Adiestramiento de Plan Vital

Rev. Diciembre 2023

Programa de Medicaid:

Medicaid es un programa del Gobierno Federal que aporta beneficios a los estados y territorios americanos, incluyendo Puerto Rico para pagar los gastos médicos de ciertos grupos de personas de bajos recursos.

- Efectivo el 1 de octubre de 2010, el Programa de Salud del Gobierno creó nuevos objetivos de política pública para transformar el sistema de salud de Puerto Rico.
- Para así, promover un enfoque integrado hacia la salud física y mental, y mejorar el acceso a servicios de cuidado primario y especializado de calidad.
- Bajo esta política el programa de salud del gobierno, previamente conocido como "Reforma", se transformó en "Mi Salud", posteriormente cambio a Plan de Salud de Gobierno (PSG).
- Desde el 1 de noviembre de 2018 el nombre del programa cambió a Plan Vital. En este modelo, los beneficiarios pueden escoger a su médico primario y grupo médico en cualquier parte de Puerto Rico.

ASES

La Ley Núm. 113 de 2 de junio de 1976, según enmendada, conocida como "Ley de Organizaciones de Servicios de Salud", incorporada en el Código de Seguros de Puerto Rico (Art. 19.020 et seq.) establece que la Administración de Seguros de Salud de Puerto Rico (ASES) es la responsable de implementar, administrar y negociar a través de contratos con Aseguradoras u organizaciones de Servicios de Salud, un sistema de seguro de salud que proporcione a todos los residentes de la isla, acceso a atención médica hospitalaria de calidad, independientemente de la condición económica y la capacidad de pago de quienes lo requieran.

Centros de Llamadas
Tel.: 787-474-3300 / 1-800-981-2737
Para más información https://www.asespr.org/

Plan Vital

El modelo de Plan Vital estableció una región de servicio para toda la isla desde el 2018.

En septiembre de 2022, el gobierno de Puerto Rico anunció que las mismas aseguradoras que hasta entonces se mantenían ofreciendo servicios a los beneficiarios del Plan Vital revalidaron para un nuevo contrato por un término de 3 años. Estas son:

- **MMM Multi Health**
- First Medical Health Plan
- Plan de Salud Menonita
- Triples S Salud

Población Foster Care Children & Población Sobreviviente de Violencia Doméstica

Población *Foster Care* y Víctimas Sobrevivientes de Violencia Doméstica

- Conocida comúnmente como la Región Virtual.
- Desde enero 2023, MMM MH se encarga del manejo y necesidad de esta población.

Esta región comprende a todos los beneficiarios bajo la custodia;

- Departamento de la Familia (ADFAN)
  - ✓ Niños y jóvenes de 0-21 años cumplidos (una vez cumplen los 21 años salen del programa)
- Oficina de la Procuradora de la Mujer
  - ✓ Población sobreviviente a violencia de genero

Población *Foster Care* y Víctimas Sobrevivientes de Violencia Doméstica

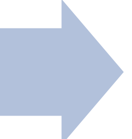
- MMM MH tiene personal dedicado para atender esta población.
- La persona encargada de la coordinación de citas, comunicaciones y otros asuntos con las agencias del gobierno lo es la Sra. Myriam Rivera Molina, Directora de Trabajo Social ; y podrá ser contactada a través de su correo electrónico: Myriam.Rivera-Molina@mso-pr.com
- El Departamento de Servicio al Beneficiario "Member Service" tiene recursos dedicados a servir de enlace con el Departamento de Trabajador Social.

Importante: Ningún empleado está autorizado a proveedor información relacionada a esta población.

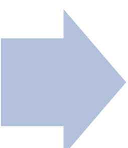
La población Virtual tiene las siguientes características:

- No se asigna PCP
- No se asigna PMG
- Tienen turnos preferenciales en las oficinas e instalaciones médicas
- Tienen acceso a toda la Red de Proveedores de MMM Multi Health
- No necesitan referido
- Las tarjetas y cartas de bienvenida NO se envían por correo
- Las entregaremos una vez a la semana al contacto del organismo que atiende al paciente (Familia, violencia doméstica)

Solo empleados autorizados tienen acceso a la información de esta población



Se crearon restricciones en nuestros sistemas con este propósito (C3PO/EMMA)



Si usted recibe cualquier situación relacionada a esta población, por favor, notifique inmediatamente a su supervisor.

Confidencialidad

Ejemplo del mensaje que aparecerá nuestros sistemas:

Membership File Management Queues Tools Settings Reports

0089999999998

First Name	Last Name 1	Last Name 2	Birth Date	Gender	SSN	Phone Number
TEST	TEST		08/01/1989	Unknown	555555555	

Confirm

WARNING: Member 0089999999998 belongs to protected group: "Domesic Violence (Women's Attorney Office)".

Confirm | Close

Determinantes Sociales de la Salud (DSS)

¿Qué son los Determinantes Sociales de la Salud?

De acuerdo con la Organización Mundial de la Salud, los determinantes sociales de la salud son "las circunstancias en que las personas nacen, crecen, trabajan, viven y envejecen, incluido el conjunto más amplio de fuerzas y sistemas que influyen sobre las condiciones de la vida cotidiana".

Las fuerzas y condiciones incluyen el sistema político, factores económicos, ambientales, culturales, sociales y, visto a nivel individual, se refiere a factores relacionados a la educación, empleo, redes de apoyo, vivienda y acceso a servicios médicos y de índole social.

Todas las condiciones antes descritas varían de persona en persona, así como en los subgrupos poblacionales. Estas diferencias dan paso a desigualdades que, en instancias pueden ser inevitables, pero también pueden ser atendidas y eventualmente prevenibles.

Determinantes Sociales de la Salud

Es un programa clínico en que la participación será voluntaria, el beneficiario puede optar por no participar y salir de este en cualquier momento.

Se deben establecer asociaciones a lo largo de todo el proceso de atención, incluso con otras organizaciones de atención de salud y organizaciones comunitarias.

Cada plan será establecido de manera individual y con la intervención directa del participante, esto con el propósito que refleje sus prioridades, intereses y necesidades. La participación en el programa es un beneficio que se determinará de manera individual.

Responsabilidades de MMM Multi Health:

- Evaluar las necesidades de los beneficiarios relacionadas con los determinantes sociales de la salud utilizando una herramienta de detección estandarizada proporcionada por ASES.

- Referir los beneficiarios a los servicios y el apoyo de la comunidad, según sea necesario, basado en los resultados de la evaluación de determinantes sociales.

- Ofrecer seguimiento a los referidos para servicios sociales e incluir a los trabajadores sociales o comunitarios de la salud en los equipos de coordinación de la atención y en otras iniciativas de coordinación de la atención que promuevan una atención holística y centrada en el beneficiario en contextos médicos y no médicos.

- En el escenario que los resultados de la evaluación inicial demuestren que el beneficiario necesita servicios específicos relacionados con los determinantes sociales de la salud, se tiene que garantizar que las actividades detalladas en el contrato sean realizadas por un trabajador social o trabajador comunitario de salud.

Regla de Interoperabilidad

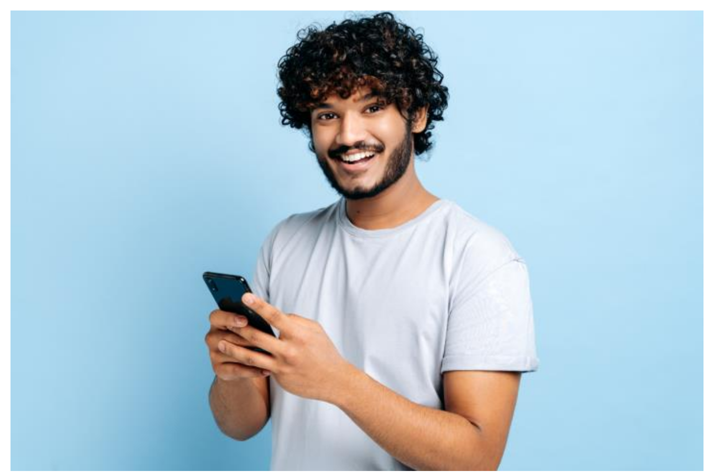
¿Qué es la regla de interoperabilidad de los Centros de Servicios de Medicare y Medicaid (CMS)?

