action and targeted interventions as deemed necessary based on ASES's review of such COMP reports and data. ASES shall issue further guidance as to Contractor's expectations and obligations under the COMP. Should COMP requirements materially impact the obligations of Contractor under this Contract, ASES shall seek an amendment to this Contract to accommodate said requirement.

17. Section 13.1.6 shall be amended and replaced in its entirety as follows:

13.1.6 The Contractor shall submit its proposed compliance plan, Fraud, Waste, and Abuse policies and procedures, and its program integrity plan to ASES for prior written approval according to the timeframe specified in Attachment 12 to this Contract.

18. Section 13.1.7 shall be amended and replaced in its entirety as follows:

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

19. Immediately following Section 13.1.11 a new Section 13.1.12 shall be inserted stating as follows:

13.1.12 The Contractor shall participate in any efforts by ASES, the Medicaid Program Integrity Office, or the Medicaid Fraud Control Unit to engage MCOs and facilitate outreach, discussion and coordination on Fraud, Waste and Abuse prevention, including attendance at meetings and trainings covering Fraud, Waste and Abuse prevention and detection techniques and best practices. ASES, the Medicaid Program Integrity Office and Medicaid Fraud Control Unit preserve the right to directly pursue Fraud, Waste and Abuse efforts, in the event of any noncompliance by the Contractor. Likewise, should Medicaid Program Integrity Office or Medicaid Fraud Control Unit for any reason decide to not pursue cases referred, ASES shall address such cases according to the terms and conditions of the Contract. Such efforts and other compliance activities shall be conducted by ASES, the Medicaid Program Integrity Office and the Medicaid Fraud Control Unit in accordance with the signed Memorandum of Understanding between the agencies.

20. Section 13.2 shall be amended and replaced in its entirety as follows:

13.2 **Effective Compliance Program**

13.2.1 The Contractor shall implement an effective compliance program. The program's goals and objectives, scope, and methodology to evaluate program performance shall be documented in a comprehensive compliance plan to be maintained and updated by Contractor. A paper and electronic copy of the compliance plan shall be provided to ASES annually for prior written approval. ASES shall provide notice of approval, denial, or modification to the Contractor within thirty (30) Calendar Days of receipt. The Contractor shall make any necessary changes required by ASES within an additional thirty (30) Calendar Days of the request.

13.2.2 At a minimum, the Contractor's compliance program shall, in accordance with 42 CFR 438.608 and the U.S. Department of Justice's Federal Sentencing Guidelines:

13.2.2.1 Ensure that all of its officers, directors, managers and employees know and understand the elements of the Contractor's compliance program;

13.2.2.2 Require the designation of a compliance officer and a compliance committee that are accountable to the Contractor's senior management. The compliance officer shall have express authority to provide unfiltered reports directly to the Contractor's most senior leader and governing body;

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

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

13.2.2.5 Ensure effective lines of communication between the Contractor's compliance officer and the Contractor's employees to ensure that employees understand and comply with the Contractor's compliance program;

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

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

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

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

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

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

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

13.2.2.10.3 Reviewing Providers for over, under and inappropriate Utilization;

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

13.2.2.10.5 Reviewing and trending Enrollee Complaints regarding Providers.

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

13.2.4 The Contractor shall include in the Enrollee Handbook, as set forth by ASES, a description of its compliance program, instructions on how to report Fraud, Waste, and Abuse, and the protections for whistleblowers.

21. Section 13.3.1.7 shall be amended and replaced in its entirety as follows:

13.3.1.7 Defines mechanisms, including automated mechanisms, to monitor frequency of Encounters and services rendered to Enrollees billed by Providers, and to flag suspicious activity and potential incidents of Fraud, Waste and Abuse that warrant further investigation;

22. Section 16.1.6 shall be amended and replaced in its entirety as follows:

16.1.6 To be processed, all Claims submitted for payment shall comply with the Clean Claim standards as established by Federal regulation (42 CFR 447.46), and with the standards described in Section 16.6.2 of this Contract.

23. Section 18.2.2.8. shall be amended in its entirety as follows:

18.2.2.8 The Contractor shall submit a monthly HCHN Pre-Registry Report for ASES to process monthly PMPM Payments. The report shall provide information on all HCHN Enrollees that are identified by the Contractor following the procedures established in Attachment 28 to this Contract.

24. Section 22.1.1.2 shall be amended and replaced in its entirety as follows:

22.1.1.2 PMPM Payment rates included in Attachments 11 and 11-A to this Contract, as amended, shall be effective to account for any new requirements set forth in Sections 10.5.1.5.1 and 10.5.1.5.2. ASES will increase the PMPM Payments to account for the additional costs incurred by Contractor with respect to the minimum fee schedule and increase in Subcapitated amounts, as of the effective date of the Amendment.

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25. **Section 22.3.1 shall be amended and replaced in its entirety as follows:**

22.3.1 If the Contractor wishes to contest the amount of payments made by ASES in accordance with the terms outlined in Section 22.1 for services provided under the terms of this Contract, the Contractor shall submit to ASES, in the format defined by ASES, all relevant documentation supporting the Contractor's objection no later than (90) Calendar Days after payment is made. In the event ASES notifies changes to the files or file layouts necessary for payment reconciliation, the term for submitting an objection to payment shall start to run sixty (60) days after notice of changes to the files or file layouts has been issued by ASES. Once this term has ended, the Contractor forfeits its right to claim any additional amounts, regarding the period in dispute. The terms specified in this Section 22.3.1 shall be applicable from this Amendment's effective date.

Section 22.3.2 shall be amended and replaced in its entirety as follows:

22.3.2 Within thirty (30) Calendar Days after the Contractor's submission of all relevant information, the Contractor and ASES will meet to discuss the matter. If after discussing the matter and analyzing all relevant Data it is subsequently determined that an error in payment was made, the Contractor and ASES will develop a plan to remedy the situation, which must include a timeframe for resolution agreed to by both Parties, within a time period mutually agreed upon by both Parties. The remedial plan for any error in payment or ASES' response to the Contractor's objection to payment will be reduced to writing within ninety (90) Calendar Days from the date the objection was submitted by the Contractor. The total resolution and payment for the cases objected to and accepted by ASES shall not exceed one-hundred eighty (180) days from the date on which Contractor submitted the objection. The terms specified in this Section 22.3.1 shall be applicable from this Amendment's effective date.

26. **Section 23.3.4 shall be amended and replaced in its entirety as follows:**

23.3.4 The Contractor's stop-loss responsibility shall not be transferred to a PMG unless the PMG and the Contractor expressly agree in writing to the PMG's assuming this risk. In this event, Contractor shall evaluate and accept any stop-loss insurance and reinsurance obtained by the PMG from a licensed insurer or reinsurer that meets agreed-upon coverage amounts and other requirements, and shall neither refuse to accept such qualifying coverage nor obligate the PMG to utilize insurance provided by the Contractor. Stop-loss and reinsurance coverage must comply with Puerto Rico insurance law, as applicable.

27. Section 38.2.3 shall be amended and replaced in its entirety as follows:

38.2.3 At the request of either party, ASES will evaluate any enacted Federal, state or local legislative or regulatory changes with applicability to the GHIP program that materially impact the PMPM Payment. If after a process of actuarial evaluation, using credible data, ASES determines that the enacted legislative and/or regulatory changes materially impact the PMPM Payment, ASES will adjust the PMPM rates to reflect the above-referenced changes after the adjusted rates are approved by CMS. Any revisions to the PMPM Payments under this Section would be applicable from November 1, 2018 until

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October 31, 2019, from the effective date of any new law or regulation, whichever is later, and with the review and approval from FOMB in the event said review and approval is applicable. "Materially impact" shall mean that a recalculation of current PMPM Payments is required in order to remain actuarially sound.

In the event that the Commonwealth of Puerto Rico intends to expand the Medicaid-eligible population via an increase of the Puerto Rico Poverty Line ("PRPL"), such expansion will be considered a material amendment to the Contract, which shall require prior approval from the FOMB. Consequently, any amendments must be submitted to the FOMB for its review and approval prior to execution, even if it does not have an immediate budgetary impact on state funds in the current fiscal year.

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28. **Attachment 9 shall be renamed as follows:**

ATTACHMENT 9: INFORMATION SYSTEM

29. **The following amended attachments, copies of which are included, are substituted in this Contract as follows:**

ATTACHMENT 7:	UNIFORM GUIDE FOR SPECIAL COVERAGE
ATTACHMENT 11:	PER MEMBER PER MONTH PAYMENTS
ATTACHMENT 19:	HEALTH CARE IMPROVEMENT PROGRAM (HCIP) MANUAL
ATTACHMENT 27:	POLICY FOR MEDICATION EXCEPTION REQUESTS
ATTACHMENT 28:	HCHN RATE CELLS

II. RATIFICATION

All other terms and provisions of the original Contract, as amended by Contracts Number 2019- 000049A, B, C, D, E, F, G, H, I, J, K, and L, and of any and all documents incorporated by reference therein, not specifically deleted or modified herein shall remain in full force and effect. The Parties hereby affirm their respective undertakings and representations as set forth therein, as of the date thereof. Capitalized terms used in this Amendment, if any, shall have the same meaning assigned to such terms in the Contract.

III. EFFECT; CMS and FOMB APPROVAL

The Parties agree and acknowledge that this Amendment, including any attachments, is subject to approval by the United States Department of Health and Human Services Centers for Medicare and Medicaid Services ("**CMS**") and the Financial Oversight and Management Board for Puerto Rico ("**FOMB**"), and that ASES shall submit this Amendment for CMS and FOMB approval. Once approvals are granted, ASES shall promptly notify the Contractor in writing. CMS and FOMB approvals, as well as ASES's written communication to the Contractor, shall be incorporated and made a part of the Contract between the Parties.

IV. AMENDMENT EFFECTIVE DATE

Contingent upon approval of CMS, and unless a provision in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2020 until September 30, 2021.

V. ENTIRE AGREEMENT

This Amendment constitutes the entire understanding and agreement of the Parties with regards to the subject matter hereof, and the Parties by their execution and delivery of this Amendment to the Contract hereby ratify all of the terms and conditions of the Contract Number 2019-000049 including amendments A, B, C, D, E, F, G, H, I, J, K, L, and this Amendment M.

The Parties agree that ASES will be responsible for the submission and registration of this Amendment in the Office of the Comptroller General of the Commonwealth, as required under law and applicable regulations.

ACKNOWLEDGED BY THE PARTIES by their duly authorized representatives on this 15 day of September, 2020.

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES)

Name: Jorge E, Galva Rodríguez, JD, MHA
EIN: 66-05000678

9-15-2020
Date

FIRST MEDICAL HEALTH PLAN, INC.

José A. Pagán Torres, Administrative Vice-President
EIN: 66-0537624

9-15-2020
Date

Account No. 256-5325 to 5330

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ATTACHMENT 11

Administracion de Seguros de Salud July 1, 2020 to September 30, 2021 GHP (Vital) PMPM Premium Rates	
Rate Cell	**PMPM**
Medicaid Pulmonary	$239.21
Medicaid Diabetes/Low Cardio	$390.94
Medicaid High Cardio	$774.30
Medicaid Renal	$1,356.27
Medicaid Cancer	$2,551.40
Medicaid Male 45+	$149.32
Medicaid Male 19-44	$98.38
Medicaid Male 14-18	$83.54
Medicaid Female 45+	$195.64
Medicaid Female 19-44	$131.30
Medicaid Female 14-18	$88.69
Medicaid Age 7-13	$76.22
Medicaid Age 1-6	$112.84
Medicaid Under 1	$303.69
Commonwealth Pulmonary	$188.32
Commonwealth Diabetes/Low Cardio	$236.30
Commonwealth High Cardio	$439.87
Commonwealth Renal	$755.94
Commonwealth Cancer	$1,519.82
Commonwealth Male 45+	$101.35
Commonwealth Male 19-44	$65.03
Commonwealth Male 14-18	$77.04
Commonwealth Female 45+	$136.76
Commonwealth Female 19-44	$103.19
Commonwealth Female 14-18	$80.98
Commonwealth Age 7-13	$77.54
Commonwealth Age1-6	$107.95
Commonwealth Under 1	$373.32
CHIP Pulmonary	$262.17
CHIP Diabetes	$1,067.40
CHIP Age 7-13	$87.90
CHIP Age14+	$98.01
CHIP Age 1-6	$126.98
CHIP Under 1	$306.79
Dual Eligible Part A and B	$339.08
Dual Eligible Part A Only	$341.51
Maternity Delivery Kick Payment	$5,370.02
FCDA	$449.76

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Administracion de Seguros de Salud June 1, 2020 until May 31, 2021 PSG (MI Salud) PMPM Premium Rate	
Rate Cell	**PMPM Premium Rate**
Law 72, Article VI Public Employees and Pensioners*	$191.88

Enrollees within the Law 72, Article VI Public Employees and Pensioners rate cell are not subject to Attachment 28, and instead shall remain in the Law 72, Article VI Public Employees and Pensioners rate cell during the term of their enrollment.

Government of Puerto Rico
Puerto Rico Health Insurance Administration

ASES

Plan de Salud VITAL
High Cost High Need
Reports Management
Standard Operating Procedures

Responsible Party: Plan VITAL
Managed Care Organizations & ASES

Version 2.0
September 2020

Table of Contents

1 Acronyms and Terms

The table below provides definitions for the acronyms and terms used throughout this document.

Table 1: Acronyms and Terms

Acronym	Definition
ASES	Administración de Seguros de Salud de Puerto Rico
Enrollee	A person who is currently enrolled in the Contractor's GHP Plan, as provided in the Contract, and who, by virtue of relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 1.3.1 of the Contract.
HCHN	High Cost High Need
HCHN Enrollee	A person who is currently enrolled in the Contractor's GHP Plan, as provided in the Contract, who meets the qualifying criteria of a HCHN Condition Category as defined in Attachment 28 of the contract.
Report 8 (HCHN)	This is the report that each Contractor is required to submit on the 15th of each month containing the identification of HCHN conditions for enrollees along with their qualifying health condition data.
MCO	Managed Care Organizations. An insurance company, health care organization, or any other approved health organization in Puerto Rico that meets the CMS definition.

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Encounter / qualified encounter for HCHN	A distinct set of services provided to an Enrollee in a Telehealth, Telemedicine, Tele dentistry, or face-to-face setting on the dates that the services were delivered and properly documented on the appropriate health record, regardless of whether the Provider is paid on a Fee-for-Service, Capitated, salary, or alternative payment methodology basis. Encounters with more than one (1) Provider, and multiple Encounters with the same Provider, that take place on the same day in the same location will constitute a single Encounter, except when the Enrollee, after the first Encounter, suffers an illness or injury requiring an additional diagnosis or treatment. A qualified encounter that validates an Enrollee in the High Cost High Need Registry includes all described that also present a diagnosis of a HCHN condition, except laboratory and radiology and denied services. Note that in accordance with the previous definition a pharmacy claim is not considered a qualified encounter.
CLM File	Monthly report of the Encounter Data submitted by the MCO to ASES using the *CLAIMSSERVICES Input File Layout*
Effective Date for Payment	Effective date for payment will be the month following the reporting month; i.e. cases reported in July will affect payment for August if all required information is submitted timely and passes validation procedures by ASES.
Exceptional Period	Grace period from November 2018 thru June 2019 in which ASES will be adjudicating retroactive payments for the HCHN cases identified through a certified encounter by the ASES actuaries.

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HCHN Validity Period	Qualified Encounter Classification: Twelve (12) month moving period starting in the month following the Diagnosis Date of a qualified encounter. This period is extended once a new qualified encounter is. Pre-Registry Classification: Six (6) month initial period starting in the month following the submission of Report 8 with a valid HCHN Notification submitted in by the MCO stating that the HCHN condition is present. This period is made invalid if no qualified encounter is received within those 6 months.
HCHN Registry	Contains all members of Plan Vital that have been reported to present a category of HCHN condition for a Validity Period.
HCHN Pre-Registry	Contains all members in the HCHN Registry that have not been validated by a qualified encounter and are subject to a removal.
HCHN Rate Cell	A function of the enrollee's Category of Eligibility (COE) including Medicaid, CHIP, and State-funded (Commonwealth) enrollees that considers age and gender, along with High Cost High Need (HCHN) condition categories that have been defined by ASES. Each of the HCHN rate cells have a distinct premium that will be paid to the Contractor for each enrollee.
Plan de Salud VITAL	Government Healthcare Plan.

2 Purpose

This HCHN Reports Management Standard Operating Procedure (SOP) outlines the process that is in place for the proper reporting of the HCHN Population of the Plan de Salud VITAL. It also establishes the validation processes that will be implemented in order to adjudicate HCHN Rate Cells to enrollees with the purpose of maintaining a HCHN Population Registry which will be used as one of the sources to adjudicate the Rate Cells for the members in the Capitation Payment processes.

3 Background

ASES has established a capitation payment method, based on rate cells, for the population of the qualified Managed Care Organizations (MCO) participating in Plan Vital.

The rate cells defined by ASES include, among other variables, the evaluation of six (6) categories of High Cost High Need (HCHN) conditions identified by a specific set of diagnosis codes.

For these purposes, ASES keeps a registry of the population that presents a category of HCHN condition. This registry is identified as the *HCHN Registry* and is fed using data from the Contractor through the monthly submission of the following reports:

- Report 8 – High Cost High Needs (HCHN) Report
- CLM files

In order to keep the HCHN Registry accurate for payments, the Contractor is required to identify from all of its members those presenting a potential HCHN condition. The identified members are notified to ASES by the submission of Report 8.

The initial identification of a HCHN condition will result in the inclusion of the member in a Pre-Registry status for a period of six (6) months. This inclusion is conditional, and it will be revoked after six (6) months if ASES has not received a qualified encounter reported in the CLM File during that period.

Only once a qualified encounter is received, it will grant a twelve (12) month validity period from the service date of the encounter containing the HCHN diagnosis. In order to extend this period a new qualified encounter must be received by ASES with a more recent service date.

All inclusions of a member in the HCHN Registry are performed prospective to the Report Date. Also, the inclusion of a member in the HCHN Registry in a specific period will be used to adjudicate the rate cell to the member for the capitation payment on the same period.

ASES may retroactively review the assignment of any enrollee into a rate cell based on a category of HCHN condition. The retroactive review will be performed considering the methodology for the HCHN identification and validations which may include, but are not limited to:

1. Analysis of Report 08 (HCHN)
2. Analysis of Eligibility and Enrollment history.
3. Analysis of Encounter and Claims history.
4. Direct contact with enrollee's PCP, specialist or physician directing the enrollee HCHN care plan.

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5. Review of enrollee behavioural health data
6. Review of enrollee pharmacy data
7. Referrals

After these validations are concluded, a report will be produced confirming the adequacy of the payments previously adjudicated. In the case that ASES determines that a member has been inappropriately classified as a HCHN beneficiary the corresponding premium payments will be retroactively adjusted.

Special Transition Period

ASES has delimited an exceptional period from November 2018 through June 2019 in which a qualified encounter will result in a retroactive payment from the month of the encounter's service date onwards for valid months within Plan Vital. This only applies to encounters reported and received by ASES during the defined period in full compliance with the HCHN requirements.

After the exceptional period is over, ASES will adjudicate HCHN rate cells for each enrollee prospectively to the reported date.

4 Process Trigger

The HCHN reporting and validation process begins each month, with MCO submission of Report 08 (HCHN) and the Encounters and Claims File (CLM File). Both submissions are due on the first day of each month and will remain so until the 15th of each month.

5 Scope

This SOP addresses the following procedures:

- HCHN Population Identification and Validation
  - HCHN Population Identification by the MCO
  - HCHN Population Validation by ASES
- HCHN Registry Generation and Maintenance
- Impact of HCHN Registry in Rate Cell Adjudication and Capitation Payment

6 Responsible Parties

The following parties are responsible for the execution of this SOP.

1. Plan VITAL Managed Care Organizations (MCOs)
2. Puerto Rico Health Insurance Administration (ASES)
    a. Actuary
    b. HCHN Division
    c. Eligibility and Enrollment Division
    d. Premium Payment Division

7 HCHN Reports Management Standard Operating Procedures

This SOP has the purpose of delineating the procedures that lie behind the identification of the HCHN Population to maintain the HCHN Registry. In addition, an overview of the whole process is inserted as an introductory section.

7.1. HCHN Procedure Overview

Table 2: Step by Step Procedure for HCHN Reports Management Processes Overview

Step	Definition	Responsible
1	Identify the assigned population with a category of HCHN Condition. Submit the following reports before the 15th of the month: • Report 8 (HCHN) • CLM File	MCO
2	Identify the population with qualified encounters validating or extending the validation of a category of HCHN condition. The Encounter Data validated is feed with the transactions received in the CLM Files. Submit the following report before the 26th of the month: • HCHN Actuary Report.	ASES Actuary
3	Process Report 8 (HCHN) and submit evaluation Results and Findings to the MCO. Process HCHN Actuary Report and submit evaluation Results and Findings to ASES Actuary. Update HCHN Registry. Generate and Submit HCHN Registry File to MCO.	ASES HCHN Division

	This is performed as part of the End-Of-Month processes within ASES.	
4	Adjudicate Member Rate Cells. Generate and Submit MRC File to MCO. This is performed as part of the End-Of-Month processes within ASES.	ASES Eligibility & Enrollment Division
5	Generate the Capitation Payment for the corresponding Premium Payment Cycle. Submit the Explanation of Payment to MCO (820) by the 15th day of the month.	ASES Premium Payment Division

7.2 HCHN Population Identification and Validation

The MCO is responsible for the establishment of a program to actively identify and maintain the reporting of members diagnosed with any of the categories of HCHN condition. The prompt identification of these members will impact the PMPM received in the Capitation Payment by the MCO.

7.2.1 Step by Step for the HCHN Population identified by the MCO

Table 3: Step-by-Step for the HCHN Population Identified by the MCO

Step	Definition	Responsible
1	Identify the members that have been diagnosed with a new category of HCHN condition. Use the diagnosis codes (ICD10) shared by ASES. The identification methods are: • Encounter • Pharmacy • Certification of Diagnosis	MCO

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	• Inpatient Admission. When using Encounter Data note that: • Encounter containing a services line for Laboratory or Radiology procedure cannot be used to identify a HCHN Condition. • Only for inpatient admission, a services line for laboratory or radiology procedure will be excluded but the admission procedure line will be consider a qualified encounter if it is not denied. • Service Lines Adjudicated with a Denied Status by the MCO cannot be used to identify a HCHN Condition, unless otherwise stated by ASES, if so, there must be a Normative Letter issued by ASES or an update to attachment 28 with the specific instructions that will also modify this document.	
2	Identify the members that have a new encounter for the same category of HCHN Condition already included in the HCHN Registry. The new encounter will extend the validity period of this member in the HCHN Registry for the corresponding category. The extension is counted using 12 months starting from the next month of the encounter service date.	MCO
3	Review the transactions submitted in previous reports and identify any transactions with any defect that may need an amendment or withdrawal procedure.	MCO
4	Use the identified members and transactions on previous steps to generate: *Report 8 – High Cost High Needs (HCHN) Report* Follow the instructions from: • *Plan Vital Reporting Guide.*	MCO

5	Upload the resulting Report 8 file to the ASES FTP Server within the due period • Due Period is from the 1st day to the 15th day of every month. A file uploaded after the 15th day of the month won't be evaluated.	MCO
6	Upload Report 8 file to ASES HCHN subsystem database. If a file can not be processed due to a wrong file layout ASES may notify the MCO in order to allow for a new file to be submitted within the Due Period. If no file is received with the correct file layout the next steps won't be executed.	ASES HCHN Division
7	Process transactions received on Report 8. At this point ASES won't match transactions received on Report 8 with the Encounter Data. The only exception is for transactions for which ASES already has evidence in the Encounter Data that the service line has a Laboratory or Radiology procedure. These transactions will be denied. Approve all transactions that comply with the required reporting instructions and Deny those that do not comply. Approved transactions will be used in the maintenance of the HCHN Registry. Produce a Result file with all transactions Approved and Denied. For denied transactions a Finding file is also generated.	ASES HCHN Division

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8	Submit Results and Findings File to the MCO.	ASES HCHN Division

7.2.1 Step by Step for the HCHN Population validated by ASES

Table 4: Step-by-Step for the HCHN Population validated by ASES

Step	Definition	Responsible
1	Generate CLM File. Follow the instructions from: • *Carrier to ASES Data Submissions - CLAIMSSERVICES Input FIle Layout* Verify that all transactions reported, used to identify a category of HCHN condition for a member, contain the required information, specially but not limited to: service date, procedure codes, diagnosis codes and payment status.	MCO
2	Upload the resulting CLM file to the ASES FTP Server within the due period • Due Period is from the 1st day to the 15th day of every month.	MCO
5	Upload CLM file to ASES Encounter subsystem database. If a file can not be processed due to a wrong file layout ASES may notify the MCO in order to allow for a new file to be submitted within the Due Period. If no file from a MCO is received with the correct file layout within the Due Period, the next steps won't be executed.	ASES

6	Process CLM File to Identify the Last Encounter validating a category of HCHN Condition for all members in the received CLM Files for all MCO participating in Plan Vital.	ASES Actuary
7	Generate the HCHN Actuary Report and submit it to ASES.	ASES Actuary
8	Upload HCHN Actuary Report file to ASES HCHN subsystem database. All transactions received will be used in the maintenance of the HCHN Registry.	ASES HCHN Division

7.3 HCHN Registry Generation and Maintenance

The HCHN Registry is evaluated on a monthly basis. For each month all members qualifying with a category of HCHN condition will be included with new transactions for that month.

The HCHN Registry was first generated for the start of Plan Vital using the Encounter Data received before November 2018 and evaluated by ASES Actuary.

Step	Definition	Responsible
1	HCHN Registry inclusion on Pre-Registry status: Add all members identified by the MCO on Report 8 not yet validated by the HCHN Actuary Report. If a member has been on the HCHN Registry for 6 months on a category of HCHN Condition and it's not yet validated by the HCHN Actuary Report, it won't be added to the new month.	ASES HCHN Division
2	HCHN Registry inclusion on Validated status: Add all members validated by the HCHN Actuary Report.	ASES HCHN Division

	if a member has been on the HCHN Registry for a date exceeding 12 months from the next month of the service date of the last encounter, it won't be added to the new month.	
3	Remove members expiring the Pre-Registry period. This is with the removal of all members that have been 6 months in the HCHN Registry for the category of HCHN Condition they have not been validated by the HCHN Actuary Report. The member is removed for all of the 6 months that was included in the HCHN Registry for that category.	ASES HCHN Division
4	Evaluate Eligibility and Enrollment Data. Dual Members or Members on the Virtual Region are removed in the HCHN Registry from the month they started in those conditions. Members losing their eligibility are removed from the HCHN Registry for the month they lost their eligibility. Members changing carriers will be seen as removed or not included for the carrier losing the member from the date the change is effective.	ASES HCHN Division
5	Export HCHN Registry and submit to each MCO.	ASES HCHN Division

7.4 Pharmacy Rule (Pre-Registry using Pharmacy Claims)

Applicable rules for the use of pharmacy claims in the identification of enrollees potentially eligible for HCHN program, with incurred date on or after July 1, 2020.

The Contractor may use pharmacy claims for the identification of enrollees potentially eligible for HCHN, when the medication is approved and used for a medical condition defined in the HCHN Program.

These cases shall be considered for the pre-registry. Therefore, the Contractor must register a qualified encounter within 180 days from the Prescription Date as reported in the CLM File. This will permit the validation of the enrollee in the HCHN Registry for a period of 12 months including the pre-registry elapsed months.

The next extension of the enrollee in the HCHN Registry beyond the 12 months shall be subject to the identification of a qualified encounter, not a pharmacy claim, with service date after the one that was used to initially validate the case.

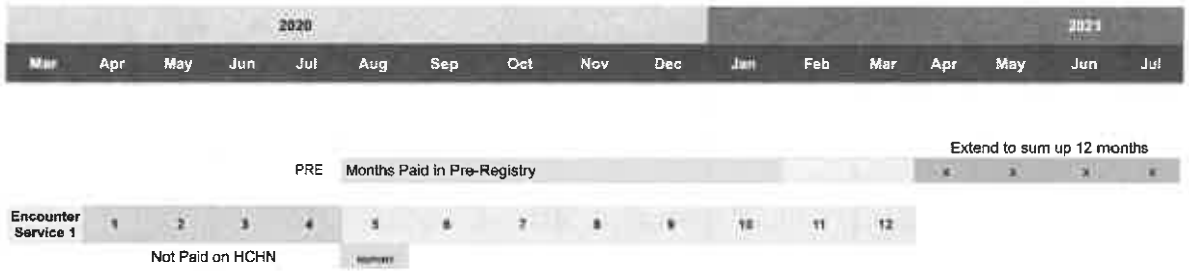
7.5 Extension of HCHN Validity Period for Pre-Registry cases (Subject to Actuarial Evaluation)

In accordance with Attachment 28 and this SOP, the Encounters or any other valid claim transaction to register an Enrollee in the HCHN Program, is subject to the period in which the provider submits the claims to the MCO for payment of services provided, which create a gap that may result in such payment period for Enrollees registered in the HCHN Program to be less than twelve (12) months.

Changes related to the Pre-Registry are subject to ASES's actuary's determination that they are feasible. If the actuary determines otherwise, the parties agree to meet within fifteen (15) days of the execution of the Amendment M to negotiate new changes to the Pre-Registry that ensure twelve (12) months of PMPM payment from the first payment month.

The following procedure will apply for Pre-Registry Enrollees:
If the Contractor submit to ASES a qualified encounter within 180 days from the Service Date as reported in the CLM File, this will permit the validation of the enrollee in the HCHN Registry for a period of 12 months including the Pre-Registry elapsed months.

Figure: Example



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7.6 HCHN Rate Cell Adjudication and Capitation Payment

ASES performs the procedures for Rate Cell Adjudication and Capitation Payment on a monthly basis for all members in Plan Vital.

This document explains the relevant elements taking place in those processes in relation to the HCHN Registry.

- The Rate Cell Adjudication verifies if the member is active in a category of HCHN condition in order to assign the corresponding rate cell based on the hierarchy defined by ASES.
- Rate cells for Dual Members and Virtual Region Population have more priority than the rate cells associated with any category of HCHN condition.
- If a member is removed or changed in the HCHN Registry for a previous period, the Rate Cell will be retroactively adjudicated.
- Once a rate cell is adjudicated for a member, the Premium Payment process will use that information for calculating the Capitation Payment.

  If there is a retroactive rate cell adjudication a Capitation Payment Adjustment will be performed for the incurred period.

8. Successors

The HCHN Procedures are defined to generate and maintain the HCHN Registry.
The following procedures are impacted by this procedure

- Member Rate Cell Adjudication
  - Rate Cells for members presenting a category of HCHN Condition require the HCHN Registry up to date.
- Premium Payment
  - Capitation Payment Rates are calculated based on HCHN rate cells matching the latest maintenance of the HCHN Registry.

Mandated and Uniform Protocol for Conditions Included in Special Coverage

Initiation:

Any primary or specialist physician who have evaluated a patient may submit a request for Register subject to having available all required documentation for said condition. The insurer shall make a determination of approval or denial of registration and inform this decision in writing to the insured and the physician requesting the registration. If the physician requesting the registry is not the primary physician of the insured, the insurer shall send a copy of the determination to the primary care physician. The insurance company will make a final determination on the application for special coverage in a 72-hour period, after receiving the complete documentation as required by this Protocol for each condition.

Once a Provider supplies all the required information for the Contractor to process a registration and the Contractor processes such information, Special Coverage shall take effect retroactively as of the date the Provider reaches a diagnosis, including documentation of test results, for any condition included in Special Coverage. In case Information is submitted to the Contractor after the diagnosis was reached, coverage can be made retroactive up to sixty (60) Calendar Days before the date on which Provider submitted the registration request. (Contract Section 7.7.5)

Reactivation: Any insured who have lost eligibility for PSG for over one year period, will be required a new certification by the primary care physician that evidence current treatment plan to be reactivated in the special coverage. Any insured that loses its eligibility for a period less than 12 months, will be register without documents or additional certifications, unless there is any other limit for the specific condition.

Risk allocation*: the distribution of the special coverage between insurer and primary medical groups risk is defined in the following table. The same may be modify at the request of the insurance company subject to prior review and approval by ASES.

Note: Covered medications are those included in the pharmacy benefit and ASES drug formulary (FMC).

Special Condition	Definitive diagnosis criteria for inclusion in the coverage	Special Coverage Effectiveness and Duration	Services included in Special Coverage	Risk Allocation*
1. Aplastic Anemia	1-Diagnosis certification by a hematologist/oncologist with treatment plan 2- Evidence of: a. Absolute Neutrophils Count b. Platelets Counts c. Reticulocytes Counts d. Results of bone Marrow aspiration or biopsy	**Effectiveness** = From the date of the diagnosis by the hematologist/oncologist or date the biopsy was performed if its reading establishes the definitive diagnosis. **Duration**= Special coverage will begin from the date the definitive diagnosis is established. Special cover will be in effect as long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of Aplastic Anemia. 2. All medical services provided or ordered by the hematologist/oncologist 3. Medication prescribed by the oncologist/ hematologist and specific to treat the condition.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.
2. Rheumatoid Arthritis	1-Diagnosis certification by the rheumatologist in accordance with the criteria established by the American College of Rheumatology. (The insurance company will provide a sheet with the criteria and treatment plan to be fill by the specialist.) 2-Evidence of laboratory tests: ESR, ANA Test, CRP, RA Factor.	**Effectiveness** = From the date of the diagnosis by the rheumatologist. **Duration** = Special cover will be in effect as long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of Rheumatoid Arthritis. 2. All medical services provided or ordered by the rheumatologist. 3. Medication prescribed by the rheumatologist and specific to treat the condition, including DMARD.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP** – Will receive the monthly capitation corresponding to the insured.

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	3- Evidence of relevant radiologic studies 4-Evidence of treatment with a DMARD medication.			
4. Autism **a. Provisional Coverage**	a. Certification of risk by the primary care physician and evidence of the screening tool utilized. Codes to be used during the provisional coverage: 1. **R63.50** Unspecified lack of expected normal psychological development in childhood 2. **R62.0** Delayed Milestone in childhood 3. **F88** Other disorders of psychological development 4. **F80.2** Mixed receptive and expressive language disorders	**Provisional Special Coverage:** a. **Effectiveness:** If the risk of developing the condition is confirm using the instruments established in the Protocol of Autism from the Department of Health, the primary care physician will complete the registration form for provisional special coverage and send it to the insurer. Once the provisional special coverage for autism is activate, a referral or authorization from the primary care physician to access the services of a qualified provider for the diagnostic evaluation process will not be required. **Duration:** The provisional coverage will last for six months. If the evaluation process is not completed, the provisional coverage may be renew for six additional months.	**Provisional Special Coverage:** **a.** Diagnostic evaluation according to the Protocol of the Dept. of Health that includes family history, development and health, interview with tutors on the skills, behavior, communication and social interactions of the person, observation of the conduct of the person in interaction with others and own age play and socialization activities and the results of the most recent version of at least one instrument to document current behaviors.	a. **Insurer** – All services rendered by providers qualified for diagnostic evaluation. **GMP/PCP** – Will receive the monthly capitation corresponding to the insured.

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b. Permanent Special Coverage	**b.1.** Diagnosis certification by a clinical psychologist, school psychologist, counselor psychologist, neurologist, psychiatrist or a pediatrician development specialist. Professionals should have training or experience in the area of Autism, as required by the Protocol of Autism from the Department of Health of PR. **b. 2** Evidence of the relevant screening tests according to the Protocol of Autism from the Department of Health of PR.	**b. Effectiveness:** From the date of the diagnosis certification by one of the listed professionals, the effective date will be the earliest certification date. **Duration:** Special coverage will be valid, provided the insured eligibility to the PSG, until 21 years of age. After 21 years, to continue in the special coverage, a certification by a neurologist or psychiatrist establishing the need for the condition management and treatment as an adult is required.	**b.** Medical services rendered or ordered by the psychiatrist, psychologist, neurologist, or any other qualified provider according to the Protocol of Autism from the Department of Health of PR will not require referral from the primary physician. Medicines for the specific management of the condition, prescribed by a qualified provider, will not require PCP authorization.	**b. Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP** – Will receive the monthly capitation corresponding to the insured.

5. Cancer	1. Diagnostic certification with stage, by a hematologist/ oncologist or specialist physician in charge of the management of the condition, treatment plan with estimated start and completion dates. The insurer shall provide a specific form to be used as the Registry Application and Cancer Certification to be completed by the specialist. 2-Evidence of diagnosis by biopsy result. 3- In cases where the diagnosis cannot be confirmed by a pathology study, evidence of diagnostic studies of CT, MRI, PET Scan, ultrasonography supporting diagnosis or stage will be taken into consideration.	**Effectiveness** = from the date of certification of the diagnosis by the hematologist/oncologist or the biopsy date if its results establishes the definitive diagnosis. **Duration** = until the end of active treatment of the condition with radiotherapy or chemotherapy. All insured will receive a certification of registration until the date in which the insured meets their surgical treatment, chemotherapy and/or radiation therapy. The insured will have the benefit of covered visits to his oncologist/hematologist to a maximum of one year. At the end of the year, if needed, the hematologist/oncologist may perform a request for extension of registration documenting the condition stage and the treatment plan for next year. A temporary register up to a maximum of 30 days shall be granted to receive documentation on the Cancer Registration Extension form	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of Cancer. 2-All medical services provided or ordered by the hematologist/oncologist. . 3- Medications prescribed by the hematologist/oncologist specific to treat the cancer condition.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP** – – Will receive the monthly capitation corresponding to the insured.

		provided by the insurer. If this process is not completed, the insured will automatically lose its registration for special coverage. In cases of prostate cancer, treatment with hormonal chemotherapy will qualify the member to continue active in the cancer registry. Their visits to the urologist and medical orders and treatment ordered by this specialist (urologist) will be cover. In the cases of breast cancer, once active treatment with radiotherapy and chemotherapy ends, they will no longer remain in the registry. However, patients receiving treatment with anti-estrogens will continue being consider under cancer special coverage.		
6. Skin Cancer: Carcinoma IN SITU	- Positive Biopsy Report	**Effectiveness**: Special coverage in skin cancer and carcinoma in	Surgical removal and all related services on said day and any other subsequent	**Insurer:** Medical services and medications as defined

		situ will only apply to the surgery day. **Duration:** the day or days for surgical removal and all services on said day and any other radiotherapy treatment used any time.	radiotherapy/chemotherapy treatment.	for the special coverage condition in this document. **GMP/PCP** – – Will receive the monthly capitation corresponding to the insured.
7. Skin Cancer such as Invasive Melanoma or squamous cells with evidence of metastasis.	- Positive biopsy or pathology - Special studies like CT Scan, MRI, Sonogram - Registry certification completed by a dermatologist or a hematologist/oncologist.	**Effectiveness**: From the date the diagnosis is established. **Duration** = until the end of the active treatment of the condition with radiotherapy or chemotherapy. All insured will receive a certification of registration for up to a year. At the end of the year, if needed, the dermatologist or hematologist/oncologist may request an extension of registration documenting the condition stage and the treatment plan for next year. A temporary register up to a maximum of 30 days shall be granted to receive documentation on the Cancer Registration Extension form provided by the insurer. If this	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of indicated Skin Cancer. 2-All medical services provided or ordered by the dermatologist or hematologist/oncologist. 3- Medications prescribed by the dermatologist or hematologist/oncologist specific to treat the cancer condition.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.