Es un mandato de CMS que permite ampliar el acceso de los pacientes a su información de salud protegida, de manera electrónica. Todos los planes Medicaid y Medicare Advantage deben cumplir este mandato.

¿Cuál es el propósito de la regla?

La intención es facilitar un mayor acceso del paciente a su información de salud protegida (PHI), para ayudarle a involucrarse más en sus decisiones de atención médica, reduciendo la probabilidad de pruebas duplicadas y otras ineficiencias.

Este acceso a intercambio de información de salud (interoperabilidad) ayuda a garantizar que los proveedores tengan acceso al historial médico de un individuo para tomar decisiones clínicas informadas, lo que puede conducir a un mejor cuidado coordinado.



¿Qué implica esta regla?

Nuestros beneficiarios pueden descargar y registrarse en una aplicación externa de su elección, y dirigir esa aplicación para bajar y acceder a la información de salud que tengamos disponible.

Segunda Opinión

Segunda Opinión

Todo asegurado bajo la cubierta de Plan Vital tiene el derecho de solicitar una segunda opinión médica ;

- ✓ MMM MH proporcionará una segunda opinión en cualquier situación en la que exista una duda con respecto a un diagnóstico, las opciones de cirugía o los tratamientos alternativos de una afección de salud cuando lo solicite cualquier Inscripto, o un padre, tutor u otra persona que ejerza una responsabilidad de custodia sobre el Inscripto.
- ✓ La segunda opinión será proporcionada por un proveedor de la red cualificado o, si un proveedor de la red no está disponible, MMM MH coordinará con un proveedor fuera de la red de ser necesario.
- ✓ La segunda opinión se proporcionará sin costo alguno para el beneficiario.

Segunda Opinión

MMM MH cuenta con esta información en:

- Página Web- https://www.multihealth-vital.com/proteccion.html
- Manual del beneficiario
- Guía del proveedor
- Políticas internas

Departamento de Cumplimiento-Medicaid

Visión

La Administración de Seguros de Salud (ASES), al igual que los Centros de Servicios de Medicare y Medicaid ("CMS", por sus siglas en inglés), requieren adiestramientos durante los primeros noventa (90) días desde el comienzo de contratación y luego adiestramientos anuales sobre los programas de Cumplimiento, Integridad (Fraude, Desperdicio y Abuso "FWA" por sus siglas en inglés) Código de Conducta corporativa, Privacidad y Seguridad para las organizaciones y entidades que proveen y/o administran servicios de Salud.

MMM MH Vital está comprometido con la ética, el cumplimiento corporativo y todas las leyes, regulaciones y guías que rigen los requisitos del Programa de Medicaid.

Compliance Officer–Medicaid Liza Rivera Ortiz

Roles y Responsabilidades del Oficial de Cumplimiento:
Estar al tanto sobre cambios regulatorios y/o enmiendas contractuales e informar a todas las áreas operacionales;
Mantener una comunicación continua y efectiva con las entidades reguladoras;
Evaluar desempeño de las operaciones y requerir acciones correctivas y disciplinarias de ser necesario;
Mantener informados a la alta gerencia de MMM MH Vital sobre todos los aspectos y requisitos regulatorios;
Identificar, corregir y dar seguimientos a los aspectos que pueden representar un nivel de riesgo corporativo, que hayan sido identificados de forma interna o externa;
Proveer un ambiente de "puertas abiertas" para el fácil acceso de los empleados en donde puedan referir y atender los aspectos regulatorios, sin temor a represalias.
Apoyar todos los esfuerzos de Cumplimiento establecidos a través de la empresa.

¿Cuál es mi responsabilidad como Individuo, Empleado, Contratista o Subcontratista de MMM MH Vital?

Cumplir con todos los requerimientos, estatutos y regulaciones de ASES y Medicaid, políticas y procedimientos corporativos y el código de ética y conducta corporativa.

Reportar cualquier violación sobre comportamiento no ético, sospecha de fraude, desperdicio, abuso, privacidad o seguridad, a la gerencia y/o a la Oficial de Cumplimiento de Medicaid.

Cumplir con todos los adiestramientos operacionales, regulatorios y de Cumplimiento que son parte de los programas de Cumplimiento e Integridad de PSG.

Agencias Regulatorias atentas con el FWA

- Oficina del Comisionado de Seguros de Puerto Rico
- Unidad de Control de Fraude de Medicaid (MFCU, por sus siglas en inglés) según creada en PR bajo la nueva ley aprobada en el 2018.
- Departamento de Justicia
- Departamento de Salud
- ASES – Administración de Seguros de Salud

¿Cómo Reportar cualquier situación de no cumplimiento si eres beneficiario, proveedor o FDRs ?

- Por Internet a través de la página "Ethics Point" (por su nombre en inglés): www.psg.ethicspoint.com
- Línea telefónica de "Ethics Point": 1-844-256-3953
- Refiere a través de correo electrónico: : VitalSIU@mmmhc.com

Todo **empleado de MMM** tiene la responsabilidad de reportar cualquier situación de conducta inapropiada :
Sospechas u observas cualquier conducta inapropiada, incluyendo violaciones al Código de Conducta, políticas y procedimientos de la compañía, leyes y regulaciones o alguna otra situación, usted debe reportar a través de;

1. Hablar con su supervisor inmediato
2. Completar la solicitud a través de la web:**elevancehealthethicshelpline.com**
3. Llamar a la línea de ayuda de Ética & Cumplimiento: (877-725-2702)
4. Enviar un correo electrónico a: **ethicsandcompliance@elevancehealth.com**
5. Enviar una carta a la siguiente dirección:

Ethics Department
VP, Chief Ethics and Privacy Officer
220 Virginia Avenue
Indianapolis, IN 46204 United States

Información de Contacto:

Departamento de Cumplimiento - Vital

Shahayra Aguilú Benítez

Gerente de Cumplimiento-Medicaid

Cel.787-402-9737

Correo electrónico: shahayra.aguilu@mmmhc.com

Liza Rivera-Ortiz

Oficial de Cumplimiento - Medicaid

P.O. Box 71114

San Juan, PR 00936-8014

Cel. 787-918-7332

Correo electrónico: liza.rivera@mmmhc.com

Materiales de Mercadeo

Materiales de Mercadeo

- Todo tipo de comunicación por parte de MMM MH a cualquier persona elegible o posible beneficiario que pueda interpretarse razonablemente como una intención de influir en el individuo, para que se inscriba con nosotros, para que no se inscriba en otro plan, o para que se desafilie de otro plan, se considera como mercadeo.

- Además, también se describe como material de mercadeo a cualquier material producido en cualquier medio, por MMM MH o en su nombre, y que puedan interpretarse razonablemente como destinados a comercializar con los posibles inscritos.

Actividades y materiales permitidos:

- Distribuir información general a través de los medios de comunicación (es decir, periódicos, revistas y otras publicaciones periódicas, radio, televisión, Internet, publicidad en el transporte público y otros medios de comunicación);

- Realizar llamadas telefónicas, envíos por correo y visitas a domicilio solo a los beneficiarios actualmente inscritos en el plan, con el único propósito de educarlos sobre los servicios ofrecidos o disponibles a través de MMM MH

- Distribuir folletos y exhibir carteles en las oficinas de los Proveedores que informen a los pacientes que el proveedor forma parte de la Red de Proveedores del GHP(MMM MH); y

- Asistir a actividades que beneficien a toda la comunidad, como ferias de salud u otras actividades de educación y promoción de la salud.

- Si se realiza una actividad permitida, se debe llevar a cabo esa actividad en toda la isla.

Actividades y materiales no permitidos

- Participar directa o indirectamente en actividades de marketing puerta a puerta, por teléfono, por correo electrónico, por mensajes de texto u otras actividades de marketing como las llamadas telefónicas conocidas en inglés como "cold call".
- Ofrecer favores, incentivos o regalos, promociones u otros productos de seguros que estén diseñados para inducir la inscripción en el Plan de MMM MH;
- Distribuir planes y materiales que contengan declaraciones que ASES determine que son inexactas, falsas o engañosas. Las declaraciones consideradas falsas o engañosas incluyen, pero no se limitan a, cualquier afirmación o declaración (ya sea escrita u oral) de que el Plan del Contratista (MMM MH) está respaldado por el Gobierno Federal o el Gobierno, o una entidad similar;
- Distribuir materiales que, según ASES, induzcan a error o describan falsamente la Red de Proveedores MMM MH, la participación o disponibilidad de los Proveedores de la Red, las calificaciones y habilidades de los Proveedores de la Red (incluyendo sus habilidades bilingües); o los horarios y ubicación de los servicios de la red;
- Tratar de influir en la afiliación junto con la venta u oferta de cualquier seguro privado;
- Afirmar o declarar por escrito o verbalmente que el beneficiario o posible beneficiario debe inscribirse con MMM MH.

Proceso de Aprobación*

Mercadeo envía el Material →

Departamento de Cumplimiento lo evalúa
- Si es educativo o informativo no necesita ser enviado a ASES
- Si es enviado a ASES tiene que cumplir con lo establecido la Carta Normativa 18- 205

→

ASES
- Evalúa el material, si cumple con lo establecido es aprobado
- Recibe Número de Aprobación
- Tiene 15 días para responder

↓

Cumplimiento lo Recibe , incluye el número de aprobación y lo incluye en el log interno.

Lo reenvía a Marketing para que se le incluya # de aprobación

→

Marketing lo devuelve a Cumplimiento con el número de aprobación

→

Cumplimiento le envía a ASES la confirmación del número de aprobación incluido en los materiales.

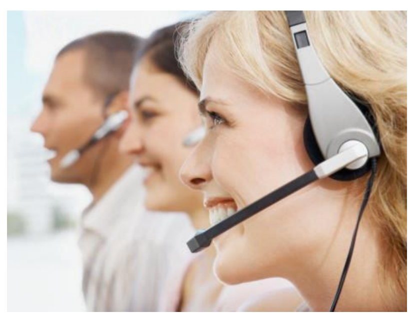
*** Esta descripción es solo un resumen y no pretende ser una explicación exhaustiva y detallada del proceso***

Operaciones Plan Vital MMM Multi Health

Líneas de Servicio de Plan Vital

Líneas de servicios

1-844-336-3331 (libre de cargo)
787-523-2656 (área Metro)
787-999-4411 TTY



Lunes a Viernes
7:00 a.m. to 7:00 p.m.

Línea de consulta médica

Haciendo Contacto

1-844-337-3332 (libre de cargo)
787-523-2653 (área Metro)
787-522-3633 TTY

24 horas/ 7 días a la semana

Unidad de Investigación de Servicio al Cliente

- Primer enlace entre el beneficiario y todas las unidades MMM MH.
- Coordinación de citas con especialistas.
- Coordinación de citas de recertificación al Programa de Medicaid.
- Encuestas de satisfacción
- Apoyo en estrategias de retención de membresía.
- Resolución de casos del sitio web de MMM MH, redes sociales y prensa.
- Servicio exclusivo para casos recibidos de ASES y Fortaleza.
- Manejo de la solicitud de materiales del beneficiario (Directorio de proveedores, Manual del beneficiario, cartas, EOB y tarjetas de identificación).
- Servicio al cliente

PSG-Research-Team@mmmhc.com

Principales oficinas de MMM Multihealth

Hato Rey Oficina Administrativa

Edificio Torre Chardón
350 Avenida Carlos E. Chardón #500
San Juan, P.R. 00918

- Lunes a viernes de 8:00 a.m. a 5:00 p.m.

También tenemos áreas que manejan las operaciones de Plan Vital en las oficinas de Kennedy y Torre Chardón

Oficinas de Servicio (Atlántico)

Carolina

Carolina Shopping Court

- Lunes de 8:00 a.m. a 7:00 p.m.
- Martes a viernes from 8:00 a.m. to 5:00 p.m.
- último sábado del mes de 8:00 a.m. a 5:00 p.m.

Humacao

Boulevard Plaza Office Center

- Boulevard del Río, Ramal 3
- Lunes a viernes de 8:00 a.m. a 5:00 p.m.

Vieques

Centro de Servicios Integrados

- Carretera Estatal Núm. 200 km 0.4, Urb. Industrial Belén Castaño Vda. Díaz
- Lunes a viernes de 7:30 a.m. a 12:00 p.m. y de 1:00 p.m. a 4:30 p.m.

Fajardo

- Carr. #3 km. 44.1 Local #2 Bo. Quebrada
- Lunes a viernes de 8:00 a.m. to 5:00 p.m.

Manatí

El Trigal Plaza

- Carretera #2, KM 4.8
- (Esquina) Carr. 149
- Barrio Cotto Norte
- Lunes a viernes de 8:00 a.m. a 5:00 p.m.

Oficinas de Servicio (Caribe)

Guayama	Ponce	Orocovis	Coamo	Mayagüez	Aguadilla
Edificio FISA I Carr. 54, km 2.2, Solar #6 • Lunes de 8:00 a.m. a 7:00 p.m. • Martes a viernes de 8:00 a.m. a 5:00 p.m. • Último sábado del mes de 8:00 a.m. a 5:00 p.m.	Carretera #2 Ponce by Pass Edificio San Jorge Mall • Lunes a viernes de 8:00 a.m. a 5:00 p.m.	Edificio Borinquen Carretera 155 km 15.3 Bo. Gato • Lunes a viernes de 8:00 a.m. a 5:00 p.m.	Calle Ruiz Belvis # 24 • Lunes a viernes de 8:00 a.m. a 5:00 p.m.	Complejo Office Park III Carretera #2, KM 157 • Lunes a viernes de 8:00 a.m. a 5:00 p.m.	Plaza Victoria Shopping Center Carr. #2 KM 129.5 • Lunes a viernes de 8:00 a.m. a 5:00 p.m.

Servicios disponibles en las oficinas regionales y Satelitales

Materiales disponibles para los Beneficiarios:

- Tarjetas de Identificación;
- Manual del Beneficiario;
- Directorio de Proveedores.

Transacciones:

- Entrega de Tarjetas de Identificación;
- Carta de Certificación de Cubierta;
- Cambios de PCP y GMP;
- Matriculas nuevas;
- Matriculas - recién nacido;
- Matricula ELA Puro;
- Radicación de quejas, querellas y apelaciones;
- Coordinación de Beneficios;
- Tramite y envío de documentos de Pre-Autorizaciones;
- Trámite y envío de documentos de Manejo de casos.

Información/Clarificación relacionada a:

- Beneficios y Procedimientos;
- Elegibilidad;
- Cubierta;
- Red de Proveedores (PCP's / GMP's);
- Programa de Medicaid;
- Salud Mental;
- Pre-Autorizaciones;
- Cubierta Especial;
- Manejo de Casos;
- ELA Puro;
- Beneficios de Farmacia;
- Quejas, Querellas y Apelaciones;
- Coordinación de Beneficios;
- Información sobre "PHI, por sus siglas en inglés" sobre información protegida de pacientes.;
- Entre otros.

Elegibilidad

Elegibilidad

Personas elegibles bajo la ley 72 de 7 de septiembre de 1993:

- Ciudadanos americanos
- Personas de bajo o ningún ingreso
- Población Medicaid Federal
- Población Medicaid Estatal
- Niños bajo el programa Children's Health Insurance Program (CHIP)
- Empleados públicos, retirados y sus dependientes
- Policía de Puerto Rico; sus viudas, viudos e hijos que les sobrevivan
- Veteranos
- Niños bajo la custodia del Estado –Región Virtual
- Sobrevivientes de violencia doméstica- Región Virtual

Proceso de Inscripción

- El Programa Medicaid Puerto Rico determinará si el beneficiario es elegible a Plan Vital.
- De ser elegible, Medicaid entrega la forma Notificación de Decisión al beneficiario (antes conocida como MA-10).
- El documento contiene:
  - ✓ Nombre
  - ✓ MPI
  - ✓ Tipo de Elegibilidad
  - ✓ Fecha de efectividad de elegibilidad con Plan Vital
  - ✓ Fecha de Vencimiento de elegibilidad
  - ✓ Código de Cubierta
  - ✓ Tope de copagos
  - ✓ El documento contiene la aseguradora seleccionada al momento de realizar su proceso de certificación
  - ✓ El beneficiario puede tener acceso a los servicios cubiertos utilizando la Notificación de Decisión mientras recibe su tarjeta.
- La aseguradora enviará una carta de ***Bienvenida a Plan Vital***

MMM multihealth

Período de Inscripción Abierta (OEP)

- El Período de inscripción abierta (OEP) será a partir del **1ro de enero al 14 de febrero de 2024.**

- Un beneficiario puede solicitar un cambio de aseguradora por justa causa en cualquier momento durante el periodo de inscripción abierta, contactando al consejero de inscripción o a ASES:

Centro de Llamada de ASES
Tel.: 787-474-3300 / 1-800-981-2737

Aplicación Móvil ASES

- ASES tendrá a disposición una aplicación móvil para que los beneficiarios elijan el plan médico con que quieren afiliarse.
- Beneficiario que no elija libremente su aseguradora de Vital en el periodo abierto de inscripción , ASES le asignará a una.