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		process is not completed, the insured will automatically lose its registration for special coverage.		
8. Chronic Renal Disease **Level 1 and 2** **Level 3 and 4**	The Glomerular Filtration Rate (GFR) is used. Evidence of recent results of Creatinine in blood and age, sex and race of the insured. **Level 1:** GFR over 90, ICD-10-N18.1 **Level 2:** GFR between 60 to 89, ICD-10-N18.2 **Level 3:** GFR between 30 to 59, ICD-10-N18.3 **Note: Starting on October 2020 the ICD-10 Codes for CKD3 will change. N18.0 will no longer be used. Subcategories of CKD3 will be identified as follows:** ***N18.30 Chronic kidney disease, stage 3 unspecified** ***N18.31 Chronic kidney disease, stage 3a** ***N18.32 Chronic kidney disease, stage 3b**	**Level 1 and 2:** Does not qualify for registry under special coverage. **Level 3 and 4:** Qualifies for special coverage registry. **Effectiveness**: From the date the diagnosis is established. **Duration** = As long as the insured is eligible in the PSG.	**GMP/PCP**: Levels 1and 2 are total risk of GMP. **Level 3 and 4**-The insurer assumes the nephrologist visits (without referrals), renal laboratory and diagnostic studies ordered by this specialist, peripheral vascular studies to document hemodialysis access and drugs ordered by the nephrologist, related to the condition and limited to immunosuppressants, erythrocytes stimulants,	**GMP/PCP**: Levels 1and 2 are total risk of GMP. **Level 3 and 4:** **Insurer**: All medical services provided or ordered by nephrologist from the date of effectiveness of the coverage. Additionally including: -insertion of catheters for dialysis - surgeries for arteriovenous (AV) fistulas

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	Level 4: GFR between 15 to 29, ICD-10-N18.4		Megace, renal antidotes and systemic corticosteroids	-Administration of hematopoietic agents - blood transfusions **GMP/PCP** **Level 3 and 4:** Will receive the monthly capitation corresponding to the insured.
Level 5	**Level 5:** GFR less than 15 ICD-10-N18.5 ICD-10-N18.6 (ESRD)	**Level 5:** **Effectiveness**: From the date the diagnosis is established. **Duration** = As long as the insured is eligible in the PSG	**Level 5-**All services covered by the PSG as long as the insured is active in the Special Coverage Registry.	**Level 5: Insurer:** Once the registration for chronic kidney condition is authorized, the insured received a notice by mail, indicating the changes in the coverage or the change of the GMP to one of the Renal-GMP (Dialysis Center). The change of GMP will be effective the month in which the change request is done. From this moment, the monthly capitation to the GMP for this insured is discontinued. The risk of the services received by the insured prior to the exchange of

				GMP or registration of the insured will be at the risk of the GMP, except those dealing directly with dialysis. Outpatient services, except emergency, provided to the insured in the Renal GMP have to be coordinated by the nephrologist, who will become the primary physician of the insured. **GMP/PCP:** **Level 5** – Will not receive monthly capitation for the insured.
8. Scleroderma	1. Diagnosis certification by the rheumatologist including signs and symptoms supporting the diagnosis. 2. Evidence of a positive ANA Test > or equal to1:80 dil 3. Positive skin biopsy The insurer will develop a Registry form for this condition to be completed by the specialist certifying the condition, the criteria used to establish the	**Effectiveness**: From the diagnosis certification date by the rheumatologist. **Duration =** As long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of Scleroderma. 2. All medical services provided or ordered by the rheumatologist. 3. Medication prescribed by the rheumatologist and	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.

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	diagnosis and the treatment plan.		specific to treat the condition.	
9. Multiple Sclerosis (MS)and Amiotrophic Lateral Sclerosis (ALS)	1. Certification of the diagnosis by a neurologist confirming condition and plan of treatment 2. Evidence of relevant diagnostic studies performed to reach diagnosis such as: MRIs, EMG, Evoked potentials, NCS, lumbar punction, Genetic studies, etc.	**Effectiveness**: From the date a definitive diagnosis is certified and a treatment plan is established by the neurologist. **Duration =** As long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of MS or ALS. 2. All medical services provided or ordered by the neurologist. 3. Medication prescribed by the neurologist and specific to treat the condition.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.
10. Cystic Fibrosis	1. Sweat test 2. Evidence of treatments 3. Diagnosis certification by a pneumologist.	**Effectiveness**: From the date a definitive diagnosis is certified and a treatment plan is established by the pneumologist. **Duration =** As long as the insured is eligible in the PSG	All services covered by the PSG as long as the insured is active in the Special Coverage Registry.	**Insurer**- All medically necessary services cover by the PSG. **GMP/PCP:** Monthly capitation does not apply for this insured.
11. Hemophilia	1. Certification of diagnosis by a hematologist 2. Evidence of relevant studies and test	**Effectiveness**: From the date a definitive diagnosis is certified and a treatment plan is established by a hematologist.	1- All hospital services, emergency room or medical specialist services provided with a diagnosis of hemophilia.	**Insurer:** Medical services and medications as defined for the special coverage

		Duration = As long as the insured is eligible in the PSG	2-All medical services provided by the hematologist. 3-Medications prescribed by the hematologist specifics to treat the condition and anti-hemophilic drugs administered to the insured.	condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.
12. Leprosy	1. Evidence of skin biopsy result 2.Infection positive cultures 3. Diagnosis certification by an infectologist or a dermatologist.	**Effectiveness** = starts from the date of certification, which establishes the definitive diagnosis by the infectious disease specialist or a dermatologist. **Duration**= It ends when the treatment is complete.	1. All hospital services, emergency room or specialist, cultures, and biopsies of follow-up, provided with a diagnosis of leprosy. (ICD-10 A30) 2. All medical services provided by the infectious disease specialist or dermatologist. 3. Medications prescribed by the infectious disease specialist or dermatologist.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.
13. Systemic Lupus Erythematosus (SLE)	1-Diagnosis certification by a rheumatologist with evidence of the following tests: ANA Test, DS-DNA, Anti Sm y Anti Phospholipids.	**Effectiveness =** from the date of certification establishing the definitive diagnosis by the rheumatologist **Duration =** As long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of SLE.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:**

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			2. All medical services provided or ordered by the rheumatologist. 3. Medication prescribed by the rheumatologist and specific to treat the condition of SLE.	Will receive the monthly capitation corresponding to the insured.
14. Children with Special Health Needs	Complete the Registration Form for children with special health care needs by the primary care physician with evidence of the condition according to the list of diagnoses included by ASES as an attachment to the contract, entitled "Conditions to include patients in the Register of Children with Special Health Needs", revision of June 2015. Medical evidence will consist of relevant laboratories or tests, evidence of current treatment, diagnosis certifications by specialist physicians consulted and others.	**Effectiveness=** From the diagnosis certification date **Duration** = depends on whether the condition is temporary or permanent. The case manager will determine based on the Protocol established by the insurer the Registry duration, provided that the insured is under 21 years old.	As defined in the Conditions List revised on June 2015.	Refer to the listing of diagnosis codes of the conditions for Children with Special Needs Registry.
15. Obstetric	Obstretic Registry Form Certification of pregnancy by the obstretric gynecologist	**Effectiveness:** After registration, a certification of	All services covered by the PSG as long as the insured is active in the Special Coverage Registry.	**Insurer:** All cover medical services and medications

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		the special coverage will be mail to the insured. **Duration:** Registration will be effective since the estimated day of conception according to certification provided by the obstetrician and will continue to be effective until 56 days after the delivery date, provided this occur after the 20th week. If pregnancy ends in miscarriage before week 20, will only granted 30 days after the event.	**Sterilization**: Sterilization carried out in a separate admission, after childbirth or caesarean section, will be responsibility of the primary medical group, therefore it will require referral from the PCP **Newborn:** newborn children will be cover as long as the mother have eligibility for the PSG, and until the Obstetrics Registration in in effect (56 days of the date of birth) at risk of the insurance company. Under the Obstetric Registry coverage, the assistance of the pediatrician during delivery by caesarean section or high risk and routine care for the newborn in the hospital (nursery room) are part of the obstetrics special coverage.	as long as the insured is active under this special coverage category. **GMP/PCP:** Will not receive monthly capitation for the insured. **Newborn:** per capita payment shall be paid for the newborn once the mother is out of the registration or the newborn is certified by the mother, whichever occurs first.
16. **Tuberculosis (Tb)**	Pneumologist Certification with treatment plan and evidence of: 1- Tb test result 2- Chest radiology findings	**Effectiveness** = from the date of certification establishing the definitive diagnosis by the pneumologist.	-Medical services related to the condition, follow-up, complications, complications of the diagnostic procedure and treatment shall be at the risk of	**Insurer:** Medical services and medications as defined for the special coverage

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	3- Samples of sputum or bronchial wash for Acid-Fast Basillus (AFB) and culture for Mycobacterium tuberculosis. 4- Biopsies of the affected area, if applicable. 5- HIV test results	**Duration:** Coverage will be variable, depending on the duration of the treatment, which can fluctuate between six (6) months to (1) year, depending on the plan of treatment certified by the pulmonologist. After the first year, if the patient requires continuing treatment, a re-evaluation of the case by the pulmonologist will be requested and according to the new plan of treatment, special coverage may be extended.	the insurer from the date of effectiveness of the special coverage. -Special coverage includes medications to treat or control the special condition or conditions that may arise as part of diagnostic studies performed or from complications of the disease. -Chest radiology for follow up until the treatment is completed will be responsibility of the insurer. **Department of Health of PR covers:** - **Tuberculin** - **Culture** - **Bronchial washing** - **Medical treatment**	condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.

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17. HIV/AIDS	Evidence of the result of any of the following laboratories; 1-Western Blot positive 2- positive HIV Viral load 3- positive 4th generation test with validation of the subtypes of antibody or Antigen for acute infection. The registration may be requested by one of the following providers: -Primary Care Physician -HIV/AIDS Clinics Physician -VIH/AIDS Clinics Case Manager	**Effectiveness =** from the date of certification establishing the definitive diagnosis **Duration =** As long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of HIV/AIDS. 2-All medical services provided or ordered by HIV/AID treaters. 3- Medications prescribed by the HIV/AID treaters specific to treat the HIV/AID condition.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP** – Will receive the monthly capitation corresponding to the insured.
18. Adults with phenylketonuria (PKU)	When the special coverage is a continuation to the coverage under children with special conditions, once the beneficiary reaches age 21, no additional evidence is required. The evidence that qualifies he/she as a child, serves the purpose for the continuation of coverage under the category of adult PKU. If it is not a continuation of coverage, the registry has to be request by the geneticist and shall include a treatment history and	**Effectiveness:** it is a continuation of the registry under children with special conditions, after the beneficiary reaches age 21. **Duration** = As long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of PKU. 2. All medical services provided or ordered by the geneticist. 3. Medication prescribed by the geneticist and specific to treat the condition of PKU.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.

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	evidence of the result of the genetic study.			
19. Pulmonary Hypertension	Diagnosis certification and treatment plan by the Pneumologist or Cardiologist and evidence of supporting test(s).	**Effectiveness** = from the date of certification establishing the definitive diagnosis by the pneumologist or cardiologist. **Duration** = As long as the insured is eligible in the PSG	1. All hospital services, emergency room or medical specialist services provided with primary diagnosis of Pulmonary Hypertension or its complications. 2. All medical services provided or ordered by the pneumologist or cardiologist to treat the condition or its complications. 3. Medication prescribed by pneumologist or cardiologist to treat the condition or its complications.	**Insurer:** Medical services and medications as defined for the special coverage condition in this document. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.
20. Post-Transplant	The primary care physician or the specialist (nephrologist, pneumologist, cardiologist, hepatologist or gastroenterologist) must submit: • A certification of the post transplant status including the diagnosis and transplant date • Treatment plan with starting dates	**Effectiveness** = from the date of certification and treatment plan **Duration**: Special cover will be in effect as long as the insured is eligible in de PSG	1. All hospital services, emergency room or medical specialist services provided related to the primary condition of post-transplant or its complications. 2. All medical services provided or ordered by the specialist or primary care physician to treat the post-	**Insurer**- All medically necessary services cover by the PSG. **GMP/PCP:** Will receive the monthly capitation corresponding to the insured.

	• Specific immunosuppressors, doses and route of administration.		transplant condition or its complications. 3. Medication prescribed by the specialists or primary care physician to treat the post-transplant condition or its complications.	
21. HCV (Chronic Hepatitis C) (Refer to **"Policy for the management of patients diagnosed with Chronic Hepatitis-C under the GHIP" and to CN 20-0326)**	For its registry will be necessary to submit diagnosis certification including evidence of the following: • Positive result for HCV antibody (Ab) test and • Positive Quantitative RNA test • Treating physician should document and submit the treatment plan with estimated start and completion dates. • Treating physician should include in the registry, documents of letter of willingness to be treated from the beneficiary and agreements to start treatment immediately upon Registry in Special Condition Registry.	**Effectiveness=** From the date of registration with required certification and test results. **Duration=** HCV special coverage will be in effect since the time the patient is registered on this special coverage until six (6) months after completing treatment with the direct-acting antiviral drug (DDA) with evidence of sustained virological response not detected. If after six (6) months after completion of treatment, there is no evidence of sustained virologic response, then the Gastroenterologist or treating physician MUST document next step of management and treatment with specific start and completion dates. Otherwise the Beneficiary will revert to regular	1. Direct access to the specialist or subspecialist that handles condition without referral of the PCP. 2. Treatment with the direct-acting antiviral drug (DDA) as established under the Coverage of medication of ASES without countersignature of the PCP. 3. Medically Necessary Laboratories for the condition without referral of the PCP. 4. Imaging, sonography, MRI, CT or any other radiological imaging medically necessary for the condition without referral of the PCP.	**Insurer-** Medical services as defined for the special coverage condition in this document. Including but **not limited to**: Laboratories, (CMP, PT & INR, CBC, Renal function test's, genotype, RNA quantitative, resistant test as needed, radiological imagines (sonogram, =with and w/o elastography, Liver CT and MRI if clinically indicated)and or any other medically necessary laboratories or tests to identify gradation and estimated degree of liver fibrosis in Hepatitis C, including liver biopsy with or w/o imaging guidance, & pathology report. Also included are the visits to Gastroenterologist or

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		coverage and will be discontinued from special registry and coverage		other specialized authorized physician as described in the **"Policy for the management of patients diagnosed with Chronic Hepatitis-C under the GHIP"** Laboratories, tests, imaging studies and interventional radiologist evaluation, biopsy and pathological report are covered from the moment the patient is included in the special coverage and until discharged from the special coverage inclusion. The recommended follow up during the medical treatment is included in the **"Policy for the management of patients diagnosed with Chronic Hepatitis-C under the GHIP" as guidelines. (see pages 22-23).** **GMP/PCP:** Will receive the monthly capitation corresponding to the insured. **ASES:** Pharmacological treatment with direct-acting antiviral drug (DDA).

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ATTACHMENT 28 – HCHN Rate Cells

HCHN Rate Cell Assignment

Starting on November 1, 2018 each Enrollee in the GHP will be assigned to one of 37 distinct rate cells. **Appendix A** lists each rate cell by eligibility group. The rate cell assignment is a function of the Enrollee's Category Of Eligibility (COE) including Federal, Dual Eligible, CHIP, and State-funded (Commonwealth) Enrollees, Age, Gender, Medicare status, and Domestic Abuse and Foster Children (formerly Virtual region) and select High Cost High Need (HCHN) condition categories. Each of the 37 rate cells will have a distinct premium that will be paid to the Contractor for each Enrollee.

Rate Cell Assignment Prior to November 1, 2018

Prior to November 1, 2018 ASES will identify the HCHN conditions using the carrier reported claims data according to the methodology described below. The Contractor will receive an enrollment data file (.exp) (please refer to Attachment 09) that will contain the Enrollees assigned to the Contractor according to the auto-enrollment algorithm. The file will contain fields that identify the rate cell and if applicable the specific HCHN condition(s) for each Enrollee. In addition, the file will include date of initial diagnosis, date of last encounter with the diagnosis, and end date of HCHN rate cell eligibility (12 months after the date of last encounter).

Rate Cell Assignment

By the 15th day of each month the Contractor shall submit a HCHN Pre- Registry Report that will contain of the changes regarding of HCHN conditions identified. The file shall be formatted in the data layout contained in **Appendix C**.

The report number 8 describe the format that the Contractor must submit to ASES the HCHN Pre - Registry Report.

If the Contractor provides all required information in a timely manner, ASES will disburse the premium for each Enrollee according to HCHN Pre- Registry Report in the subsequent month. If the report is not received with the required information or in the specified timeline, ASES would not be able to include the update in the HCHN registry. No retroactive premium will be paid due to pre-register reports that do not comply with the procedures established by ASES.

The Contractor can internally identify Enrollees with the specific HCHN conditions with methods other than claims data (Clinical Review, Behavioral health data, Pharmacy data, Care Management, and referrals etc.). The Contractor should not consider laboratories or radiology claims as a source of information for the pre-registry.

The Encounters or any other valid claim transaction to register an Enrollee in the HCHN Program, is subject to the period in which the provider submits the claims to the MCO for payment of services provided, which create a gap that may result in such payment period for Enrollees registered in the HCHN Program to be less than twelve (12) months.

In order to mitigate any gap that results in payments for less than twelve (12) months, ASES will evaluate alternative methods that allows early identification and registration of Enrollees that qualifies for the HCHN program with the objective of guaranteeing twelve (12) months of payments from the initial payment month. In the event the alternative method or methods represent a material impact in the established and certified rates, a new actuarial certification shall be in place, as well as the corresponding Contract amendment. On the other hand, should the alternative method identified by ASES do not represent a material impact on the already certified rates, ASES shall issue a Normative Letter notifying. "Material impact" shall mean that a recalculation of current PMPM Payments is required in order to remain actuarially sound. Within fifteen (15) days from the execution of this Amendment, ASES shall conclude the referred evaluation and share the proposed alternative methods with Contractor. The proposed alternative methods shall be subject to the approval of CMS and the FOMB. Within the same fifteen (15) days' period the proposed alternative methods shall be submitted to CMS and the FOMB for their approval, as applicable.

It is the responsibility of the Contractor to report the Enrollee's Encounter or any other claims transaction, excluding laboratory or radiology, with the specific diagnosis codes that qualify for a HCHN rate cell. See below for specific diagnostic codes that qualify as a HCHN rate cell.

Denied Claims will not be considered by the Contractor, unless ASES determines so by issuing a Normative Letter describing the process for which type of denied claims may be included, which will be notified by ASES on or before thirty (30) days from the execution of this Amendment.

Considering that there are Enrollees in eligibility groups that are not currently included in the Rate Cell List of this Attachment 28, that require treatments that would otherwise be considered as HCHN, the parties agree to identify those scenarios and submit for approval to CMS the proposed changes to this attachment, on or before April 1st, 2021.

Retroactive Review of HCHN Registry Report

ASES reserves the right to retroactively review the assignment of any Enrollee into a HCHN condition rate cell. In addition, ASES can at any time request information regarding the diagnosis, supporting documentation, revised HCHN pre-registry report, encounters or claims and care management plan of the Enrollee. In the case that ASES determines that the member should not have been enrolled into a HCHN rate cell, premium will be retroactively recovered in the amount equal to the difference of the HCHN premium and the corresponding lower hierarchy HCHN premium or Age Gender premium, for each eligible month.

The retroactive review will be performed but not limited to the methodology the HCHN identification described in this attachment, such as:

1. Review of Enrollee's medical claims history based on the diagnosis codes contained in **Appendix B**, with appropriate exclusions.
2. Direct contact with Enrollee's PCP, specialist or physician directing the Enrollee HCHN care plan.
3. Review of Enrollee behavioral health data
4. Review of Enrollee pharmacy data

5. Compliance with time frame report of Claims Files (CLM) as specified in Attachment 9 of the Contract
6. Referrals

The Contractor will not be allowed to perform any adjustments to the medical claims data submitted to ASES modifying diagnosis codes, procedure codes or any other claim information to evidence HCHN diagnosis.

ASES can at any time review policies and efforts undertaken by the MCO to adjust claims or alter data for diagnosis codes to evidence enrollment into a HCHN rate cell. This practice can result in recoupment of premium and possible additional sanctions.

HCHN Rate Cell Assignment Methodology

The assignment of HCHN condition rate cells is based on specific diagnosis codes contained in **Appendix B** for cancer, diabetes, renal, cardiologic, and pulmonary conditions reported in the encounter or claims data, excluding laboratories, radiology or denied. The laboratory or radiology even being billed by an Inpatient hospital facility are excluded from the identification process.

For rate cell assignment, Domestic abuse, Foster Children, and Dual members (Medicare Part A and Part AB) population supersedes the other rate cells available.

An Enrollee is assigned to a HCHN rate cell if in the previous 12 months they had an encounter or claims (see the exclusions) flagged for one or more HCHN conditions. In the case where the Enrollee had more than one HCHN condition the assignment is according to the condition hierarchy as follows:

1. Federal
    i. Enrollee with a HCHN flag for cancer
    ii. Enrollee with a HCHN flag for medium, very high, and extra high Renal Disease
    iii. Enrollee with a HCHN flag for very high and medium cardiovascular disease
    iv. Enrollee with a HCHN flag for diabetes and/or low and extra low cardiovascular disease
    v. Enrollee with a HCHN flag for pulmonary disease
    vi. Enrollee with none of the above HCHN condition flag by age and gender
        - Male 14-18
        - Male 19-44
        - Male 45+
        - Female 14-18
        - Female 19-44
        - Female 45+
        - Age 0-1
        - Age 1-6
        - Age 7-13
2. State-funded (Commonwealth)

i. Enrollee with a HCHN flag for cancer
ii. Enrollee with a HCHN flag for medium, very high, and extra high Renal Disease
iii. Enrollee with a HCHN flag for very high and medium cardiovascular disease
iv. Enrollee with a HCHN flag for diabetes and/or low and extra low cardiovascular disease
v. Enrollee with a HCHN flag for pulmonary disease
vi. Enrollee with none of the above HCHN condition flag by age and gender
    - Male 14-18
    - Male 19-44
    - Male 45+
    - Female 14-18
    - Female 19-44
    - Female 45+
    - Age 0-1
    - Age 1-6
    - Age 7-13

3. CHIP
    i. Enrollee with HCHN flag for pulmonary disease
    ii. Enrollee with HCHN flag for diabetes
    iii. Enrollee with none of the above HCHN condition flag by age and gender
        - Age 0-1
        - Age 1-6
        - Age 7-13
        - Age 14+

Appendix A: Rate Cell List

Eligibility Group	Rate Cell Group	Category
Federal	Domestic Abuse and Foster Children	Other
Commonwealth	Domestic Abuse and Foster Children	Other
CHIP	Domestic Abuse and Foster Children	Other
Federal	A only	Other
Commonwealth	A only	Other
Federal	A and B	Other
Commonwealth	A and B	Other
Federal	Cancer	HCHN
Federal	Renal	HCHN
Federal	Cardio	HCHN
Federal	Cardio and/or Diabetes	HCHN
Federal	Pulmonary	HCHN
Federal	Male 14-18	Other
Federal	Male 19-44	Other

Federal	Male 45+	Other
Federal	Female 14-18	Other
Federal	Female 19-44	Other
Federal	Female 45+	Other
Federal	Age 0-1	Other
Federal	Age 1-6	Other
Federal	Age 7-13	Other
Commonwealth	Cancer	HCHN
Commonwealth	Renal	HCHN
Commonwealth	Cardio	HCHN
Commonwealth	Cardio and/or Diabetes	HCHN
Commonwealth	Pulmonary	HCHN
Commonwealth	Male 14-18	Other
Commonwealth	Male 19-44	Other
Commonwealth	Male 45+	Other
Commonwealth	Female 14-18	Other
Commonwealth	Female 19-44	Other
Commonwealth	Female 45+	Other
Commonwealth	Age 0-1	Other
Commonwealth	Age 1-6	Other
Commonwealth	Age 7-13	Other
CHIP	Pulmonary	HCHN
CHIP	Diabetes	HCHN
CHIP	Age 0-1	Other
CHIP	Age 1-6	Other
CHIP	Age 7-13	Other
CHIP	Age 14+	Other

Appendix B: Diagnosis Codes Used to Identify HCHN Rate Cells

Rate Cell	CDPS Condition Category	Diagnosis Codes
Cancer	Cancer, high	150, 1500, 1501, 1502, 1503, 1504, 1505, 1508, 1509, 151, 1510, 1511, 1512, 1513, 1514, 1515, 1516, 1518, 1519, 155, 1550, 1551, 1552, 156, 1560, 1561, 1562, 1568, 1569, 158, 1580, 1588, 1589, 162, 1620, 1622, 1623, 1624, 1625, 1628, 1629, 163, 1630, 1631, 1638, 1639, 183, 1830, 1832, 1833, 1834, 1835, 1838, 1839, 191, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 192, 1920, 1921, 1922, 1923, 1928, 1929, 20030, 20031, 20032, 20033, 20034, 20035, 20036, 20037, 20038, 20040, 20041, 20042, 20043, 20044, 20045, 20046, 20047, 20048, 20050, 20051, 20052, 20053, 20054, 20055, 20056, 20057, 20058, 20060, 20061.

Rate Cell	CDPS Condition Category	Diagnosis Codes
		20062, 20063, 20064, 20065, 20066, 20067, 20068, 20070, 20071, 20072, 20073, 20074, 20075, 20076, 20077, 20078, 2020, 20200, 20201, 20202, 20203, 20204, 20205, 20206, 20207, 20208, 2021, 20210, 20211, 20212, 20213, 20214, 20215, 20216, 20217, 20218, 20270, 20271, 20272, 20273, 20274, 20275, 20276, 20277, 20278, 204, 2040, 20400, 20401, 20402, 2041, 20410, 20411, 20412, 2042, 20420, 20421, 20422, 2048, 20480, 20481, 20482, 2049, 20490, 20491, 20492, 205, 2050, 20500, 20501, 20502, 2051, 20510, 20511, 20512, 2052, 20520, 20521, 20522, 2053, 20530, 20531, 20532, 2058, 20580, 20581, 20582, 2059, 20590, 20591, 20592, 206, 2060, 20600, 20601, 20602, 2061, 20610, 20611, 20612, 2062, 20620, 20621, 20622, 2068, 20680, 20681, 20682, 2069, 20690, 20691, 20692, 207, 2070, 20700, 20701, 20702, 2071, 20710, 20711, 20712, 2072, 20720, 20721, 20722, 2078, 20780, 20781, 20782, 208, 2080, 20800, 20801, 20802, 2081, 20810, 20811, 20812, 2082, 20820, 20821, 20822, 2088, 20880, 20881, 20882, 2089, 20890, 20891, 20892, 20900, 20901, 20902, 20903, 20910, 20911, 20912, 20913, 20914, 20915, 20916, 20917, 20920, 20921, 20922, 20923, 20924, 20925, 20926, 20927, 20929, 20930, 20931, 20932, 20933, 20934, 20935, 20936, 20970, 20971, 20972, 20973, 20974, 20975, 20979, 23877, 99685, C153, C154, C155, C158, C159, C160, C161, C162, C163, C164, C165, C166, C168, C169, C220, C221, C222, C223, C224, C227, C228, C229, C23, C240, C241, C248, C249, C33, C3400, C3401, C3402, C3410, C3411, C3412, C342, C3430, C3431, C3432, C3480, C3481, C3482, C3490, C3491, C3492, C384, C450, C451, C480, C481, C482, C488, C4A0, C4A10, C4A11, C4A12, C4A20, C4A21, C4A22, C4A30, C4A31, C4A39, C4A4, C4A51, C4A52, C4A59, C4A60, C4A61, C4A62, C4A70, C4A71, C4A72, C4A8, C4A9, C561, C562, C569, C5700, C5701, C5702, C5710, C5711, C5712, C5720, C5721, C5722, C573, C574, C700, C701, C709, C710, C711, C712, C713, C714, C715, C716, C717, C718, C719, C720, C721, C7220, C7221, C7222, C7230, C7231, C7232, C7240, C7241, C7242, C7250, C7259, C729, C7A00, C7A010, C7A011, C7A012, C7A019, C7A020, C7A021, C7A022, C7A023, C7A024,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		C7A025, C7A026, C7A029, C7A090, C7A091, C7A092, C7A093, C7A094, C7A095, C7A096, C7A098, C7A1, C7A8, C7B00, C7B01, C7B02, C7B03, C7B04, C7B09, C7B1, C7B8, C8200, C8201, C8202, C8203, C8204, C8205, C8206, C8207, C8208, C8209, C8210, C8211, C8212, C8213, C8214, C8215, C8216, C8217, C8218, C8219, C8220, C8221, C8222, C8223, C8224, C8225, C8226, C8227, C8228, C8229, C8230, C8231, C8232, C8233, C8234, C8235, C8236, C8237, C8238, C8239, C8240, C8241, C8242, C8243, C8244, C8245, C8246, C8247, C8248, C8249, C8260, C8261, C8262, C8263, C8264, C8265, C8266, C8267, C8268, C8269, C8280, C8281, C8282, C8283, C8284, C8285, C8286, C8287, C8288, C8289, C8290, C8291, C8292, C8293, C8294, C8295, C8296, C8297, C8298, C8299, C8310, C8311, C8312, C8313, C8314, C8315, C8316, C8317, C8318, C8319, C8331, C8332, C8333, C8334, C8335, C8336, C8337, C8338, C8339, C8380, C8381, C8382, C8383, C8384, C8385, C8386, C8387, C8388, C8389, C8400, C8401, C8402, C8403, C8404, C8405, C8406, C8407, C8408, C8409, C8440, C8441, C8442, C8443, C8444, C8445, C8446, C8447, C8448, C8449, C8460, C8461, C8462, C8463, C8464, C8465, C8466, C8467, C8468, C8469, C8470, C8471, C8472, C8473, C8474, C8475, C8476, C8477, C8478, C8479, C8520, C8521, C8522, C8523, C8524, C8525, C8526, C8527, C8528, C8529, C884, C9100, C9101, C9102, C9110, C9111, C9112, C9130, C9131, C9132, C9150, C9151, C9152, C9160, C9161, C9162, C9190, C9191, C9192, C91A0, C91A1, C91A2, C91Z0, C91Z1, C91Z2, C9200, C9201, C9202, C9210, C9211, C9212, C9220, C9221, C9222, C9230, C9231, C9232, C9240, C9241, C9242, C9250, C9251, C9252, C9260, C9261, C9262, C9290, C9291, C9292, C92A0, C92A1, C92A2, C92Z0, C92Z1, C92Z2, C9300, C9301, C9302, C9310, C9311, C9312, C9330, C9331, C9332, C9390, C9391, C9392, C93Z0, C93Z1, C93Z2, C9400, C9401, C9402, C9420, C9421, C9422, C9430, C9431, C9432, C9480, C9481, C9482, C9500, C9501, C9502, C9510, C9511, C9512, C9590, C9591, C9592, D45, D47Z1, T8600, T8601, T8602, T8603, T8609, V4281, V580, V581, V5811, V5812, Z510, Z5111, Z5112, Z9481

Rate Cell	CDPS Condition Category	Diagnosis Codes
Cancer	Cancer, low	140, 1400, 1401, 1403, 1404, 1405, 1406, 1408, 1409, 141, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1418, 1419, 142, 1420, 1421, 1422, 1428, 1429, 143, 1430, 1431, 1438, 1439, 144, 1440, 1441, 1448, 1449, 145, 1450, 1451, 1452, 1453, 1454, 1455, 1456, 1458, 1459, 146, 1460, 1461, 1462, 1463, 1464, 1465, 1466, 1467, 1468, 1469, 147, 1470, 1471, 1472, 1473, 1478, 1479, 148, 1480, 1481, 1482, 1483, 1488, 1489, 149, 1490, 1491, 1498, 1499, 160, 1600, 1601, 1602, 1603, 1604, 1605, 1608, 1609, 161, 1610, 1611, 1612, 1613, 1618, 1619, 172, 1720, 1721, 1722, 1723, 1724, 1725, 1726, 1727, 1728, 1729, 173, 1730, 17300, 17301, 17302, 17309, 1731, 17310, 17311, 17312, 17319, 1732, 17320, 17321, 17322, 17329, 1733, 17330, 17331, 17332, 17339, 1734, 17340, 17341, 17342, 17349, 1735, 17350, 17351, 17352, 17359, 1736, 17360, 17361, 17362, 17369, 1737, 17370, 17371, 17372, 17379, 1738, 17380, 17381, 17382, 17389, 1739, 17390, 17391, 17392, 17399, 174, 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 175, 1750, 1759, 179, 180, 1800, 1801, 1808, 1809, 181, 182, 1820, 1821, 1828, 184, 1840, 1841, 1842, 1843, 1844, 1848, 1849, 185, 186, 1860, 1869, 187, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 188, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 189, 1890, 1891, 1892, 1893, 1894, 1898, 1899, 190, 1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 193, 195, 1950, 1951, 1952, 1953, 1954, 1955, 1958, C000, C001, C002, C003, C004, C005, C006, C008, C009, C01, C020, C021, C022, C023, C024, C028, C029, C030, C031, C039, C040, C041, C048, C049, C050, C051, C052, C058, C059, C060, C061, C062, C0680, C0689, C069, C07, C080, C081, C089, C090, C091, C098, C099, C100, C101, C102, C103, C104, C108, C109, C110, C111, C112, C113, C118, C119, C12, C130, C131, C132, C138, C139, C140, C142, C148, C300, C301, C310, C311, C312, C313, C318, C319, C320, C321, C322, C323, C328, C329, C430, C4310, C4311, C4312, C4320, C4321, C4322, C4330, C4331, C4339, C434, C4351, C4352, C4359, C4360, C4361, C4362, C4370, C4371, C4372, C438, C439, C4400, C4401, C4402, C4409, C44101, C44102, C44109, C44111, C44112, C44119, C44121, C44122, C44129, C44191, C44192,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		C44199, C44201, C44202, C44209, C44211, C44212, C44219, C44221, C44222, C44229, C44291, C44292, C44299, C44300, C44301, C44309, C44310, C44311, C44319, C44320, C44321, C44329, C44390, C44391, C44399, C4440, C4441, C4442, C4449, C44500, C44501, C44509, C44510, C44511, C44519, C44520, C44521, C44529, C44590, C44591, C44599, C44601, C44602, C44609, C44611, C44612, C44619, C44621, C44622, C44629, C44691, C44692, C44699, C44701, C44702, C44709, C44711, C44712, C44719, C44721, C44722, C44729, C44791, C44792, C44799, C4480, C4481, C4482, C4489, C4490, C4491, C4492, C4499, C457, C50011, C50012, C50019, C50021, C50022, C50029, C50111, C50112, C50119, C50121, C50122, C50129, C50211, C50212, C50219, C50221, C50222, C50229, C50311, C50312, C50319, C50321, C50322, C50329, C50411, C50412, C50419, C50421, C50422, C50429, C50511, C50512, C50519, C50521, C50522, C50529, C50611, C50612, C50619, C50621, C50622, C50629, C50811, C50812, C50819, C50821, C50822, C50829, C50911, C50912, C50919, C50921, C50922, C50929, C510, C511, C512, C518, C519, C52, C530, C531, C538, C539, C540, C541, C542, C543, C548, C549, C55, C577, C578, C579, C58, C600, C601, C602, C608, C609, C61, C6200, C6201, C6202, C6210, C6211, C6212, C6290, C6291, C6292, C6300, C6301, C6302, C6310, C6311, C6312, C632, C637, C638, C639, C641, C642, C649, C651, C652, C659, C661, C662, C669, C670, C671, C672, C673, C674, C675, C676, C677, C678, C679, C680, C681, C688, C689, C6900, C6901, C6902, C6910, C6911, C6912, C6920, C6921, C6922, C6930, C6931, C6932, C6940, C6941, C6942, C6950, C6951, C6952, C6960, C6961, C6962, C6980, C6981, C6982, C6990, C6991, C6992, C73, C760, C761, C762, C763, C7640, C7641, C7642, C7650, C7651, C7652, C768, D030, D0310, D0311, D0312, D0320, D0321, D0322, D0330, D0339, D034, D0351, D0352, D0359, D0360, D0361, D0362, D0370, D0371, D0372, D038, D039, V524, Z4430, Z4431, Z4432, Z45811, Z45812, Z45819