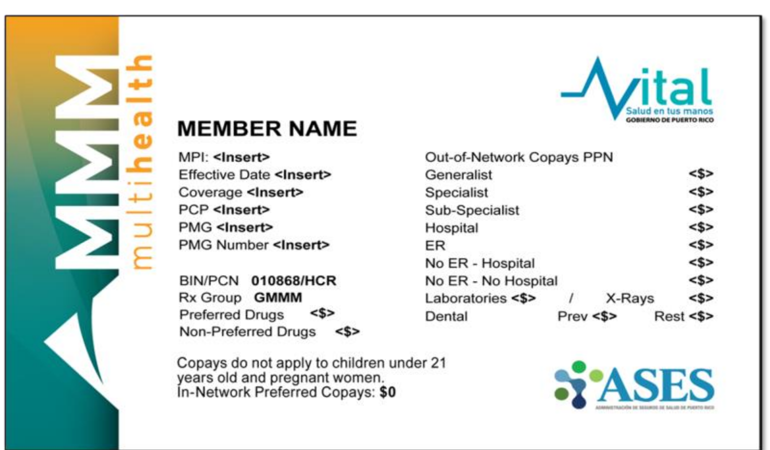
Tarjeta del Plan

- La tarjeta del plan se enviará por correo postal al beneficiario en o antes de 5 días de haber cargado la elegibilidad en el sistema.
- Si no puede esperar debe pasar por una Oficina Regional de Servicio o comunicarse a Servicio al Cliente
- Se puede enviar una certificación de cubierta por fax o correo electrónico al beneficiario o a la oficina médica
- Ningún hospital puede negarle servicios de emergencia por no tener la tarjeta.

Tarjeta del Beneficiario

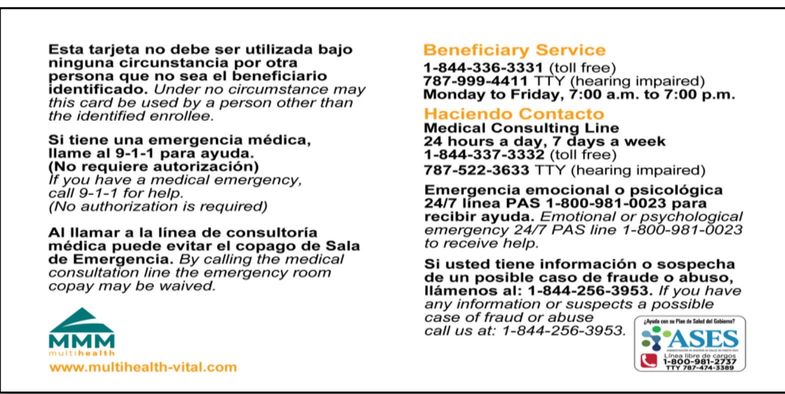
En el frente de la tarjeta, encontrará la siguiente información

- Nombre y ambos apellidos;
- Número de contrato;
- PCP y PMG elegido
- Cobertura;
- Copagos y coaseguros



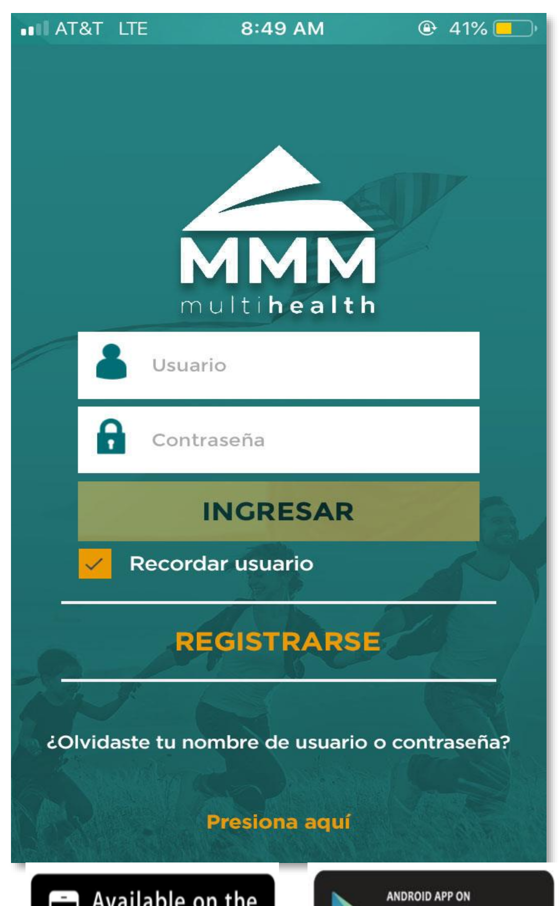
En la parte posterior de la tarjeta, encontrará la siguiente información:

- Evitar uso fraudulento de la tarjeta
- Número contacto ante una emergencia de salud
- Número de Servicio al Cliente
- Línea ***Haciendo Contacto*** (consultoría médica)
- Línea ***PAS*** – emergencia emocional



Aplicación Móvil Plan Vital

- Diseñada para servir como enlace facilitador
- Contiene la información de los beneficiarios como aparece en nuestros sistemas
- Permite a los beneficiarios y cuidadores tener una participación mayor en su atención de salud
- Gratuita, segura y fácil de usar
- Descargándola desde las plataformas de App Store y Google Play



Aplicación Móvil Plan Vital

La función de **PERFIL** permite al beneficiario ver su información personal, clínica, tarjeta del plan, medico primario, cuidadores y configuración de la aplicación

Los datos sobre **SALUD** ayudan a organizar iniciativas de prevención y seguimiento a los cuidados. El beneficiario podrá mostrar su lista de medicamentos de hasta 6 meses cuando visite los especialistas.

La función de **MENSAJES** permite a los beneficiarios y/o sus cuidadores recordar datos importantes, recibir invitaciones y anotar sus citas próximas.

En la función de **CALENDARIO** el beneficiario puede ver todos los eventos programados en su calendario y los Eventos MMM disponibles.

En **SERVICIOS** la aplicación permite recibir notificaciones para conocer el estatus de las pre autorizaciones, gastos e información para comunicarse al plan.

Con la función de **DIRECTORIO** el beneficiario puede realizar búsquedas más específicas de Cuidado Primario, Especialistas y Profesionales de la Salud entre otros.

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Departamento de Matrícula - Información de Contactos

¿Cómo me puedo comunicar con mi plan médico?

El beneficiario puede acudir a una de nuestras Oficinas de Servicio:

www.Multihealth-vital.com/contacto.html

Llamar a la Línea de Servicio al Beneficiario:

1-844-336-3331 (Libre de Cargo) o TTY (Audio-impedidos): **787-999-4411**

Correo Electrónico:

PSG_Enrollment@mmmhc.com

Facsímil: **1-844-330-9330**

Correo Postal:

PSG Enrollment - ENR-001
PO BOX 72010
San Juan PR 00936-7710

Jeanette Fernández

Asistente Administrativa

Tel (787) 622-3000 | Ext. 52542

Correo Electrónico: Jeanette.Fernandez@mmmhc.com

Héctor M Jové

Gerente

Tel (787) 622-3000 | Ext. 53614

Cel. 787-918-5693

Correo Electrónico: hector.jovecalderon@mmmhc.com

Solange de Lahongrais

COO of Medicaid

Tel. (787) 622-3000 | Ext. 52542

Correo Electrónico: Solange.delahongrais@mmmhc.com

Periodo de Transición

Periodo de Transición

MMM MH garantizará el acceso continuo a los servicios durante la transición de un beneficiario de una aseguradora de salud contratada por ASES, cumpliendo con lo siguiente:

- Garantizar que el beneficiario tenga acceso a los servicios de manera coherente con el acceso que tenía anteriormente, y se le permita conservar su proveedor actual durante noventa (90) días calendario si ese proveedor no es un proveedor de la Red; se deberá referir al beneficiario a un proveedor de la Red.
- Cumplir plena y oportunamente con las solicitudes de datos históricos de utilización del nuevo contratista u otra entidad en cumplimiento de las leyes federales y estatales;
- Garantizar que el nuevo proveedor del beneficiario pueda obtener copias de los registros médicos del beneficiario, según corresponda.
- Cumplir con cualquier otro procedimiento necesario especificado por CMS o ASES para asegurar el acceso continuo a los servicios para prevenir un detrimento grave de la salud del beneficiario o reducir el riesgo de hospitalización.

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Programas Clínicos

Cubierta Especial

- Es un componente de los Servicios Cubiertos descrito en el contrato de ASES, en la sección 7.7 y Anejo 7. Estos servicios incluyen beneficios más extensivos que la Cubierta Básica.
- La Cubierta Especial está disponible para los beneficiarios con condiciones específicas que requieren cuidado médico intensivo causado por una enfermedad compleja de salud.
- Los beneficiarios matriculados en el ***Registro de Cubierta Especial*** tienen acceso directo a los especialistas que manejan sus situaciones de salud relacionadas a la condición por la cual están registrados.

Condiciones de Cubierta Especial

- Anemia Aplásica
- Autismo
- Cáncer
- Niños con Necesidades Especiales
- Enfermedad Renal
  - Niveles 3, 4 & 5
- Enfermedad Renal Terminal (ESRD)
- Fibrosis Cística
- Hepatitis – C
- VIH-SIDA
- Lepra
- Esclerosis Múltiple & ALS
- Obstetricia
- Hipertensión Pulmonar
- PKU- Adulto
- Artritis Reumatoide
- Escleroderma
- Lupus Eritematoso Sistémico
- Tuberculosis
- Hemofilia
- Cernimiento Auditivo Neonatal
- Fallo Cardiaco Congestivo (Etapas III & IV)
- Post- Trasplantes
- Discinesia Ciliar Primaria

Programa de Manejo Caso Complejo y Manejo de Cuidado

- Provee apoyo y educación en salud para beneficiarios identificados con condiciones de salud tanto crónicas como complejas.
- Tiene un enfoque holístico incluyendo cambios saludables en hábitos y en estilos de vida.
- Provee apoyo en la coordinación de cuidado, según sea necesario.
- Integra herramientas de cernimiento tanto de salud física como mental como criterio esencial para el desarrollo del plan de cuidado.
- Desarrolla de un plan de cuidado individualizado.
- Enfocado en la prevención.

Programa de Manejo Caso Complejo y Manejo de Cuidado

Enfocado específicamente en:

- Condiciones de Cubierta Especial;
- Condiciones Complejas de salud física y mental,
- Cuidado Prenatal y Postparto,
- Altos Utilizadores de Salas de Emergencias,
- Condiciones Crónicas - Auto cuidado

Los candidatos son identificados a través de:

- Referidos del Médico Primario o Especialista;
- Registro de Cubierta Especial;
- Análisis de Utilización de Servicios;
- Referidos a través de otros Programas Clínicos

Programa Prenatal

Programa de apoyo para mujeres durante su período prenatal y posparto;

El Programa está enfocado en:

- Promover un embarazo saludable
- Prevención de complicaciones
- Salud mental
- Educación en salud
- Cuidado del recién nacido

Mujeres participantes del programa reciben intervenciones educativas presenciales incluyendo clases de parto y lactancia.

Meta contractual Medicaid: Asegurar que el 85% de las embarazadas reciban servicios bajo el Programa Prenatal y Maternidad.

¿Qué es EPSDT?

EPSDT son siglas en inglés para Temprano, Periódico, Cernimiento, Diagnóstico y Tratamiento ***(Early, Periodic, Screening, Diagnostic and Treatment)***

- Son servicios de salud mandatorios para niños y jóvenes menores de 21 años, elegibles a servicios de Medicaid;

- EPSDT está contemplado dentro de Medicaid desde el 1967, con un enfoque principalmente preventivo:
  - Identificar cualquier problema en etapas tempranas para brindar los servicios necesarios para aminorar, tratar o curar cualquier condición o enfermedad en la niñez.

Cubierta de Farmacia

Cubierta de Farmacia

Los beneficiarios de Vital tienen acceso a una cubierta de medicamentos acorde a los Formularios de Medicamentos Preferidos (PDL):

- Los listados de medicamentos están compuestos de medicamentos preferidos que son evaluados para su exclusión o inclusión en el PDL, por el Comité de Farmacia y Terapéutica de la ASES.
- Para acceder el Formulario de Medicamentos en Cubierta del PSG, utilice los siguientes enlaces:
  https://abarcahealth.com/clients/ases-spanish/
  https://www.asespr.org/proveedores-2/farmacia/formularios-de-medicamentos/
  https://www.multihealth-vital.com/eng/formulary.html

Los copagos correspondientes a los beneficiarios varían de acuerdo a los niveles de ingreso del beneficiario o grupo familiar.

Adicional al PDL, existe el ***Listado de Medicamentos No preferido (NPDL***), el mismo está compuesto por medicamentos que han sido evaluados y avalados por el Comité de Farmacia y Terapéutica (P&T por sus siglas en inglés) a ser cubierto por el proceso de excepción. Medicamentos fuera del PDL y el NPDL pudieran ser cubierto por el beneficio de farmacia siempre y cuando el medicamento no sea excluido.

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Cubierta de Farmacia

- En la cubierta de medicamentos es mandatorio que el medicamento sea genérico, excepto en el caso de que el genérico bio-equivalente no esté disponible. La aseguradora no puede negarse a cubrir un medicamento porque el genérico no esté disponible.

- **Condiciones agudas:** El máximo de despacho será para cubrir una terapia de quince (15) días. Cuando sea médicamente necesario se cubrirán recetas adicionales.

- **Condiciones crónicas:** El máximo de despacho será terapia para treinta (30) días, prescripción original y cinco (5) repeticiones.

Pre-Autorización de Medicamentos

- Algunos medicamentos están sujetos a autorización previa según establecido por el Comité de Farmacia y Terapéutica de la ASES.

- Parámetros de tiempo para ofrecer una determinación sobre la pre-autorización: Todas las determinaciones de pre-autorización serán procesadas dentro de 24 horas luego de que MMM MH reciba la información mínima requerida para poder evaluar el caso.

- Si la petición no incluye la información mínima requerida para evaluación, MMM MultiHealth debe devolver la petición dentro de las primeras 24 horas. Sin embargo, en el caso de existir una emergencia, MMM MultiHealth evaluara la petición solicitada para otorgar un suplido de emergencias donde se pudiera autorizar un suplido de 72 horas.

- De la solicitud requerir información adicional para completar su criterio clínico la misma puede pasar por el proceso de NMI (**N**eed **M**ore **I**nformation) el cual le brinda 72 horas adicionales a las 24 horas iniciales para su evaluación.

Medicamentos por excepción

- Cuando se receta un medicamento que no está en el PDL, se autoriza su despacho a través del proceso de excepción (el medicamento debe estar aprobado por la FDA para el tratamiento de la condición).

- Para esto el médico que prescribe debe proveer al Departamento de Farmacia justificación clínica por escrito y firmada indicando la razón o los motivos clínicos por los cuales el medicamento solicitado es clínicamente necesario para tratar la enfermedad o condición médica del beneficiario y la duración de la terapia solicitada.

- Adicional, el médico que prescribe debe evidenciar lo siguiente:
  - ✓ Paciente ha experimentado serias reacciones adversas a las alternativas disponibles en el PDL; para las drogas fuera de PDL el prescriptor debe evidenciar que paciente ha experimentado serios efectos adversos a las alternativas en PDL y NPDL;
  - ✓ Fallos terapéuticos a todas las alternativas en el PDL y/o NPDL, ya sea porque esas alternativas fueron ineficaces o podrían afectar adversamente la Salud o condición del paciente;
  - ✓ Otra circunstancia particular como EPSDT y su política.