Rate Cell	CDPS Condition Category	Diagnosis Codes
Cancer	Cancer, medium	152, 1520, 1521, 1522, 1523, 1528, 1529, 153, 1530, 1531, 1532, 1533, 1534, 1535, 1536, 1537, 1538, 1539, 154, 1540, 1541, 1542, 1543, 1548, 164, 1640, 1641, 1642, 1643, 1648, 1649, 165, 1650, 1658, 1659, 170, 1700, 1701, 1702, 1703, 1704, 1705, 1706, 1707, 1708, 1709, 171, 1710, 1712, 1713, 1714, 1715, 1716, 1717, 1718, 1719, 194, 1940, 1941, 1943, 1944, 1945, 1946, 1948, 1949, 196, 1960, 1961, 1962, 1963, 1965, 1966, 1968, 1969, 199, 1990, 1991, 1992, 200, 2000, 20000, 20001, 20002, 20003, 20004, 20005, 20006, 20007, 20008, 2001, 20010, 20011, 20012, 20013, 20014, 20015, 20016, 20017, 20018, 2002, 20020, 20021, 20022, 20023, 20024, 20025, 20026, 20027, 20028, 2008, 20080, 20081, 20082, 20083, 20084, 20085, 20086, 20087, 20088, 201, 2010, 20100, 20101, 20102, 20103, 20104, 20105, 20106, 20107, 20108, 2011, 20110, 20111, 20112, 20113, 20114, 20115, 20116, 20117, 20118, 2012, 20120, 20121, 20122, 20123, 20124, 20125, 20126, 20127, 20128, 2014, 20140, 20141, 20142, 20143, 20144, 20145, 20146, 20147, 20148, 2015, 20150, 20151, 20152, 20153, 20154, 20155, 20156, 20157, 20158, 2016, 20160, 20161, 20162, 20163, 20164, 20165, 20166, 20167, 20168, 2017, 20170, 20171, 20172, 20173, 20174, 20175, 20176, 20177, 20178, 2019, 20190, 20191, 20192, 20193, 20194, 20195, 20196, 20197, 20198, 202, 2022, 20220, 20221, 20222, 20223, 20224, 20225, 20226, 20227, 20228, 2023, 20230, 20231, 20232, 20233, 20234, 20235, 20236, 20237, 20238, 2024, 20240, 20241, 20242, 20243, 20244, 20245, 20246, 20247, 20248, 2025, 20250, 20251, 20252, 20253, 20254, 20255, 20256, 20257, 20258, 2026, 20260, 20261, 20262, 20263, 20264, 20265, 20266, 20267, 20268, 2028, 20280, 20281, 20282, 20283, 20284, 20285, 20286, 20287, 20288, 2029, 20290, 20291, 20292, 20293, 20294, 20295, 20296, 20297, 20298, C170, C171, C172, C173, C178, C179, C180, C181, C182, C183, C184, C185, C186, C187, C188, C189, C19, C20, C210, C211, C212, C218, C37, C380, C381, C382, C383, C388, C390, C399, C4000, C4001, C4002, C4010, C4011, C4012, C4020, C4021, C4022, C4030, C4031, C4032, C4080, C4081, C4082, C4090, C4091, C4092, C410, C411, C412, C413, C414, C419, C452, C459,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		C470, C4710, C4711, C4712, C4720, C4721, C4722, C473, C474, C475, C476, C478, C479, C490, C4910, C4911, C4912, C4920, C4921, C4922, C493, C494, C495, C496, C498, C499, C49A0, C49A1, C49A2, C49A3, C49A4, C49A5, C49A9, C7400, C7401, C7402, C7410, C7411, C7412, C7490, C7491, C7492, C750, C751, C752, C753, C754, C755, C758, C759, C770, C771, C772, C773, C774, C775, C778, C779, C800, C801, C802, C8100, C8101, C8102, C8103, C8104, C8105, C8106, C8107, C8108, C8109, C8110, C8111, C8112, C8113, C8114, C8115, C8116, C8117, C8118, C8119, C8120, C8121, C8122, C8123, C8124, C8125, C8126, C8127, C8128, C8129, C8130, C8131, C8132, C8133, C8134, C8135, C8136, C8137, C8138, C8139, C8140, C8141, C8142, C8143, C8144, C8145, C8146, C8147, C8148, C8149, C8170, C8171, C8172, C8173, C8174, C8175, C8176, C8177, C8178, C8179, C8190, C8191, C8192, C8193, C8194, C8195, C8196, C8197, C8198, C8199, C8250, C8251, C8252, C8253, C8254, C8255, C8256, C8257, C8258, C8259, C8300, C8301, C8302, C8303, C8304, C8305, C8306, C8307, C8308, C8309, C8330, C8350, C8351, C8352, C8353, C8354, C8355, C8356, C8357, C8358, C8359, C8370, C8371, C8372, C8373, C8374, C8375, C8376, C8377, C8378, C8379, C8390, C8391, C8392, C8393, C8394, C8395, C8396, C8397, C8398, C8399, C8410, C8411, C8412, C8413, C8414, C8415, C8416, C8417, C8418, C8419, C8490, C8491, C8492, C8493, C8494, C8495, C8496, C8497, C8498, C8499, C84A0, C84A1, C84A2, C84A3, C84A4, C84A5, C84A6, C84A7, C84A8, C84A9, C84Z0, C84Z1, C84Z2, C84Z3, C84Z4, C84Z5, C84Z6, C84Z7, C84Z8, C84Z9, C8510, C8511, C8512, C8513, C8514, C8515, C8516, C8517, C8518, C8519, C8580, C8581, C8582, C8583, C8584, C8585, C8586, C8587, C8588, C8589, C8590, C8591, C8592, C8593, C8594, C8595, C8596, C8597, C8598, C8599, C860, C861, C862, C863, C864, C865, C866, C9140, C9141, C9142, C960, C962, C964, C969, C96A, C96Z
Cancer	Cancer, very high	157, 1570, 1571, 1572, 1573, 1574, 1578, 1579, 197, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 198, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 19881, 19882, 19889, 203, 2030, 20300, 20301, 20302, 2031, 20310, 20311, 20312, 2038, 20380, 20381, 20382,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		C250, C251, C252, C253, C254, C257, C258, C259, C7800, C7801, C7802, C781, C782, C7830, C7839, C784, C785, C786, C787, C7880, C7889, C7900, C7901, C7902, C7910, C7911, C7919, C792, C7931, C7932, C7940, C7949, C7951, C7952, C7960, C7961, C7962, C7970, C7971, C7972, C7981, C7982, C7989, C799, C882, C883, C888, C889, C9000, C9001, C9002, C9010, C9011, C9012, C9020, C9021, C9022, C9030, C9031, C9032
Low Cardio	Cardiovascular, extra low	401, 4010, 4011, 4019, 402, 4020, 40200, 4021, 40210, 4029, 40290, 403, 4030, 40300, 4031, 40310, 4039, 40390, 404, 4040, 40400, 4041, 40410, 4049, 40490, 405, 4050, 40501, 40509, 4051, 40511, 40519, 4059, 40591, 40599, I10, I119, I129, I1310, I150, I151, I152, I158, I159, I160, I161, I169, N262
Low Cardio	Cardiovascular, low	410, 4100, 41000, 41001, 41002, 4101, 41010, 41011, 41012, 4102, 41020, 41021, 41022, 4103, 41030, 41031, 41032, 4104, 41040, 41041, 41042, 4105, 41050, 41051, 41052, 4106, 41060, 41061, 41062, 4107, 41070, 41071, 41072, 4108, 41080, 41081, 41082, 4109, 41090, 41091, 41092, 411, 4110, 4111, 4118, 41181, 41189, 412, 413, 4130, 4131, 4139, 414, 4140, 41400, 41401, 41402, 41403, 41404, 41405, 41406, 4141, 41410, 41411, 41412, 41419, 4142, 4143, 4144, 4148, 4149, 420, 4200, 4209, 42090, 42091, 42099, 421, 4211, 4219, 422, 4220, 4229, 42290, 42291, 42292, 42293, 42299, 423, 4230, 4231, 4232, 4233, 4238, 4239, 42511, 42518, 426, 4260, 4261, 42610, 42611, 42612, 42613, 4262, 4263, 4264, 4265, 42650, 42651, 42652, 42653, 42654, 4266, 4267, 4268, 42681, 42682, 42689, 4269, 427, 4270, 4271, 4272, 4273, 42731, 42732, 4274, 42741, 42742, 4275, 4276, 42760, 42761, 42769, 4278, 42781, 42789, 4279, 4293, 441, 4410, 44100, 44101, 44102, 44103, 4411, 4412, 4413, 4414, 4415, 4416, 4417, 4419, 442, 4420, 4421, 4422, 4423, 4428, 44281, 44282, 44283, 44284, 44289, 4429, 443, 4430, 4431, 4432, 44321, 44322, 44323, 44324, 44329, 4438, 44381, 44382, 44389, 4439, 444, 4440, 44401, 44409, 4441, 4442, 44421, 44422, 4448, 44481, 44489, 4449, 445, 4450, 44501, 44502, 4458, 44581, 44589, 446, 4460, 4461, 4462, 44620, 44621, 44629, 4463, 4464, 4465, 4466, 4467, 451, 4510, 4511, 45111, 45119, 4512, 4518, 45181, 45182, 45183, 45184, 45189,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		4519, 452, 453, 4530, 4531, 4532, 4533, 4534, 45340, 45341, 45342, 45350, 45351, 45352, 4536, 45371, 45372, 45373, 45374, 45375, 45376, 45377, 45379, 4538, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45389, 4539, 4540, 4542, 4548, 745, 7450, 7451, 74510, 74511, 74512, 74519, 7452, 7453, 7454, 7455, 7456, 74560, 74561, 74569, 7457, 7458, 7459, 746, 7460, 74600, 74601, 74602, 74609, 7461, 7462, 7463, 7464, 7465, 7466, 7467, 7468, 74681, 74682, 74683, 74684, 74685, 74686, 74687, 74689, 7469, 747, 7470, 7471, 74710, 74711, 7472, 74720, 74721, 74722, 74729, 7473, 74731, 74732, 74739, 7474, 74740, 74741, 74742, 74749, 7475, 7476, 74760, 74761, 74762, 74763, 74764, 74769, 7478, 74781, 74782, 74783, 74789, 7479, 9960, 99600, 99601, 99602, 99603, 99604, 99609, 99661, 99671, 99672, I200, I201, I208, I209, I2101, I2102, I2109, I2111, I2119, I2121, I2129, I213, I214, I220, I221, I222, I228, I229, I240, I241, I248, I249, I2510, I25110, I25111, I25118, I25119, I252, I253, I2541, I2542, I255, I256, I25700, I25701, I25708, I25709, I25710, I25711, I25718, I25719, I25720, I25721, I25728, I25729, I25730, I25731, I25738, I25739, I25750, I25751, I25758, I25759, I25790, I25791, I25798, I25799, I25810, I25811, I2582, I2583, I2584, I2589, I259, I300, I301, I308, I309, I310, I311, I312, I313, I314, I318, I319, I32, I339, I400, I401, I408, I409, I41, I421, I422, I440, I441, I442, I4430, I4439, I444, I445, I4460, I4469, I447, I450, I4510, I4519, I452, I453, I454, I455, I456, I4581, I4589, I459, I462, I468, I469, I470, I471, I472, I479, I480, I481, I482, I483, I484, I4891, I4892, I4901, I4902, I491, I492, I493, I4940, I4949, I495, I498, I499, I517, I670, I7100, I7101, I7102, I7103, I711, I712, I713, I714, I715, I716, I718, I719, I720, I721, I722, I723, I724, I725, I726, I728, I729, I7300, I7301, I731, I7381, I7389, I739, I7401, I7409, I7410, I7411, I7419, I742, I743, I744, I745, I748, I749, I75011, I75012, I75013, I75019, I75021, I75022, I75023, I75029, I7581, I7589, I7770, I7771, I7772, I7773, I7774, I7775, I7776, I7777, I7779, I790, I791, I798, I8000, I8001, I8002, I8003, I8010, I8011, I8012, I8013, I80201, I80202, I80203, I80209, I80211, I80212, I80213, I80219, I80221, I80222, I80223, I80229, I80231, I80232, I80233, I80239, I80291, I80292, I80293, I80299, I803, I808, I809, I81, I820, I821,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		I82210, I82211, I82220, I82221, I82290, I82291, I823, I82401, I82402, I82403, I82409, I82411, I82412, I82413, I82419, I82421, I82422, I82423, I82429, I82431, I82432, I82433, I82439, I82441, I82442, I82443, I82449, I82491, I82492, I82493, I82499, I824Y1, I824Y2, I824Y3, I824Y9, I824Z1, I824Z2, I824Z3, I824Z9, I82501, I82502, I82503, I82509, I82511, I82512, I82513, I82519, I82521, I82522, I82523, I82529, I82531, I82532, I82533, I82539, I82541, I82542, I82543, I82549, I82591, I82592, I82593, I82599, I825Y1, I825Y2, I825Y3, I825Y9, I825Z1, I825Z2, I825Z3, I825Z9, I82601, I82602, I82603, I82609, I82611, I82612, I82613, I82619, I82621, I82622, I82623, I82629, I82701, I82702, I82703, I82709, I82711, I82712, I82713, I82719, I82721, I82722, I82723, I82729, I82811, I82812, I82813, I82819, I82890, I82891, I8290, I8291, I82A11, I82A12, I82A13, I82A19, I82A21, I82A22, I82A23, I82A29, I82B11, I82B12, I82B13, I82B19, I82B21, I82B22, I82B23, I82B29, I82C11, I82C12, I82C13, I82C19, I82C21, I82C22, I82C23, I82C29, I83001, I83002, I83003, I83004, I83005, I83008, I83009, I83011, I83012, I83013, I83014, I83015, I83018, I83019, I83021, I83022, I83023, I83024, I83025, I83028, I83029, I83201, I83202, I83203, I83204, I83205, I83208, I83209, I83211, I83212, I83213, I83214, I83215, I83218, I83219, I83221, I83222, I83223, I83224, I83225, I83228, I83229, I83811, I83812, I83813, I83819, I83891, I83892, I83893, I83899, M300, M301, M302, M303, M308, M310, M311, M312, M3130, M3131, M314, M315, M316, M317, M3212, P293, Q200, Q201, Q202, Q203, Q204, Q205, Q206, Q208, Q209, Q210, Q211, Q212, Q213, Q214, Q218, Q219, Q220, Q221, Q222, Q223, Q224, Q225, Q226, Q228, Q229, Q230, Q231, Q232, Q233, Q234, Q238, Q239, Q240, Q241, Q242, Q243, Q244, Q245, Q246, Q248, Q249, Q250, Q251, Q252, Q2521, Q2529, Q253, Q254, Q2540, Q2541, Q2542, Q2543, Q2544, Q2545, Q2546, Q2547, Q2548, Q2549, Q255, Q256, Q2571, Q2572, Q2579, Q258, Q259, Q260, Q261, Q262, Q263, Q264, Q265, Q266, Q268, Q269, Q270, Q271, Q272, Q2730, Q2731, Q2732, Q2733, Q2734, Q2739, Q274, Q278, Q279, Q280, Q281, Q282, Q283, Q288, Q289, R001, T8201XA, T8202XA, T8203XA, T8209XA, T82110A, T82111A, T82118A, T82119A, T82120A, T82121A, T82128A, T82129A, T82190A, T82191A,

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Rate Cell	CDPS Condition Category	Diagnosis Codes
		T82198A, T82199A, T82211A, T82212A, T82213A, T82218A, T82221A, T82222A, T82223A, T82228A, T82512A, T82518A, T82519A, T82522A, T82528A, T82529A, T82532A, T82538A, T82539A, T82592A, T82598A, T82599A, T826XXA, T827XXA, T82817A, T82827A, T82837A, T82847A, T82857A, T82867A, T82897A, T829XXA, V422, Z953, Z954
High Cardio	Cardiovascular, medium	40201, 40211, 40291, 40401, 40411, 40491, 416, 4160, 4161, 4162, 4168, 4169, 417, 4170, 4171, 4178, 4179, 4210, 425, 4250, 4251, 4252, 4253, 4254, 4255, 4257, 4258, 4259, 428, 4280, 4281, 4282, 42820, 42821, 42822, 42823, 4283, 42830, 42831, 42832, 42833, 4284, 42840, 42841, 42842, 42843, 4289, 4295, 4296, 449, 7825, 7826, 78261, 78262, 7827, I110, I130, I234, I235, I270, I271, I272, I2781, I2782, I2789, I279, I280, I281, I288, I289, I330, I420, I423, I424, I425, I426, I427, I428, I429, I43, I501, I5020, I5021, I5022, I5023, I5030, I5031, I5032, I5033, I5040, I5041, I5042, I5043, I509, I511, I512, I76, R230, R231, R232, R233, V450, V4500, V4501, V4502, V4509, V533, V5331, V5332, V5339, Z45010, Z45018, Z4502, Z4509, Z950, Z95810, Z95818, Z959
High Cardio	Cardiovascular, very high	41407, 9961, 99662, 99674, 99683, I25760, I25761, I25768, I25769, I25812, T82310A, T82311A, T82312A, T82318A, T82319A, T82320A, T82321A, T82322A, T82328A, T82329A, T82330A, T82331A, T82332A, T82338A, T82339A, T82390A, T82391A, T82392A, T82398A, T82399A, T8241XA, T8242XA, T8243XA, T8249XA, T82510A, T82511A, T82513A, T82514A, T82515A, T82520A, T82521A, T82523A, T82524A, T82525A, T82530A, T82531A, T82533A, T82534A, T82535A, T82590A, T82591A, T82593A, T82594A, T82595A, T82818A, T82828A, T82838A, T82848A, T82858A, T82868A, T82898A, T8620, T8621, T8622, T8623, T86290, T86298, T8630, T8631, T8632, T8633, T8639, V421, V4322, Z941, Z95812
Diabetes	Diabetes, type 1 high	25021, 25023, 25031, 25033, 25041, 25043, 99686, E1011, E1021, E1022, E1029, E10641, V4283, Z9483

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Rate Cell	CDPS Condition Category	Diagnosis Codes
Diabetes	Diabetes, type 1 medium	25001, 25003, 2501, 25010, 25011, 25012, 25013, 25051, 25053, 25061, 25063, E1010, E10311, E10319, E10321, E103211, E103212, E103213, E103219, E10329, E103291, E103292, E103293, E103299, E10331, E103311, E103312, E103313, E103319, E10339, E103391, E103392, E103393, E103399, E10341, E103411, E103412, E103413, E103419, E10349, E103491, E103492, E103493, E103499, E10351, E103511, E103512, E103513, E103519, E103521, E103522, E103523, E103529, E103531, E103532, E103533, E103539, E103541, E103542, E103543, E103549, E103551, E103552, E103553, E103559, E10359, E103591, E103592, E103593, E103599, E1036, E1037X1, E1037X2, E1037X3, E1037X9, E1039, E1040, E1041, E1042, E1043, E1044, E1049, E1051, E1052, E1059, E10610, E10618, E10620, E10621, E10622, E10628, E10630, E10638, E10649, E1065, E1069, E108, E109
Diabetes	Diabetes, type 2 low	24900, 24901, 24980, 24981, 24990, 24991, 250, 2500, 25000, 25002, 2507, 25070, 25071, 25072, 25073, 2508, 25080, 25081, 25082, 25083, 2509, 25090, 25091, 25092, 25093, 3620, 36201, 36203, 36204, 36205, E08618, E08620, E08621, E08622, E08628, E08630, E08638, E08649, E0865, E0869, E088, E089, E09618, E09620, E09621, E09622, E09628, E09630, E09638, E09649, E0965, E0969, E098, E099, E1151, E1152, E1159, E11618, E11620, E11621, E11622, E11628, E11630, E11638, E11649, E1165, E1169, E118, E119, E13618, E13620, E13621, E13622, E13628, E13630, E13638, E13649, E1365, E1369, E138, E139
Diabetes	Diabetes, type 2 medium	24910, 24911, 24920, 24921, 24930, 24931, 24940, 24941, 24950, 24951, 24960, 24961, 24970, 24971, 2502, 25020, 25022, 2503, 25030, 25032, 2504, 25040, 25042, 2505, 25050, 25052, 2506, 25060, 25062, 36202, 36206, 36207, E0800, E0801, E0810, E0811, E0821, E0822, E0829, E08311, E08319, E08321, E083211, E083212, E083213, E083219, E08329, E083291, E083292, E083293, E083299, E08331, E083311, E083312, E083313, E083319, E08339, E083391, E083392, E083393, E083399, E08341, E083411, E083412, E083413, E083419, E08349, E083491, E083492,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		E083493, E083499, E08351, E083511, E083512, E083513, E083519, E083521, E083522, E083523, E083529, E083531, E083532, E083533, E083539, E083541, E083542, E083543, E083549, E083551, E083552, E083553, E083559, E08359, E083591, E083592, E083593, E083599, E0836, E0837X1, E0837X2, E0837X3, E0837X9, E0839, E0840, E0841, E0842, E0843, E0844, E0849, E0851, E0852, E0859, E08610, E08641, E0900, E0901, E0910, E0911, E0921, E0922, E0929, E09311, E09319, E09321, E093211, E093212, E093213, E093219, E09329, E093291, E093292, E093293, E093299, E09331, E093311, E093312, E093313, E093319, E09339, E093391, E093392, E093393, E093399, E09341, E093411, E093412, E093413, E093419, E09349, E093491, E093492, E093493, E093499, E09351, E093511, E093512, E093513, E093519, E093521, E093522, E093523, E093529, E093531, E093532, E093533, E093539, E093541, E093542, E093543, E093549, E093551, E093552, E093553, E093559, E09359, E093591, E093592, E093593, E093599, E0936, E0937X1, E0937X2, E0937X3, E0937X9, E0939, E0940, E0941, E0942, E0943, E0944, E0949, E0951, E0952, E0959, E09610, E09641, E1100, E1101, E1121, E1122, E1129, E11311, E11319, E11321, E113211, E113212, E113213, E113219, E11329, E113291, E113292, E113293, E113299, E11331, E113311, E113312, E113313, E113319, E11339, E113391, E113392, E113393, E113399, E11341, E113411, E113412, E113413, E113419, E11349, E113491, E113492, E113493, E113499, E11351, E113511, E113512, E113513, E113519, E113521, E113522, E113523, E113529, E113531, E113532, E113533, E113539, E113541, E113542, E113543, E113549, E113551, E113552, E113553, E113559, E11359, E113591, E113592, E113593, E113599, E1136, E1137X1, E1137X2, E1137X3, E1137X9, E1139, E1140, E1141, E1142, E1143, E1144, E1149, E11610, E11641, E1300, E1301, E1310, E1311, E1321, E1322, E1329, E13311, E13319, E13321, E133211, E133212, E133213, E133219, E13329, E133291, E133292, E133293, E133299, E13331, E133311,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		E133312, E133313, E133319, E13339, E133391, E133392, E133393, E133399, E13341, E133411, E133412, E133413, E133419, E13349, E133491, E133492, E133493, E133499, E13351, E133511, E133512, E133513, E133519, E133521, E133522, E133523, E133529, E133531, E133532, E133533, E133539, E133541, E133542, E133543, E133549, E133551, E133552, E133553, E133559, E13359, E133591, E133592, E133593, E133599, E1336, E1337X1, E1337X2, E1337X3, E1337X9, E1339, E1340, E1341, E1342, E1343, E1344, E1349, E1351, E1352, E1359, E13610, E13641
Pulmonary	Pulmonary, high	4820, 4821, 4822, 494, 4940, 4941, 7991, J14, J150, J151, J470, J471, J479, R092
Pulmonary	Pulmonary, low	07982, 476, 4760, 4761, 480, 4800, 4801, 4802, 4803, 4808, 4809, 481, 482, 4823, 48230, 48231, 48232, 48239, 4824, 48240, 48241, 48242, 48249, 4828, 48281, 48282, 48283, 48284, 48289, 4829, 483, 4830, 4831, 4838, 484, 4841, 4843, 4845, 4846, 4847, 4848, 485, 486, 488, 4880, 48801, 48802, 48809, 4881, 48811, 48812, 48819, 4888, 48881, 48882, 48889, 491, 4910, 4911, 4912, 49120, 49121, 49122, 4918, 4919, 492, 4920, 4928, 493, 4930, 49300, 49301, 49302, 4931, 49310, 49311, 49312, 4932, 49320, 49321, 49322, 4938, 49381, 49382, 4939, 49390, 49391, 49392, 496, 511, 5110, 5111, 5118, 51181, 51189, 5119, 5191, 51911, 51919, 5192, 5193, 5194, 7863, 78630, 78631, 78639, 7866, A481, B9721, J09X1, J09X2, J09X3, J09X9, J120, J121, J122, J123, J1281, J1289, J129, J13, J1520, J15211, J15212, J1529, J153, J154, J155, J156, J157, J158, J159, J160, J168, J17, J180, J181, J188, J189, J370, J371, J410, J411, J418, J42, J430, J431, J432, J438, J439, J440, J441, J449, J4520, J4521, J4522, J4530, J4531, J4532, J4540, J4541, J4542, J4550, J4551, J4552, J45901, J45902, J45909, J45990, J45991, J45998, J90, J910, J918, J920, J929, J940, J941, J942, J948, J949, J9801, J9809, J985, J9851, J9859, J986, R042, R0481, R0489, R049, R091
Pulmonary	Pulmonary, medium	507, 5070, 5071, 5078, 512, 5120, 5121, 5122, 5128, 51281, 51282, 51283, 51284, 51289, 515, 516, 5160, 5161, 5162, 5163, 51630, 51631, 51632, 51633, 51634, 51635, 51636, 51637, 5164, 5165, 5166, 51661, 51662, 51663, 51664,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		51669, 5168, 5169, 517, 5171, 5172, 5173, 5178, 518, 5180, 5181, 5182, 5183, 5184, 5185, 51851, 51852, 51853, 5186, 5187, 5188, 51881, 51882, 51883, 51884, 51889, 748, 7480, 7481, 7482, 7483, 7484, 7485, 7486, 74860, 74861, 74869, 7488, 7489, B4481, J690, J691, J698, J80, J810, J82, J8401, J8402, J8403, J8409, J8410, J84111, J84112, J84113, J84114, J84115, J84116, J84117, J8417, J842, J8481, J8482, J8483, J84841, J84842, J84843, J84848, J8489, J849, J930, J9311, J9312, J9381, J9382, J9383, J939, J951, J952, J953, J95811, J95812, J95821, J95822, J9584, J9600, J9601, J9602, J9610, J9611, J9612, J9620, J9621, J9622, J9690, J9691, J9692, J9811, J9819, J982, J983, J984, J99, M3213, M3301, M3311, M3321, M3391, M3481, M3502, Q300, Q301, Q302, Q303, Q308, Q309, Q310, Q311, Q312, Q313, Q315, Q318, Q319, Q320, Q321, Q322, Q323, Q324, Q330, Q331, Q332, Q333, Q334, Q335, Q336, Q338, Q339, Q340, Q341, Q348, Q349
Pulmonary	Pulmonary, very high	2770, 27700, 27701, 27702, 27703, 27709, 5190, 51900, 51901, 51902, 51909, 99684, E840, E8411, E8419, E848, E849, J9500, J9501, J9502, J9503, J9504, J9509, T86810, T86811, T86812, T86818, T86819, V426, V440, V460, V461, V4611, V4612, V462, V550, Z430, Z930, Z942, Z990, Z9911, Z9912, Z9981
Renal	Renal, extra high	45821, 99656, 99668, 99673, I953, T85611A, T85621A, T85631A, T85691A, T8571XA, V451, V4511, V4512, V56, V560, V561, V562, V563, V5631, V5632, V568, Z4901, Z4902, Z4931, Z4932, Z9115, Z992
Renal	Renal, medium	40301, 40311, 40391, 40402, 40403, 40412, 40413, 40492, 40493, 580, 5800, 5804, 5808, 58081, 58089, 5809, 581, 5810, 5811, 5812, 5813, 5818, 58181, 58189, 5819, 583, 5830, 5831, 5832, 5834, 5836, 5837, 5838, 58381, 58389, 5839, 5880, 5881, 59381, 99681, I120, I1311, I132, M3214, M3215, M3504, N000, N001, N002, N003, N004, N005, N006, N007, N008, N009, N010, N011, N012, N013, N014, N015, N016, N017, N018, N019, N020, N021, N022, N023, N024, N025, N026, N027, N028, N029, N040, N041, N042, N043, N044, N045, N046, N047, N048, N049, N050, N051, N052, N053, N054, N055, N056, N057, N058, N059, N060, N061, N062, N063, N064, N065, N066, N067, N068, N069, N070, N071, N072, N073, N074, N075, N076, N077, N078, N079, N08,

Rate Cell	CDPS Condition Category	Diagnosis Codes
		N140, N141, N142, N143, N144, N150, N158, N159, N16, N250, N251, N280, T8610, T8611, T8612, T8613, T8619, V420, V445, V4450, V4451, V4452, V4459, V446, V555, V556, Z435, Z436, Z9350, Z9351, Z9352, Z9359, Z936, Z940
Renal	Renal, very high	585, 5851, 5852, 5853, 5854, 5855, 5856, 5859, N181, N182, N183, N184, N185, N186, N189

Appendix C: HCHN Pre-Registry Report Data Layout

Reference current HCHN SOP, which is incorporated by reference as part of this Contract and can only be amended by mutual agreement of the parties in accordance with Article 55 of the Contract (Amendment in Writing).

ADMINISTRACION DE SEGUROS DE SALUD
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CONTENT

ASES HCIP Report

Tab		Report Name	Submission Frequency
Input Page		-	-
Content		-	-
Attestation		-	-
HCC Initiative Medicaid Federal		HCC Initiative Medicaid Federal	Quarterly
HCC Initiative CHIP		HCC Initiative CHIP	Quarterly
CCI Medicaid Federal		CCI Medicaid Federal	Quarterly
CCI CHIP		CCI CHIP	Quarterly
Healthy People Initiative		Healthy People Initiative	Quarterly
ER Initiative		ER Initiative	Quarterly

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
19-049

ATTESTATION

ASES

22. HCIP

QUARTERLY REPORTS CERTIFICATION STATEMENT OF

:

to

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES)

FOR THE PERIOD ENDING
(mm/dd/year)

12/31/2019

0
Name Of Preparer

0
Title

1/0/1900
Phone Number

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable Puerto Rico laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Contractor's agreement or contract with ASES. Failure to sign a Certification Statement will result in non acceptance of the attached reports.

date
Date Signed

Signature

ADMINISTRACION DE SEGUROS DE SALUD
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Health Care Improvement Program

High Cost Conditions Initiative	
MCO	-
Fiscal Year	Oct. 2019 to Sept. 2020

Medicaid/Federal and Commonwealth High Cost Conditions	
Period Start Date	1/1/2019
Period End Date	12/31/2019

High Cost Conditions Report

Cancer | Scored measure: Readmissions rate					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
20.06%	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Cancer | Scored measure: PHQ-9					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
13.3%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

End-Stage Renal Disease (ESRD) | Scored measure: Admissions/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
335.0	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

End-Stage Renal Disease (ESRD) | Scored Measure: PHQ-9					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
11.3%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Multiple Sclerosis | Scored Measure: Admissions/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
169	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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Health Care Improvement Program

High Cost Conditions Initiative	
MCO	-
Fiscal Year	Oct. 2019 to Sept. 2020

CHIP High Cost Conditions	
Period Start Date	1/1/2019
Period End Date	12/31/2019

High Cost Conditions Report

Cancer | Scored Measure: Readmissions rate					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
31.82%	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Children and Youth with Special Healthcare Needs | Scored Measure: Well-child visits in the 3rd, 4th, 5th and 6th years of life					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
35.71%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Children and Youth with Special Healthcare Needs | Scored Measure: Adolescent Well-care visits					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
25.41%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Autism | Scored Measure: Well-child visits in the 3rd, 4th, 5th and 6th years of life					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
29.59%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Health Care Improvement Program

Chronic Conditions Initiative		Medicaid/Federal and Commonwealth High Cost Conditions	
MCO	-	Period Start Date	1/1/2019
Fiscal Year	Oct. 2019 to Sept. 2020	Period End Date	12/31/2019

Chronic Conditions Report

Diabetes (Including CHIP population) ¦ Scored measure: Comprehensive Diabetes Care HbA1c					
National Benchmark 2018		Q1	Q2	Q3	Q4
	Numerator				
85.94%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Diabetes (Including CHIP population) ¦ Scored measure: Comprehensive Diabetes Care Eye Exam					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
38.74%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Diabetes (Including CHIP population) ¦ Scored measure: Comprehensive Diabetes Care Nephropathy screen					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
96.24%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Diabetes (Including CHIP population) ¦ Scored measure: Admissions/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
155	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Asthma (Including CHIP) ¦ Scored Measure: Admission/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
255	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Asthma (Including CHIP) ¦ Scored Measure: ED Use/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
1591	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Asthma (Including CHIP) ¦ Scored Measure: PHQ-9					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
7.40%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Severe Heart Failure¦ Scored Measure: Admissions/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
489	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Severe Heart Failure ¦ Scored Measure: PHQ-9					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
13%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Hypertension ¦ Scored Measure: ED Use/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
1020	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Chronic Obstructive Pulmonary Disease (COPD)¦ Scored Measure: Admissions/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
351	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Chronic Depression ¦ Scored Measure: Follow up after Hospitalization for Mental Illness: 7 days					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
63.71%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Chronic Depression ¦ Scored Measure: Follow up after Hospitalization for Mental Illness: 30 days					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
84.20%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Chronic Depression ¦ Scored Measure: Inpatient Admission/1000					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
169	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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Health Care Improvement Program

Healthy People Initiative			
MCO	-	Period Start Date	1/1/2019
Fiscal Year	Oct. 2019 to Sept. 2020	Period End Date	12/31/2019

Healthy People Initiative Report

Breast Cancer Screening (BCS)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
65.33%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Cervical Cancer Screening (CCS)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
53.27%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Colorectal Cancer Screening (COL)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
57.63%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
70.24%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Follow-Up After Hospitalization for Mental Illness (FUH) 30 days					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
83.78%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Adults Access to Preventive/Ambulatory Health Services (AAP)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
77.28%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Annual Dental Visit (ADV)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
62.29%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Timeliness of Prenatal Care (PPC)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
50.40%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Postpartum Care (PPC)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
21.38%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Adolescent Well-Care Visits (AWC)					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
16.17%	Denominator				
	Percent	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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Health Care Improvement Program				
Emergency Room High Utilizers Initiative				
MCO	-		Period Start Date	1/1/2019
Fiscal Year	Oct. 2019 to Sept. 2020		Period End Date	12/31/2019

Emergency Room High Utilizers Report

Overall emergency room utilization rate X 1000 on identified population with 7 or more visits to the Emergency Room					
National Benchmark 2019		Q1	Q2	Q3	Q4
	Numerator				
937	Denominator				
	Rate	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

ADMINISTRACION DE SEGUROS DE SALUD
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Puerto Rico Health Insurance Administration
Policy for Medication Exception Requests

I. PURPOSE:

To define the Puerto Rico Health Insurance Administration (ASES, for its acronym in Spanish) policy and procedures to manage exception requests from prescribers under Vital, also known as the Government Health Insurance Plan, for medications that: (i) are not in the Formulary of Medications Covered (FMC, for its acronym in Spanish); or (ii) are covered with utilization management edits under the FMC such as step therapy, quantity or dose limits or prior authorization requirements and prescribers wish to bypass such restrictions.

II. POLICY:

The Managed Care Organizations (MCOs) will maintain a standardized procedure for making timely and appropriate Exception Request decisions in accordance with ASES requirements and in compliance with 42 C.F.R. § 438.210(d)(3) to avoid delays that may jeopardize the enrollee's life, health, or ability to regain maximum function.

An exception request may be used for (i) Non-FMC drugs, or (ii) medications covered with utilization management edits under the FMC (such as step therapy, quantity or dose limits, or prior authorization requirements), when the prescriber wishes to bypass such restrictions. In those cases, the MCO must suggest that the prescriber first consider using drugs listed on the List of Medications by Exception (LME). If the prescriber demonstrates that none of the alternatives in the LME are clinically viable for the patient, then the MCO can consider approving coverage for drugs outside of the LME.

An Exception Request may also be used to bypass certain utilization management restrictions applicable to drugs that are listed on the FMC or LME, such as a step therapy requirement, quantity or dose limit, or prior authorization requirement.

III. SCOPE:

This policy applies to ASES' contracted pharmacy benefit management (PBM) organization, MCOs and their Vital providers including, but not limited to, physicians, hospitals, behavioral facilities, ambulatory facilities, and pharmacies prescribing and/or dispensing outpatient drugs.

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IV. DEFINITIONS:

TERM	DEFINITION
Formulary of Medications Covered Dugs (FMC, for its acronym in Spanish)	FMC means "Formulario de Medicamentos en Cubierta" in Spanish. The FMC is the list of preferred and non-preferred medications covered by Vital, though ASES may assign different levels of cost-sharing within the FMC.
List of Medications by Exception (LME)	List of medications that are not included in the FMC, but that have been evaluated and approved by ASES' Pharmacy and Therapeutics (P&T) Committee to be covered only through an exception process if certain clinical criteria are met. Covered outpatient drugs that are not included on the LME may still be covered under an Exception Request, unless statutorily excluded.
Exception Request	A request to obtain coverage by exception of a drug that is not included in Vital's FMC, or to bypass utilization management restrictions that apply to drugs listed on the FMC. Exception Requests may be evaluated based on the MCO's own clinical criteria or through the standards set forth under this policy.
Medical Necessity	**As defined by Section 7.2 of the Contract with MCOs** 7.2.1 Based on generally accepted medical practices specific to the medical or behavioral health condition of the enrollee at the time of treatment, Medically Necessary Services are those that relate to (i) the prevention, diagnosis, and treatment of health impairments; (ii) the ability to achieve age-appropriate growth and development; or (iii) the ability to attain, maintain, or regain functional capacity. The scope of Medically Necessary Services must not be any more restrictive than that of Puerto Rico's Medicaid program. Additionally, Medically Necessary services must be: 7.2.1.1 Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible enrollee's medical condition; 7.2.1.2 Compatible with the standards of acceptable medical practice in the community; 7.2.1.3 Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; 7.2.1.4 Not provided solely for the convenience of the enrollee or the convenience of the provider or hospital; and 7.2.1.5 Not primarily custodial care (for example, foster care). 7.2.2 In order for a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly treatment, service, or setting available.

V. BACKGROUND:

ASES' contract with the MCOs stipulates that certain medications, not otherwise covered under Vital, might be covered through an exception process by which the patient's health care provider must substantiate the clinical need for such exception.

Preferred and non-preferred medications covered by Vital are included in the FMC, though different levels of cost-sharing may apply. In addition, Vital has developed, through its Pharmacy & Therapeutics (P&T) Committee, a List of Medications by Exception (LME) that may be covered under special circumstances. The medications in the LME will be subject to the MCO's evaluation upon the participating physician's request for exception, on a case-by-case basis, to determine if it complies with the protocol established by ASES for said medication. If it is not in compliance, the medication will be denied; and if it complies, it will be approved.

Medications not included in the FMC will be not be paid for by Vital unless an Exception Request is granted. If an Exception Request is submitted, drugs listed on the LME will be preferred over non-FMC drugs or LME covered outpatient drugs. An Exception Request may also be used to bypass certain utilization management restrictions applicable to drugs that are listed on the FMC, such as a step therapy requirement, quantity or dose limit, or prior authorization requirement. A patient may appeal a decision to deny an Exception Request.

Certain drugs are considered excluded from coverage and will not be paid for by Vital even if an Exception Request is submitted. For example, under Section 1927(d)(2) of the Social Security Act, Vital will not cover drugs used to promote fertility, drugs used for cosmetic purposes or hair growth, drugs used for the symptomatic relief of cough and colds, most prescription vitamins and mineral products, non-prescription drugs or over-the counter-medication unless specifically included in Vital coverage, and drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. Drugs that are not prescribed for a medically accepted indication are also excluded and will not be covered. These drugs are considered "statutorily excluded." Also excluded are drugs prescribed for the purpose of treating a condition not covered under Vital. In addition, the Puerto Rico Medicaid State Plan excludes certain drugs from coverage, as these drug therapies are covered under other non-Medicaid government health programs. Required medication for the outpatient treatment of Hepatitis C is included under Special Coverage. Any costs incurred for required medication for the outpatient treatment of Hepatitis C shall be funded through separate payment by ASES to PBM.