Información de contacto de Farmacia

Como contactar el centro de llamadas de Farmacia proveedores:

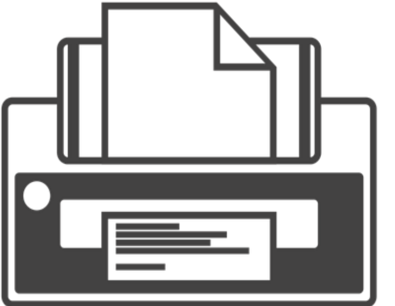
- Local: 787-523-2829
- Gratuito: 1-844-880-8820

¿Dónde puedo enviar una solicitud de farmacia?:

- Fax Farmacia: 866-349-0514
- Email: GHPPharmacylabel@mmmhc.com

- Fax Jcodes: 787-300-4897
- Email: GHP.PharmacyJcodesPA@mmmhc.com

- Para la población de Foster Care y violencia doméstica:
  Email: VirtualXPharmacyLabel@mmmhc.com



Salud Mental

¿Qué ofrece el Departamento de Salud Mental?

El Departamento de Salud Mental tiene el objetivo de evaluar y manejar efectiva y eficientemente las necesidades clínicas de salud mental de los beneficiarios a los que ofrece servicios mediante:

- Orientación sobre servicios de salud mental;
- Información sobre disponibilidad de Proveedores contratados;
- Autorización de servicios;
- Coordinación servicio al hogar;
- Línea de emergencias;
- Manejo de casos;
- Coordinación de servicios ambulatorios;
- Orientación sobre documentos y procesos para la autorización de medicamentos de salud mental.

Departamento de Salud Mental Integrada: Unidades Operacionales

Centro de Llamadas – Salud Mental

Horario: Lunes a viernes, 7:00 a.m. a 7:00 p.m.
Teléfono: 1-844-337-3332

- Orientación y coordinación de servicios ambulatorios;
- Orientación sobre documentos y procesos para la autorización de medicamentos;
- Solicitud de coordinación de servicio al hogar;
- Orientación de Proveedores contratados;
- Servicios ambulatorios prestados por Psiquiatras, Psicólogos y Trabajadores Sociales;
- Servicios hospitalarios y ambulatorios para abuso de sustancias y alcoholismo;
- Registro de condiciones de Salud Mental.

Centro de Llamadas - Manejo de Casos
Salud Mental Integrada

Servicios que requieren autorización previa*:

- Pruebas neuropsicológicas
- Programas de Hospitalización Parcial
- Terapia electroconvulsiva
- Programas Ambulatorios Intensivos

24 horas,
7 días a la semana.
1-844-337-3332

*Todos los servicios con proveedores fuera de la red requieren pre-autorización.

¿Por qué un Modelo de Integración?

- Existe una cantidad importante de beneficiarios con condiciones físicas y mentales.
- Debido a la cantidad de beneficiarios con condiciones agudas, estas deben de tratarse bajo un solo escenario de salud, evitando que el beneficiario se mueva de un lado a otro.
- La prestación de servicios de salud debe darse bajo un solo escenario, permitiendo el enfoque en la persona.
- La discusión de casos y colaboración entre proveedores es clave en el éxito del modelo integrado.

Modelo de Cuidado Integrado

Modelo de Co-locación

- Es un modelo de cuidado integrado en el cual servicios de salud mental son provistos en el mismo lugar de cuidado primario de salud física.
- El GMP debe de facilitar un espacio al Proveedor de salud mental por cada facilidad dónde se requiera.
- El Proveedor de salud mental debe estar disponible para proveer evaluaciones, consultas, y servicios de salud mental a los beneficiarios.
- Un beneficiario identificado con una condición de salud mental aguda o crónica debe ser referido a una clínica de salud mental contratada o al próximo nivel de cuidado, según sea necesario.
- A partir del 1ro de enero de 2023 todos los hospitales de cuidado primario deben de contar con un proveedor de salud mental, según definido por el modelo de colocación. En este escenario un médico primario o especialista puede requerir la intervención de un proveedor de salud mental. El profesional de salud mental proveerá intervenciones clínicas en persona o en consulta con el equipo interdisciplinario (según sea necesario) relacionadas a la salud mental de beneficiarios en sala de emergencia u hospitalizados.

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Modelo de Cuidado Integrado

Co-locación Inversa

- Modelo de cuidado integrado en el cual servicios médicos están disponibles a beneficiarios tratados en facilidades de salud mental.
- Incluye beneficiarios con condiciones con comorbilidad las cuales pueden ser crónicas o agudas, con diagnósticos de salud mental.
- Un PCP se encuentra localizado a tiempo completo o parcial en una clínica/facilidad de salud mental para monitorear la salud física de los beneficiarios.
  - Estos utilizan el expediente de salud mental del paciente y coordinan seguimiento con el GMP, según sea necesario.
  - EL PCP colocado puede llevar a cabo las mismas intervenciones médicas y referidos como lo haría un PCP en un GMP.

Ley de Paridad en Salud Mental

MMM MH cumple con el requisito general de paridad (Título 42, CFR, §438.910(b)) que estipula que las limitaciones de tratamiento para los beneficios de salud mental no pueden ser más restrictivas que las limitaciones de tratamiento aplicadas a los beneficios médicos o quirúrgicos. No se requiere un referido del PCP ni una autorización previa para que un beneficiario busque cualquier servicio de salud mental, incluida la evaluación inicial de salud mental por un proveedor de la red contratada.

Coordinación de Beneficios

Coordinación de Beneficios

- La coordinación de beneficios es un método utilizado por las aseguradoras de salud para poder determinar los pagos de las reclamaciones médicas que recibe un beneficiario cuando tiene más de un asegurador de salud.
- El plan primario es el pagador de los servicios cubiertos y el mismo pagará primero según las reglas establecidas.
- El secundario pagará por los servicios cubiertos después que el plan primario pague.
- La cubierta de Plan Vital será pagador secundario a cualquier otro plan o persona a cargo de pagar por servicios médicos.

Pagador Primario vs. Pagador Secundario

El plan primario paga hasta el máximo de su cubierta.

$

El plan secundario paga si existen costos que el asegurador primario no cubrió.

Elegibilidad Dual (Medicare)

Los beneficiarios de Medicare Parte A serán cubiertos bajo el Plan Vital una vez alcance el beneficio límite de Medicare.

Los deducibles de la Parte A de Medicare **NO** están cubiertos.

Beneficiarios de Plan Vital que también tengan Medicare Parte A y B se les cubrirá farmacia y dental.

Los copagos y deducibles de Medicare Parte B están cubiertos por Plan Vital.

- El proveedor de servicios de salud debe aceptar Medicare y Plan Vital para realizar la coordinación de beneficios.

Pre-Autorizaciones

Pre-Autorización

- Algunos servicios médicos están sujetos a autorización previa según lo establecido por el contrato entre MMM Multi Health y ASES

- Proceso de Pre Autorización revisa las solicitudes de servicios por proveedores médicos, antes de la prestación de los servicios, excepto en casos de emergencia. Estos se encuentran en una lista selecta de servicios, para determinar si el mismo es un servicio médicamente necesario. Cada caso es manejado de manera individual según sus necesidades médicas con determinaciones finales basadas en el juicio clínico.

Categorías

Categoría Expedita

- Al procesar una solicitud de pre autorización, es importante que la selección de la categoría responda a las necesidades del beneficiario. Los CMS establecen la categoría expedita cuando el beneficiario o su médico entiende que la espera podría poner la vida, la salud o la seguridad del mismo en peligro grave.
- Estas solicitudes se determinan en o antes de **24 horas** de haberse recibido en el plan.
- Categoría Expedita debe ser establecida únicamente por el médico del beneficiario en la orden médica.

Categoría Estándar

- Categoría utilizada cuando la salud del beneficiario no se encuentra en serio riesgo. Estas solicitudes se determinan en o antes de **72 horas** de haberse recibido en el plan médico.

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Parámetros de tiempo

Parámetros de tiempo para ofrecer una determinación sobre la pre-autorización para todos los servicios incluyendo medicamentos parte B son:

- Expeditas serán procesadas en o antes de 24 horas
- Estándar serán procesadas en o antes de 72 horas
- Extension-14 días adicionales si existe justa causa del beneficiario

Solicitud de Pre Autorización

Para procesar una solicitud de servicio se requiere de la siguiente documentación e información:

- Formulario para la solicitud de Pre Autorizaciones completado en todas las partes
- Referido de PCP
- Nombre y número de NPI de PCP
- Nombre y número de NPI del especialista (si aplica)
- Nombre y número de NPI de la facilidad o institución hospitalaria (si aplica)
- Código ICD-10 (Diagnóstico) con descripción
- Código CPT (Procedimiento) con descripción
- Firma del médico y numero de licencia
- Fecha de los servicios (si aplica)

Información y vías de envío

Información de apoyo

Con el propósito de obtener toda la información para la evaluación y determinación del servicio solicitado, el médico debe incluir, aparte de orden médica-referido, lo siguiente:

- Historial clínico relacionado a servicios relacionados a estudios previos
- Cualquier otra información relevante al servicio solicitado

Vías de envío

Portal de Innova MD- Electrónicas

Faxes :

- 1-844-330-1330
- 1-844-220-3220

Quejas, Querellas & Apelaciones

¿Qué son una queja, una querella y una apelación?

Queja: Cualquier expresión de insatisfacción, verbal o escrita, realizada por un asegurado a MMM MH o sus proveedores relacionada **al trato recibido**.

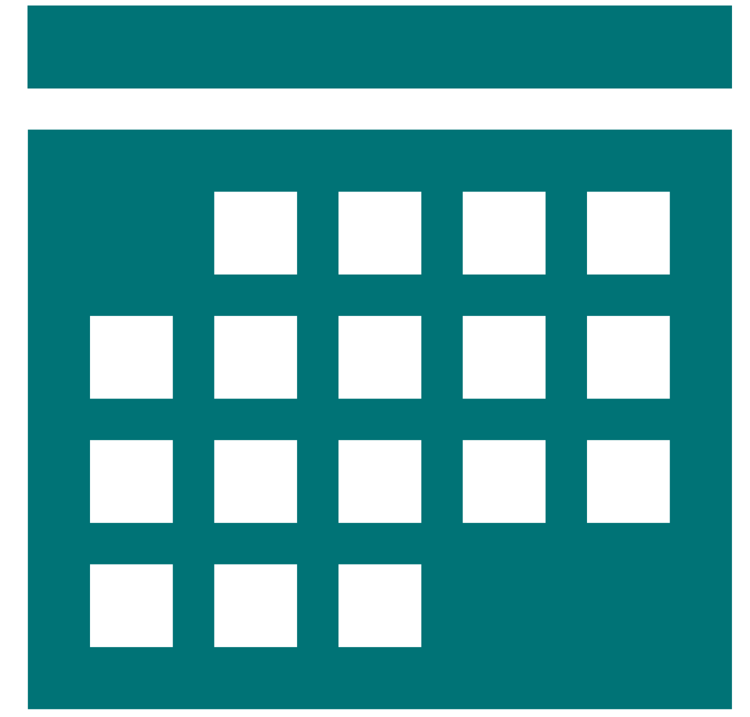
Querella: Una reclamación de insatisfacción, verbal o escrita, realizada por un asegurado a MMM MH o sus proveedores que se relaciona con los servicios recibidos bajo la cubierta del Plan Vital o aspectos de relaciones interpersonales.

Apelación: Una declaración oral o escrita de insatisfacción con una determinación adversa de las operaciones de la organización tal como: Una denegación de estudios, laboratorios y Rayos X, denegación de un procedimiento, medicamentos o la resolución de la querella.

Tiempos para radicar:

El asegurado puede radicar su planteamiento en cualquier momento siempre y cuando cumpla con los términos establecidos:

- Queja: 15 días calendarios a partir de la fecha del evento.
- Querella: En cualquier momento a partir de la fecha del evento.
- Apelación: 60 días calendarios para radicar su apelación desde la fecha en que recibió la determinación.



Términos establecidos para responder al beneficiario

Queja

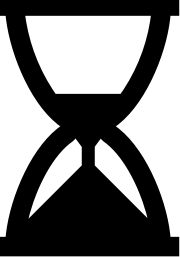
- Debe resolverse en un en 72 horas a la fecha y hora de recibo. Sino puede resolverse se convertirá en querella.

Querella

- Debe resolverse en o antes de 90 días y de requerir extensión, son 14 días adicionales; se envía a consideración de ASES.

Apelación

- Debe resolverse en o antes de 72 horas a la fecha y hora de recibo si es expedito y 30 días calendarios si es estándar. De requerir extensión son 14 días adicionales; se envía a consideración de ASES.



Querellas y Apelaciones - Información de Contactos

¿Cómo reportar una Queja, Querella o Apelación?

- El beneficiario puede acudir a una de nuestras Oficinas de Servicios.
- Línea de Servicio al Beneficiario: **1-844-336-3331** (Libre de Cargo) o TTY (Audioimpedidos): **787-999-4411.**
- Correo Electrónico: agplanvital@mmmhc.com
- Facsímil: **1-844-990-1990 | 1-844-990-2990**
- Correo Postal:

MMM Appeals & Grievances Department
PO Box 72010
San Juan PR 00936-7710

Johanna Morales González
Supervisor
Phone (787) 622-3000 | Ext. 3542
Cel. (787) 403-7357
Correo Electrónico: Johanna.Morales-Gonzalez@mso-pr.com
Michael Soto Maldonado
Gerente
Tel. (787) 622-3000 | Ext. 2513
Cel. (787) 585-0762 Correo Electrónico: michael.soto@mmmhc.com
Janice Rodríguez Brea
Director
Tel. (787) 622-3000 | Ext. 2537
Cel. (939) 717-3509 Correo Electrónico:
janice.rodriguez@mmmhc.com

Programa de Calidad

Indicadores de Calidad y Desempeño

El Plan Vital ha desarrollado una serie de indicadores como parte del proceso de mejoramiento de calidad.

- Servicios de cuidado prenatal proporcionados por su médico.
- Educación en salud y promoción de actividades de bienestar.
- Coordinación de servicios en el manejo de condiciones agudas.
- Educación al afiliado en el manejo de condiciones médicas crónicas tales como: diabetes, hipertensión y asma, entre otras.
- Educación a proveedores.
- Ayuda a los médicos a brindar una mejor calidad de cuidado.
- Nivel de servicios preventivos cubiertos.
- Monitoreo de las medidas de desempeño sobre los Determinantes Sociales de Salud (SDOH).

Provisiones generales

- Proveer un cuidado de calidad a sus beneficiarios con el propósito de mejorar su estado de salud o que mantenga una buena condición de salud.

- Trabajar en conjunto con los beneficiarios, proveedores y agencias relacionadas, para continuamente mejorar el cuidado de la salud de los beneficiarios.

- ASES, junto con otros programas federales y según las regulaciones de PR, será el encargado de monitorear el cumplimiento del cuidado de salud que se ofrezca.

Red de Proveedores

¿Qué es un Médico Primario y cuáles son sus responsabilidades?

¿Qué es un Médico Primario?

- Profesional de la Salud debidamente licenciado para ejercer la práctica de la medicina en Puerto Rico.
- Contratado por la aseguradora de salud física como médico participante dentro de un Grupo Médico.

Sus responsabilidades son:

- Realizar las evaluaciones médicas pertinentes al estado de salud de los beneficiarios.
- Brindar, coordinar y ordenar todos los servicios y tratamientos de salud que necesiten los beneficiarios de Plan Vital.
- Proveer los servicios médicos preventivos para mantener saludable los beneficiarios.
- Informarle al beneficiario cuando entienda que es necesario visitar a un especialista o subespecialista.
- Proveerle referidos a los beneficiarios cuando sea necesario.
- Coordinar las visitas a especialistas o subespecialistas fuera de la Red Preferida del Grupo Médico Primario.

MMM multihealth

¿Quiénes se consideran Médicos Primarios?