ASES, through its Pharmacy Benefit Financial Committee and Pharmacy and Therapeutics (P&T) Committee will review the FMC and LME from time to time and evaluate additional recommendations on potential cost-saving pharmacy initiatives, including the evaluation of the utilization of high-cost specialty medications and orphan drugs and the exceptions process through which such drugs are approved, under the direction and approval of ASES.

VI. PROCESSING OF REQUESTS FOR EXCEPTION:

If a medication not included on the FMC, but included on the LME, is submitted to the Pharmacy Benefit Manager (PBM) for adjudication, the pharmacy will receive the

following message at the point of sale: *LME Drug: Exception request required. Validate other alternatives in FMC before proceeding.* If a medication not included on the LME is submitted to the PBM for adjudication, the pharmacy will receive the following message at the point of sale: *Non-FMC/LME Drug. Exception request required. Validate other alternatives in FMC/LME before proceeding*.

To request an exception, the prescribing physician must complete a request using the standardized Medication Request Form or, if necessary, an equivalent form and submit it to the MCO along with the necessary medical documentation (described in Section D.1.b below) showing compliance with ASES protocol for said medication. If the request or additional documentation or evidence (described in Section D.1.b below) is included with the prescription, the pharmacy will send the case to the MCO to process the request for exception.

A. Receipt of Exception Requests

1. Exception Requests will only be accepted in writing from the patient's health care provider and shall be received in the MCO's Pharmacy Clinical Unit via regular mail, e-mail, or fax.

    i. Regular mail requests will be stamped with the date and time it is received by the MCO and will serve as the starting time for evaluation period. For e- mail or fax requests, the receipt date and time will be used.

2. Exception Requests shall include the following standard information: the prescription, a supporting statement setting forth the clinical justification and medical necessity for the prescribed medication that meets all the requirements described in Section D.1.b below, and expected duration of treatment, as required by the protocol for the medication.

3. Incomplete requests that do not include all of the information listed in Section A.2 above will be returned by the MCO or pharmacy receiving the request to the prescribing physician or health care provider by fax or e-mail, for completion as soon as practicable, and within 24 hours. The processing time starts when the information required in Section A.2 above is received.

B. Timeframes

1. The outcome of the MCO's determination to approve or deny the Exception Request shall be communicated in accordance with Section E below to the enrollee, pharmacy and prescribing physician within 24 hours after the request is received and the MCO receives the standard information necessary in Section A.2 above to make a determination.

2. In an emergency situation, the MCO must authorize at least a 72-hour supply of the requested drug as long as the drug is not statutorily excluded. An emergency situation means that a lack of access to the requested drug

may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Terms that may indicate that a request should be treated as an emergency situation include, but are not limited to, "rush," "stat," "immediately," "patient's life is in danger," "urgent," or "expedite." However, MCOs must evaluate the request to determine based on the information presented whether the patient is in an emergency situation. Such evaluations must be conducted using appropriate clinical judgment, and shall not be used to deny a 72-hour emergency supply of the requested drug if an emergency situation does in fact exist. If a requested drug cannot be dispensed in a quantity, dose or form limited to a 72-hour emergency supply, e.g. injection vials or drugs infused by a pump or other device, the emergency dispense must be authorized in the minimum necessary form or increment that exceeds the 72-hour supply.

3. If additional time is needed to process a request, the MCO shall determine whether to grant the extension as soon as practicable, and within 24 hours. ASES's authorization to grant an extension is delegated to the MCOs, as long as the MCOs comply with the intent and purpose set forth in ASES Contract Section 7.5.12.4.2.2. governing Prior Authorization, and as also applied to Exception Requests.

"ASES may, in its discretion, grant an extension of the time allowed for Prior Authorization decisions where:

i. The Enrollee, or the Provider, requests the extension; or

ii. The MCO justifies to ASES a need for the extension in order to collect additional information, such that the extension is in the Enrollee's best interest."

The maximum time allowed when granting an exception must be no more than 72 hours. However, the MCO must still authorize the required 72-hour supply of the requested drug in an emergency situation as set forth in Section B.2 above, even if an extension is granted.

C. Additional Information

1. If a request is received, but additional information is needed to complete the evaluation, the request will be placed in a status of Need More Information (NMI) in the PAHub. Required information will be requested through fax, email or by contacting the prescribing physician, notifying the prescriber that the MCO will allow 72 hours for its submission. While in NMI status, the 24-hour timeframe specified in Section B.1 above will be paused and continued once the additional information necessary to complete the evaluation is received.

a. Examples of appropriate additional information requests include, but are not limited to:

1) Diagnosis

2) Relevant patient medical history or data

3) Documentation of prior use of other alternative therapies (including the specific therapies, times used, and clinical results)

4) Medical justification for the requested drug such as: alternative drugs on the FMC which are contraindicated, patient has experienced or would experience an adverse reaction to FMC drugs, evidence of therapeutic failure after available alternatives on FMC were attempted, drug is not covered in the FMC for a particular diagnosis

5) Laboratory results, if requested on protocol

2. If the additional information needed to complete the evaluation is not submitted to the MCO within 72 hours after the request for additional information is sent, the request will be considered inactive unless the MCO, prior to the expiration of the seventy two (72) hours, confirms that the available information is sufficient for an approval. If considered inactive for lack of requested information, a notification letter will be sent to the pharmacy and the prescribing physician.

D. Evaluation and Determination

1. The MCO shall first verify that:

a. The request is for a drug:

i. That is included on the FMC with certain clinical or other utilization management restrictions that the prescriber seeks to bypass through an exception, not included in the FMC but it is included LME, or is not included on the LME but is a covered prescription drug that is not statutorily excluded, and

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ii. That has been prescribed for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act, meaning that the use of the drug is approved by the FDA or is supported by one or more citations included or approved for inclusion in the American Hospital Formulary Service Drug Information, the United States Pharmacopeia – Drug Information (or its successor publications), or the DRUGDEX Information System, and

iii. That complies with the clinical criteria and protocols established by ASES for drugs included in the LME, or is consistent with general medically accepted guidelines for non-LME drugs or where the Exception Request seeks to bypass applicable clinical criteria and protocols.

b. The prescribing physician must provide a written and signed supporting statement setting forth the clinical reason or reasons that the requested prescription drug is medically necessary to treat the patient's disease or medical condition. His or her supporting statement must indicate that the requested prescription drug is medically necessary because:

If the physician is requesting an LME alternative:

i. All FMC alternatives for the requested drugs are contraindicated with drugs that the patient is already taking. The MCO must request that the patient's medical records show such contraindication, or that the prescribing physician provide scientific literature showing the strong possibility of serious adverse health effects as a result of taking the FMC alternatives; or

ii. Patient has experienced a serious adverse reaction to the alternative drugs that appear in the FMC; or

iii. Therapeutic failure of all available alternatives on the FMC, either because these alternatives were ineffective or would adversely affect the health or condition of the patient.

If the physician is requesting an alternative not listed on FMC or LME:

i. All FMC and LME alternatives for the requested drugs are contraindicated with drugs that the patient is already taking. The MCO must request that the patient's medical records to show such contraindication, or that the prescribing physician provide scientific literature showing the strong possibility of serious adverse health effects as a result of taking the FMC and LME alternatives; or

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ii. Patient has experienced a serious adverse reaction to the alternative drugs that appear in the FMC and LME; or

iii. Therapeutic failure of all available alternatives on the FMC and LME, either because these alternatives were ineffective or would adversely affect the health or condition of the patient.

2. If a physician provides an oral supporting statement to set forth the medical necessity of the drug, the MCO shall require the physician to submit this oral statement in writing. This written supporting statement must be submitted within 72 hours.

3. During the evaluation process, the MCO clinical reviewer will conduct an in-depth review of all available documentation submitted as part of the exception request including, but not limited to:

   a. The supporting statement and other documentation submitted with the exception request by the prescribing physician

   b. Internal information such as medication utilization history from PBM's adjudication system

   c. Diagnosis reported for the condition the requested drug is treating, from the claims system

   d. Any special condition(s) the patient may have which may have qualified him or her for special coverage.

4. If a discrepancy in the available documentation is found during the review of the information indicated in Section D.3 above, the prescribing physician shall be contacted by phone to clarify the discrepancy. The MCO clinical reviewer must document this contact, including the content of what was discussed and the results of that discussion.

5. The MCO clinical reviewer should also consider whether other utilization management measures for either the FMC or LME alternative drugs, such as dose restrictions to limit the number of doses available, or alternative forms of the drug, e.g. liquid versus pill, or oral versus injected or infused, could be appropriate.

6. The MCO will make a determination, with the available information, before expiration of the applicable timeframes set forth in Section B.

E. Notification of Decision

1. If the exception request does not fully meet the established clinical criteria or protocol for the medication, it will be denied by the MCO's authorized clinician- reviewer.

   a. The prescribing physician, pharmacy and patient will be verbally notified by the MCO's representatives within the applicable timeframes required in the preceding sections.

   b. A denial letter also will be mailed within three (3) business days of verbal notification to the patient in accordance with Section 14.4.3

of the MCO Contract, including an explanation of the reasons for the denial and a description of the appeal process. This same denial letter will be sent via fax or email to the prescribing physician and pharmacy.

c. The denial determination will be documented in the PBM PA Management Application.

2. If the request is approved, the MCO will document the determination and the date and time approved in the PBM PA Management Application. The pharmacy will then process and dispense the requested medication. The dispensing pharmacy representatives will verbally notify the beneficiary and prescribing physician of the approval. An approval letter also will be mailed within three (3) business days of verbal notification to the patient. This same letter will be sent via fax or email to the prescribing physician and pharmacy.

3. If a requested medication is approved through an exception, that approval will be valid for the duration indicated by the prescribing physician or the period specified in the clinical protocol, but in any case, no longer than twelve (12) months. The MCOs may use information on record to re-approve a non-FMC or LME medication as long as the information remains accurate and complies with current clinical protocols. The approval is also valid as long as:

   a. The patient remains enrolled in Vital, and

   b. The prescribing physician continues to prescribe the drug, and

   c. The drug continues to be safe for the treatment of the patient's condition.

4. The determination (approval or denial) and supporting evidence will be documented and filed as per MCOs' internal process.

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

HEALTH CARE IMPROVEMENT PROGRAM

ATTACHMENT 19 – HEALTH CARE IMPROVEMENT PROGRAM MANUAL

GOVERNMENT HEALTH PLAN PROGRAM

NOVEMBER 1, 2018 – SEPTEMBER 30, 2021

Revised September 09, 2020

TABLE OF CONTENTS

I. INTRODUCTION

The Puerto Rico Health Insurance Administration's (ASES, its acronym in Spanish) focus is on providing quality services that are patient-centered and aimed at increasing the use of screening, prevention and appropriate delivery of care in a timely manner to all Medicaid, Children's Health Insurance Program (CHIP) and Medicare-Medicaid Dual Eligible (Platino) Enrollees in Puerto Rico. The Health Care Improvement Program (HCIP) is one of the tools developed by ASES to reach this goal for the Medicaid and Children's Health Insurance Program (CHIP) population.

The purpose of this manual is to provide the necessary guidelines for attaining the required performance indicators for each of the categories measured under the HCIP as specified and subject to revision by ASES in this Manual and incorporated in Section 12.5 of the Government Health Plan (GHP) contract (Contract) executed between the Contractor and ASES. As the HCIP guidelines and/or performance benchmarks are updated, ASES will share these changes with Contractors and update this manual.

ASES shall maintain a retention fund created by withheld amounts of the per member per month (PMPM) payment each month as part of the HCIP described in Section 22.4 of the Contract. The retained PMPM amount shall be associated with the HCIP initiatives outlined below:

1. High Cost Conditions Initiative
2. Chronic Conditions Initiative
3. Healthy People Initiative
4. Emergency Room High Utilizers Initiative

ASES will disburse the retention fund to the Contractor according to compliance with each of the categories of performance indicators for each of the four (4) HCIP Initiatives specified in this Manual. The Planning, Quality and Clinical Affairs Office will audit the results of the data in the timeframes stated in Section 22.4.2.2 of the Contract for the performance indicators in the above-named initiatives. This Manual describes, in detail, the requirements and the specific metrics for each initiative of the HCIP for the Contract period November 1, 2018 through September 30, 2021, with an option to extend to September 30, 2022, at ASES' discretion. In the event ASES exercises the optional extension, an updated HCIP Manual will be provided. The HCIP will start on the implementation date of the Contract and will be updated annually as GHP benchmarks are set and measures or metrics are revised accordingly.

II. REPORTING TIMEFRAMES

The Contractor will submit a report for each quality initiative on a quarterly basis as established in the following table. The reporting templates will be provided by ASES and the Contractor must submit them through the ASES secure File Transfer Protocol (FTP) service.

Period	Claims Data: Incurred Service Time Period - Start	Claims Data: Incurred Service Time Period - End	Submission Due Date to ASES
Year 1			
Q1	1/1/2018	12/31/2018	7/30/2019
Q2	4/1/2018	3/31/2019	7/30/2019
Q3	7/1/2018	6/30/2019	10/30/2019
Q4	10/1/2018	9/30/2019	1/30/2020
Year 2			
Q1	1/1/2019	12/31/2019	4/30/2020
Q2	4/1/2019	3/31/2020	7/30/2020
Q3	7/1/2019	6/30/2020	10/30/2020
Q4	10/1/2019	9/30/2020	1/30/2021
Year 3			
Q1	1/1/2020	12/31/2020	4/30/2021
Q2	4/1/2020	3/31/2021	7/30/2021
Q3	7/1/2020	6/30/2021	10/30/2021
Q4	10/1/2020	9/30/2021	1/30/2022

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III. EVALUATION & POINT DISTRIBUTION

The HCIP is divided into four categories:

1. High Cost Conditions Initiative
2. Chronic Conditions Initiative
3. Healthy People Initiative
4. Emergency Room High Utilizers Initiative

There is a list of conditions, indicators and performance measures listed for the HCIP in Sections VI, VII, VIII, and IX. From that list, a selection of these indicators and performance measures will be chosen by ASES for quarterly basis reporting and evaluation purposes for the HCIP. The MCOs will be notified which are the selected indicators, the definition of improvement for each metric, and the corresponding point distribution for each fiscal year before the fiscal year begins.

Period	Claims Data: Incurred Service Time Period	Evaluation criteria
Year 1	***Puerto Rico GHP Benchmark — ASES will establish the Puerto Rico GHP benchmark for the metrics included in this manual using the period from January 1, 2017 through December 31, 2017.**	
Q1	1/1/2018 - 12/31/2018	Report submission
Q2	4/1/2018 – 3/31/2019	Report submission
Q3	7/1/2018 – 6/30/2019	Report submission
Q4	10/1/2018 – 9/30/2019	Report submission
Year 2	**Contractor GHP Benchmark Data Analysis — From January 1, 2018 to December 31, 2018: To be provided by ASES.**	
Q1	1/1/2019 – 12/31/2019	Report submission
Q2	4/1/2019 – 3/31/2020	Report submission
Q3	7/1/2019 – 6/30/2020	Report submission
Q4	10/1/2019 – 9/30/2020	Report submission
Year 3	**Contractor GHP Benchmark Data Analysis — From January 1, 2019 to December 31, 2019: To be provided by ASES.**	
Q1	1/1/2020 – 12/31/2020	Report submission
Q2	4/1/2020 – 3/31/2021	Any improvement over GHP benchmark[1]
Q3	7/1/2020 – 6/30/2021	Any improvement over GHP benchmark[1]
Q4	10/1/2020--9/30/2021	Any improvement over GHP benchmark[1]

[1] Some metrics will be evaluated with the report submission criteria. Refer to session X.2.5 Definition of improvement.

The scale of values per indicator is divided into the three levels indicated below.

Report Submission:

- 1 point = Report and attestation submission on time with valid data
- 0 points = Report and attestation submission without valid data

Any Improvement:

- 1 point = Data submitted has improvement
- .5 point = Data submitted has no change; no improvement or deterioration
- 0 points = Data submitted has deteriorated

Improvement Goal Established by ASES:

- 1 Point = Full compliance with the expected goal; The results reported meets or exceeds (90%–100%) the established goal.
- 0.5 point = Partial compliance with the expected goal; The results reported are greater than or equal to 70% but less than 90% (70.00%–89.99%) of the established goal.
- 0 points = No compliance; The results reported are less than 70% (0%–69.99%) of the established goal.

The point distribution by program may vary for each fiscal year. Please see the sections specific to each fiscal year for the point distribution table for a particular year.

IV. RETENTION FUND & COMPLIANCE PERCENTAGE

ASES will withhold 2% (two percent) of the monthly PMPM payment otherwise payable to the Contractor to validate that the Contractor has met the specified performance targets of the HCIP. The retention fund, comprised of the withheld amounts, will be disbursed to the Contractor based on the determination made by ASES in accordance to the compliance of the Contractor with the improvement standards and criteria established by ASES in accordance with the HCIP manual.

TIME PERIOD (INCURRED SERVICE FROM CONTRACT TERM)	MONTHLY RETENTION FUND PERCENTAGE
Fiscal Year Quarters Defined in Section II – Reporting Timeframes	2%
HCIP INITIATIVE	
High Cost Conditions Initiative	
Chronic Conditions Initiative	
Healthy People Initiative	
Emergency Room High Utilizers Initiative	

The retention fund is associated with the HCIP initiatives outlined below for each of the specified timeframes, as per Section 22.4 of the Contract. No later than thirty (30) calendar days after the deadline of the receipt of the Contractor's quarterly submission, ASES shall determine if the Contractor has met the applicable performance objectives for each metric within the initiatives for that period. The evaluation result will determine the percent to be disbursed to the Contractor as described in the following table.

COMPLIANCE PERCENTAGE (BASED ON POINTS EARNED)	DISBURSEMENT PERCENTAGE OF MONTHLY PMPM
90.0% - 100%	100%
80.0% - 89.9%	75%
70.0%–79.9%	50%
50.0%–69.9%	25%
0.00% - 49.9%	0%

V. DEFINITIONS

The following definitions apply to measures of the HCIP Manual:

1. **Active Enrollee**: GHP Enrollee with **continuous** enrollment during the HCIP measurement quarter.

2. **Baseline:** is a measurement at a point in time.

3. **Benchmark:** is a measurement of a standard result.

4. **Continuous Enrollment:** Membership enrollment from the start of a designated period through the end of the designated period without interruption.

5. **Health Care Improvement Program (HCIP)**: Approach developed to improve the quality of services provided to enrollees. The HCIP consists of four (4) initiatives: High Cost Conditions Initiative, Chronic Condition Initiative, Healthy People Initiative and Emergency Room High Utilizers Initiative. As part of the HCIP, a Retention Fund shall be maintained by ASES from the monthly PMPM payment to incent the Contractor to meet performance indicators and targets under HCIP specified in the HCIP Manual. The Retention Fund shall be disbursed on a quarterly basis to the Contractor when a determination is made by ASES that the Contractor has complied with the quality standards and criteria established by ASES in accordance with the HCIP Manual and the Contract.

6. **Incurred date**: The date on which the service was provided.

7. **Intervention:** Activities targeted at the achievement of client stability, wellness and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration and service facilitation.

8. **Performance measures**: Periodic measurement of outcomes and results used to assess the effectiveness and efficiency of quality or improvement initiatives on selected indicators.

9. **Per member per month (PMPM) payment:** The fixed monthly amount that the Contractor is paid by ASES for each enrollee to ensure that benefits under the Contract are provided. This payment is made regardless of whether the enrollee receives benefits during the period covered by the payment.

10. **Preventive services**: Health care services provided by a physician or other provider within the scope of his or her practice under Puerto Rico law to detect or prevent disease, disability, behavioral health conditions or other health conditions; and to promote physical and behavioral health and efficiency.

11. **Primary care physician (PCP):** A licensed medical doctor (MD) who is a provider and who, within the scope of practice and in accordance with Puerto Rico certification and licensure requirements, is responsible for providing all required primary care to enrollees. The PCP is responsible for determining services required by enrollees, provides continuity of care and provides referrals for enrollees when medically necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist or pediatrician.

12. **Retention fund**: The amount withheld by ASES of the monthly PMPM payment otherwise payable to the Contractor to incentivize the Contractor to meet performance targets under the HCIP described in this manual. This amount shall be equal to the percent of that portion of the total PMPM payment that is determined to be attributable to the Contractor's administration of the HCIP described in this Manual and Sections 12.5 and 22.4 of the Contract. Amounts withheld will be disbursed to the Contractor in whole or in part (as set forth in the HCIP manual and Sections 12.5 and 22.4 of the Contract) in the event of a determination by ASES that the Contractor has complied with the quality standards and criteria established in this HCIP manual.

Note:
Definition references in this manual are from the Contract and the (National Committee for Quality Assurance (NCQA).

VI. HIGH COST CONDITIONS INITIATIVE

The High Cost Conditions Initiative focuses on those enrollees with a high cost condition that may be part of the High Cost High Need (HCHN) Program specified in Section 7.8.3 of the Contract. The Contractor must be prepared to report quarterly on the quality measures listed below for each condition. Each fiscal year, the quality measures required to be reported for the HCIP will be specified. The reporting templates for the selected condition will be provided to the Contractor. ASES shall disburse the Contractor the applicable percentage of the Retention Fund in accordance with the Contractor's performance across the scored measures and the point distribution section of this Manual.

HIGH COST CONDITIONS	QUALITY MEASURES
Medicaid/Federal and State High Cost Conditions	
Cancer	• Generic Dispensing Rate • PHQ-4 • Admissions/1000 • Emergency Department (ED) Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual
End-Stage Renal Disease (ESRD)	• Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual
Multiple Sclerosis	• Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual

HIGH COST CONDITIONS	QUALITY MEASURES
Rheumatoid Arthritis	• Disease-modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis • Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual
CHIP High Cost Conditions	
Cancer	• Generic Dispensing Rate • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual
Children and Youth with Special Healthcare Needs (CYSHCN)	• Well-child visits in first 15 months of life • Well-child visits in the 3rd, 4th, 5th and 6th years of life • Adolescent Well-care visits • Annual Dental Visit
Hemophilia	• Well-child visits in first 15 months of life • Well-child visits in the 3rd, 4th, 5th and 6th years of life • Generic Dispensing Rate • Adherence to Formulary Drugs • BMI Assessment
Autism	• Well-child visits in first 15 months of life • Well-child visits in the 3rd, 4th, 5th and 6th years of life • Generic Dispensing Rate • Adherence to Formulary Drugs • Incidence rate • Prevalence rate

VII. CHRONIC CONDITIONS INITIATIVE

The Chronic Conditions Initiative focuses on those enrollees with a chronic condition. The Contractor must be prepared to report quarterly on the quality measures listed below for each condition. Each fiscal year, the quality measures required to be reported for the HCIP will be specified. The reporting templates for the selected condition will be provided to the Contractor. ASES shall disburse the Contractor the applicable percentage of the Retention Fund in accordance with the Contractor's performance across the scored measures and the point distribution section of this Manual.

CHRONIC CONDITIONS	QUALITY MEASURES
Medicaid/Federal, State, and CHIP Chronic Conditions	

Diabetes	• Comprehensive Diabetes Care:
	  ○ HbA1c
	  ○ Eye exam
	  ○ Nephropathy screen
	• Generic Dispensing Rate
	• PHQ-4
	• Adherence to oral diabetic medications
	• Admissions/1000
	• ED Use/1000
	• Readmission Rate
	• Adherence to Formulary Drugs
	• Medication Reconciliation Post Discharge
	• Medication Reconciliation Annual

Asthma	• Medication management for people with Asthma • Asthma medication ratio • Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Ambulatory visits per quarter for population • Medication Reconciliation Post Discharge • Medication Reconciliation Annual

CHRONIC CONDITIONS	QUALITY MEASURES
Medicaid/Federal and State Chronic Conditions	
Diabetes	• Statin Use
Severe Heart Failure	• Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual
Hypertension	• Controlling High Blood Pressure • Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Medication Reconciliation Post Discharge • Medication Reconciliation Annual • Adherence to Formulary Drugs • Adherence to anti-hypertensive (RAS Agonist) medication
Chronic Obstructive Pulmonary Disease (COPD)	• Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual

CHRONIC CONDITIONS	QUALITY MEASURES
Chronic Depression	• Follow up after Hospitalization for Mental Illness 7 days and 30 days • Follow up after ED visit for Mental Illness • Use of Opioids at High Dosage • Use of Opioids from Multiple Providers • Generic Dispensing Rate • Adherence to Formulary Drugs • Inpatient Admission/1000 • Readmission Rate • Antidepressant Medication Management
Substance Use Disorders (SUD) (Buprenorphine User)	• Follow up after Emergency Department Visits for Alcohol and Other Drug Abuse or Dependence • Adherence to treatment (12 months)
Serious Mental Illness (SMI) Other than Depression	• Follow up after Hospitalization for Mental Illness • Follow up after ED visit for Mental Illness • Use of Opioids at High Dosage • Use of Opioids from Multiple Providers • Generic Dispensing Rate • Adherence to Formulary Drugs • Inpatient Admission
CHIP Chronic Conditions	

Diabetes	• Comprehensive Diabetes Care:
	  o HbA1c
	  o Eye exam
	  o Nephropathy screen
	• Generic Dispensing Rate
	• PHQ-4
	• Statin Use
	• Adherence to oral diabetic medications
	• Admissions/1000
	• ED Use/1000
	• Readmission Rate
	• Adherence to Formulary Drugs
	• Medication Reconciliation Post Discharge
	• Medication Reconciliation Annual

CHRONIC CONDITIONS	QUALITY MEASURES
Asthma	• Medication management for people with Asthma • Asthma medication ratio • Generic Dispensing Rate • PHQ-4 • Admissions/1000 • ED Use/1000 • Readmission Rate • Ambulatory visits per quarter for population • Adherence to Formulary Drugs • Medication Reconciliation Post Discharge • Medication Reconciliation Annual
Attention-Deficit/ Hyperactivity Disorder (ADHD)	• Follow up care for children with prescribed ADHD medication • Adherence to Formulary Drugs • Generic Dispensing Rate

VIII. HEALTHY PEOPLE INITIATIVE

The Healthy People Initiative focuses on preventive screening for enrollees, including populations identified with high cost and/or chronic conditions. The Contractor must be prepared to report quarterly on the quality measures listed below. Each fiscal year, the quality measures required to be reported for the HCIP will be specified. The reporting templates for the selected condition will be provided to the Contractor. ASES shall disburse the Contractor the applicable percentage of the Retention Fund in accordance with the Contractor's performance across the scored measures and the point distribution section of this Manual.

EFFECTIVENESS OF CARE	QUALITY MEASURES
Healthy People Initiative	
ABA	• Adult BMI Assessment
WCC	• Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity
CIS	• Childhood Immunization Status
BCS	• Breast Cancer Screening
CCS	• Cervical Cancer Screening
CHL	• Chlamydia Screening in Women
COL	• Colorectal Cancer Screening
AMM	• Antidepressant Medication Management
SSD	• Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications.
FUH	• Follow-Up After Hospitalization for Mental Illness: 30 days
URI	• Appropriate Treatment for Children With Upper Respiratory Infection
Access/Availability of Care	
AAP	• Adults' Access to Preventive/Ambulatory Health Services
CAP	• Children and Adolescents' Access to Primary Care Practitioners
ADV	• Annual Dental Visit

EFFECTIVENESS OF CARE	QUALITY MEASURES
PPC	• Prenatal and Postpartum Care • Timeliness of Prenatal Care • Postpartum Care
Other Utilization	
FPC	• Frequency of Ongoing Prenatal Care
W15	• Well-Child Visits in the First 15 Months of Life
AWC	• Adolescent Well-Care Visits
FSP	• Frequency of Selected Procedures
AMB	• Ambulatory Care
IAD	• Identification of Alcohol and Other Drug Services
MPT	• Overall Mental Health Utilization Readmission Rate • Mental Health Use of Opioids at High Dosage • Mental Health Use of Opioids from Multiple Providers • Overall Mental Health admission per thousand

IX. EMERGENCY ROOM HIGH UTILIZERS INITIATIVE

The Emergency Room High Utilizers Initiative is designed to identify high users of emergency services for non-emergency situations and to allow for early interventions to ensure appropriate utilization of services and resources. The Contractor must be prepared to report quarterly on the quality measures listed below. Each fiscal year, the quality measures required to be reported for the HCIP will be specified. The reporting templates for the selected condition will be provided to the Contractor. ASES shall disburse the Contractor the applicable percentage of the Retention Fund in accordance with the Contractor's performance across the scored measures and the point distribution section of this Manual.

For purpose of the HCIP, ASES will consider the UM Metric described below:

ER HU INITIATIVE	QUALITY MEASURE
ER	Overall emergency room utilization rate x 1,000 on identified population with 7 or more visits to the emergency room

X. FISCAL YEAR 2019-2020 (NOVEMBER 2019 – SEPTEMBER 2020)

X.1 Evaluation and Point Distribution

X.1.1 Point Distribution

PROGRAM	POINTS
High Cost Conditions Initiative	9
Chronic Conditions Initiative	14
Healthy People Initiative	10
Emergency Room High Utilizers Initiative	1
Total Possible Points	**34**

X.1.2 Compliance Percentage and Points Earned

COMPLIANCE PERCENTAGE	DISBURSEMENT PERCENTAGE OF MONTHLY PMPM
90.0% - 100.0%	100%
80.0%–89.9%	75%
70.0%–79.9%	50%
50.0%–69.9%	25%
0.0% - 49.9%	0%

X.2 Scored Measures for 2019-2020

X.2.1 High Cost Conditions Initiative

HIGH COST CONDITIONS	SCORED MEASURES	POINTS
Medicaid/Federal and State High Cost Conditions		
Cancer	• Readmissions rate	1
	• PHQ-9	1
End-Stage Renal Disease (ESRD)	• Admissions/1000	1
	• PHQ-9	1
Multiple Sclerosis	• Admissions/1000	1
CHIP High Cost Conditions		
Cancer	• Readmissions rate	1

HIGH COST CONDITIONS	SCORED MEASURES	POINTS
Children and Youth with Special Healthcare Needs (CYSHCN)	• Well-child visits in the 3rd, 4th, 5th and 6th years of life	1
	• Adolescent Well-care visits	1
Autism	• Well-child visits in the 3rd, 4th, 5th and 6th years of life	1
Total Points for the High Costs Conditions Initiative for Fiscal Year 2019-2020		**9**

X.2.2 Chronic Conditions Initiative

CHRONIC CONDITIONS	SCORED MEASURES	POINTS
Medicaid/Federal, State, and CHIP Chronic Conditions		
Diabetes	• Comprehensive Diabetes Care:	
	▪ HbA1c	1
	▪ Eye exam	1
	▪ Nephropathy screen	1
	• Admissions/1000	1
Asthma	• Admissions/1000	1
	• ED Use/1000	1
	• PHQ-9	1
Medicaid/Federal and State Chronic Conditions		
Severe Heart Failure	• Admissions/1000	1
	• PHQ-9	1
Hypertension	• ED Use/1000	1
Chronic Obstructive Pulmonary Disease (COPD)	• Admissions/1000	1

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Chronic Depression	• Follow up after Hospitalization for Mental Illness: 7 days	1
	• Follow up after Hospitalization for Mental Illness: 30 days	1
	• Inpatient Admission/1000	1
Total Points for the Chronic Conditions Initiative for Fiscal Year 2019-2020		**14**

X.2.3 Healthy People Initiative

EFFECTIVENESS OF CARE	SCORED MEASURES	POINTS
Healthy People Initiative		
BCS	• Breast Cancer Screening	1
CCS	• Cervical Cancer Screening	1
COL	• Colorectal Cancer Screening	1
SSD	• Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications.	1
FUH	• Follow-Up After Hospitalization for Mental Illness: 30 days	1
Access/Availability of Care		
AAP	• Adults' Access to Preventive/Ambulatory Health Services	1
ADV	• Annual Dental Visit	1
PPC	• Timeliness of Prenatal Care	1
	• Postpartum Care	1
Other Utilization		
AWC	• Adolescent Well-Care Visits	1
Total Points for the Health People Initiative for Fiscal Year 2019-2020		**10**

X.2.4 Emergency Room High Utilizers Initiative

For purpose of the HCIP, ASES will consider the UM Metrics described below for compliance and release to the applicable percent of the retention fund for this particular program.

ER HU INITIATIVE	SCORED MEASURES	POINTS
ER	Overall emergency room utilization rate x 1,000 on identified population with 7 or more visits to the emergency room	1
Total Points for the Emergency Room High Utilizer Initiative for Fiscal Year 2019-2020		1

X.2.5 Definition of Improvement

HIGH COST CONDITIONS	SCORED MEASURES	DEFINITION OF IMPROVEMENT
Medicaid/Federal and State High Cost Conditions		
Cancer	• Readmissions rate	Any decrease from the GHP benchmark
	• PHQ-9	Report submission
End-Stage Renal Disease (ESRD)	• Admissions/1000	Any decrease from the GHP benchmark
	• PHQ-9	Report submission
Multiple Sclerosis	• Admissions/1000	Any decrease from the GHP benchmark
CHIP High Cost Conditions		
Cancer	• Readmissions rate	Any decrease from the GHP benchmark
Children and Youth with Special Healthcare Needs (CYSHCN)	• Well-child visits in the 3rd, 4th, 5th and 6th years of life	Any increase from the GHP benchmark
	• Adolescent Well-care visits	Any increase from the GHP benchmark
Autism	• Well-child visits in the 3rd, 4th, 5th and 6th years of life	Any increase from the GHP benchmark

CHRONIC CONDITIONS	SCORED MEASURES	DEFINITION OF IMPROVEMENT
Medicaid/Federal, State, and CHIP Chronic Conditions		
Diabetes	• Comprehensive Diabetes Care:	

CHRONIC CONDITIONS	SCORED MEASURES	DEFINITION OF IMPROVEMENT
	○ HbA1c	Report submission
	○ Eye exam	Report submission
	○ Nephropathy screen	Report submission
	• Admissions/1000	Any decrease from the GHP benchmark
Asthma	• Admissions/1000	Any decrease from the GHP benchmark
	• ED Use/1000	Any decrease from the GHP benchmark
	• PHQ-9	Report submission
Medicaid/Federal and State Chronic Conditions		
Severe Heart Failure	• Admissions/1000	Any decrease from the GHP benchmark
	• PHQ-9	Report submission
Hypertension	• ED Use/1000	Any decrease from the GHP benchmark
Chronic Obstructive Pulmonary Disease (COPD)	• Admissions/1000	Any decrease from the GHP benchmark
Chronic Depression	• Follow up after Hospitalization for Mental Illness: 7 days	Report submission
	• Follow up after Hospitalization for Mental Illness: 30 days	Report submission
	• Inpatient Admission/1000	Any decrease from the GHP benchmark

EFFECTIVENESS OF CARE	SCORED MEASURES	DEFINITION OF IMPROVEMENT
BCS	• Breast Cancer Screening	Any increase from the GHP benchmark
CCS	• Cervical Cancer Screening	Report submission
COL	• Colorectal Cancer Screening	Any increase from the GHP benchmark

EFFECTIVENESS OF CARE	SCORED MEASURES	DEFINITION OF IMPROVEMENT
SSD	• Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications.	Report submission
FUH	• Follow-Up After Hospitalization for Mental Illness: 30 days	Report submission
AAP	• Adults' Access to Preventive/Ambulatory Health Services	Any increase from the GHP benchmark
ADV	• Annual Dental Visit	Any increase from the GHP benchmark
PPC	• Timeliness of Prenatal Care	Any increase from the GHP benchmark
	• Postpartum Care	Any increase from the GHP benchmark
AWC	• Adolescent Well-Care Visits	Any increase from the GHP benchmark

ER HU INITIATIVE	SCORED MEASURES	DEFINIATION OF IMPROVEMENT
ER	Overall emergency room utilization rate x 1,000 on identified population with 7 or more visits to the emergency room	Any decrease from the GHP benchmark

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

HEALTH CARE IMPROVEMENT PROGRAM

HEALTH CARE IMPROVEMENT PROGRAM BENCHMARKS

GOVERNMENT HEALTH PLAN PROGRAM

NOVEMBER 1, 2018 – SEPTEMBER 30, 2021

Revised September 09, 2020

HEALTH CARE IMPROVEMENT PROGRAM 2019 BENCHMARKS

HIGH COST CONDITIONS	SCORED MEASURES	2019 BENCHMARKS
Medicaid/Federal and State High Cost Conditions		
Cancer	• Readmissions rate	20.06%
	• PHQ-9	13.3%
End-Stage Renal Disease (ESRD)	• Admissions/1000	335.0
	• PHQ-9	11.3%
Multiple Sclerosis	• Admissions/1000	169
CHIP High Cost Conditions		
Cancer	• Readmissions rate	31.82%
Children and Youth with Special Healthcare Needs (CYSHCN)	• Well-child visits in the 3rd, 4th, 5th and 6th years of life	35.71%
	• Adolescent Well-care visits	25.41%
Autism	• Well-child visits in the 3rd, 4th, 5th and 6th years of life	29.59%

CHRONIC CONDITIONS	SCORED MEASURES	2019 BENCHMARKS
Medicaid/Federal, State, and CHIP Chronic Conditions		
Diabetes	• Comprehensive Diabetes Care:	
	o HbA1c	85.94%
	o Eye exam	38.74%
	o Nephropathy screen	96.24%
	• Admissions/1000	155
Asthma	• Admissions/1000	255
	• ED Use/1000	1591
	• PHQ-9	7.40%
Medicaid/Federal and State Chronic Conditions		
Severe Heart Failure	• Admissions/1000	489
	• PHQ-9	13%

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CHRONIC CONDITIONS	SCORED MEASURES	2019 BENCHMARKS
Hypertension	• ED Use/1000	1020
Chronic Obstructive Pulmonary Disease (COPD)	• Admissions/1000	351
Chronic Depression	• Follow up after Hospitalization for Mental Illness: 7 days	63.71%
	• Follow up after Hospitalization for Mental Illness: 30 days	84.20%
	• Inpatient Admission/1000	169

EFFECTIVENESS OF CARE	SCORED MEASURES	2019 BENCHMARKS
BCS	• Breast Cancer Screening	65.33%
CCS	• Cervical Cancer Screening	53.27%
COL	• Colorectal Cancer Screening	57.63%
SSD	• Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications.	70.24%
FUH	• Follow-Up After Hospitalization for Mental Illness: 30 days	83.78%
AAP	• Adults' Access to Preventive/Ambulatory Health Services	77.28%
ADV	• Annual Dental Visit	62.29%
PPC	• Timeliness of Prenatal Care	50.40%
	• Postpartum Care	21.38%
AWC	• Adolescent Well-Care Visits	16.17%

ER HU INITIATIVE	SCORED MEASURES	2019 BENCHMARKS
ER	Overall emergency room utilization rate x 1,000 on identified population with 7 or more visits to the emergency room	937

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