- Médicos Generalistas
- Médicos de Familia
- Pediatras
- Ginecólogos/ Obstetras
- Internistas

Red Preferida del Grupo/Médico Primario

- Médicos especialistas y subespecialistas
- Servicios médicos ancilares
- Laboratorios Clínicos
- Pruebas Diagnósticas Especializadas
- Centros de Imágenes
- Centros de Cirugía Cardiovascular y Cateterismo
- Hospitales
- Sala de Urgencias
- Sala de Emergencias

Red General de Proveedores

- Médicos especialistas, subespecialistas y facilidades de servicios de salud.
- Contratados por su aseguradora de salud física para brindar apoyo a los Grupos Médicos Primarios.
- Brinda servicios que el beneficiario no pueda obtener a través de la Red Preferida de su Grupo Médico Primario.
- Para visitar esta red el beneficiario deberá obtener el referido de su Médico Primario y aplicarán los copagos correspondientes.
- ASES establece un tarifario mínimo requerido para el pago de proveedores basado en un por ciento del Medicare Fee Schedule conforme a la especialidad del proveedor.
- ASES establece un pago mínimo por miembro por mes (PMPM) para el medico primario que actualmente es $18 PMPM

¡Gracias!

Adiestramiento de Programa de Cumplimiento e Integridad Para Proveedores y Entidades Delegadas

Plan Vital - 2024

Programa de Cumplimiento

- Como Individuo, Proveedor o Entidad que provee servicios Salud a beneficiarios de Medicaid bajo el Plan Vital,
- **Cada acción que se tome** tiene el potencial de afectar a los beneficiarios.

Visión

La Administración de Seguros de Salud (ASES), al igual que los Centros de Servicios de Medicare y Medicaid ("CMS", por sus siglas en inglés), requieren adiestramientos durante los primeros noventa (90) días desde el comienzo de contratación y luego adiestramientos anuales sobre los programas de Cumplimiento, Integridad (Fraude, Desperdicio y Abuso "FWA" por sus siglas en inglés), Privacidad y Seguridad para las organizaciones y entidades que proveen y/o administran servicios de Salud.

MMM MH Vital está comprometido con la ética, el cumplimiento corporativo y todas las leyes, regulaciones y guías que rigen los requisitos del Programa de Medicaid.

¿Cuál es mi responsabilidad como proveedor, contratista o subcontratista de MMM Multihealth Plan Vital?

Cumplir con todos los requerimientos, estatutos y regulaciones de ASES y Medicaid,

Reportar cualquier violación sobre comportamiento no ético, sospecha de fraude, desperdicio, abuso, privacidad o seguridad, a la gerencia y/o a la Oficial de Cumplimiento de Medicaid.

Cumplir con todos los adiestramientos operacionales, regulatorios y de Cumplimiento que son parte de los programas de Cumplimiento e Integridad de PSG.

¿Qué es un Programa de Cumplimiento?

Un Programa de Cumplimiento es un conjunto de controles internos y medidas para asegurar que las entidades siguen las reglas y regulaciones aplicables, que rigen a los programas federales, tales como Medicare y Medicaid.

La adopción de un Programa de Cumplimiento reduce significativamente el riesgo de fraude, desperdicio y abuso, mientras que garantiza acceso a servicios de calidad y cuidado a los pacientes.

7 Elementos de un Programa de Cumplimiento Efectivo

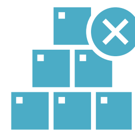
Políticas, Procedimientos y estándares de Conducta: desarrollar y mantener políticas y procedimientos escritos.

Oficial de Cumplimiento, Comité de Cumplimiento y comunicación a nivel de la alta gerencia: Designación de un Oficial y un Comité que tengan la responsabilidad y autoridad de operar y monitorear el Programa de Cumplimiento.

Adiestramientos y Educación Efectiva: Desarrollo e implementación de adiestramientos y educación continua y efectiva.

Sistema efectivo para Auditoría y Monitoreo continuo e identificación de riesgos de Cumplimiento: Uso de técnicas de evaluación de riesgos y auditorías para monitorear el cumplimiento y ayudar a reducir situaciones identificadas en las áreas.

7 Elementos de un Programa de Cumplimiento Efectivo



Mecanismos de Disciplina adecuadamente publicados: Políticas para establecer acciones disciplinarias y reforzar consistentemente los estándares

Líneas efectivas de comunicación: Entre el Oficial de Cumplimiento, empleados y la gerencia de la organización, así como también con los contratistas, subcontratistas y entidades relacionadas. Debe existir un sistema para responder a preguntas sobre regulación, reportes o situaciones con potencial de incumplimiento; Cada persona debe tener las herramientas para reportar sospechas de incumplimiento de manera confidencial y anónima.

Procedimientos para responder de manera rápida y oportuna a situaciones de Cumplimiento: Políticas de respuesta y acción correctiva inmediata para prevenir y evitar situaciones similares en el futuro.

¿Qué se considera no estar en cumplimiento?

- El incumplimiento es una conducta ilícita o contraria a la regulación y/o, políticas de una organización.
- El incumplimiento tiene un impacto en los servicios que brindamos a nuestros Proveedores y Beneficiarios del Plan Vital.

Política de No Represalia

No habrá represalia contra usted por reportar de buena fe sospechas de incumplimiento.

MMM MH Vital ofrece métodos para reportar, que son:

- Confidenciales
- Anónimos
- Sin represalia

¿Cómo Reportar cualquier situación de no cumplimiento si eres beneficiario, proveedor o FDRs ?

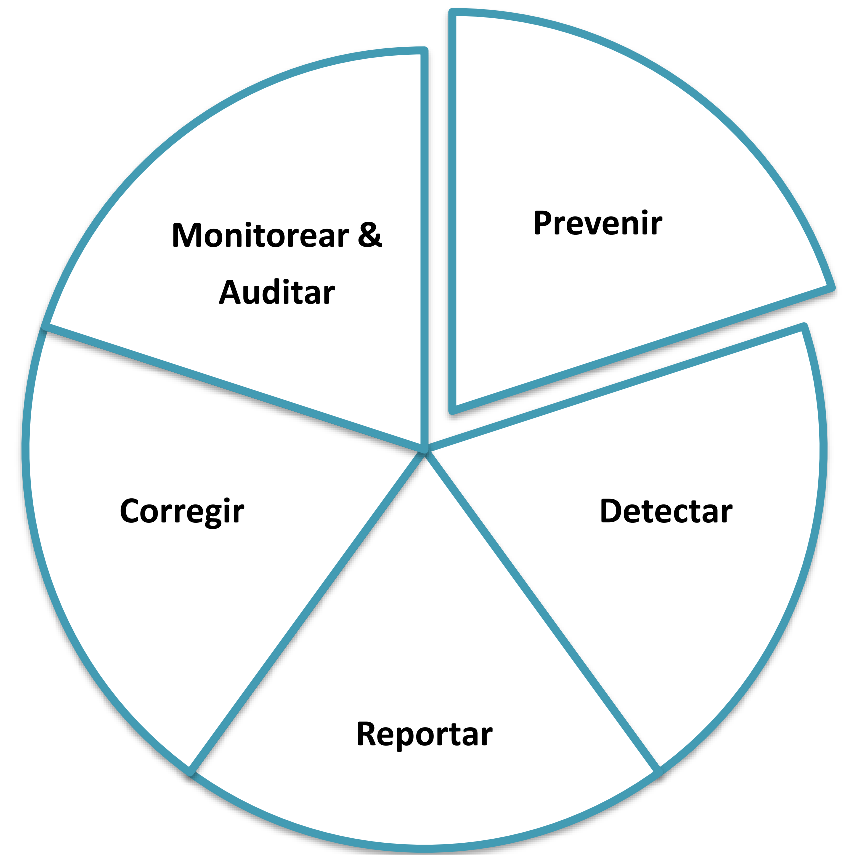
- Por Internet a través de la página “Ethics Point” (por su nombre en inglés): www.psg.ethicspoint.com
- Línea telefónica de “Ethics Point”: 1-844-256-3953
- Refiere a través de correo electrónico: : VitalSIU@mmmhc.com

¿Cómo prevenir que recurra el incumplimiento?

Una vez que se detecte y corrija el incumplimiento, un proceso de evaluación es de suma importancia para asegurar que no vuelva a suceder el mismo incidente.

El monitoreo de actividades son revisiones regulares las cuales aseguran el cumplimiento y que las acciones correctivas sean llevadas a cabo efectivamente.

La auditoría es una revisión formal de cumplimiento con un conjunto de estándares particulares (ej. políticas y procedimientos, leyes y regulaciones) utilizadas como base de medida.



Ética – ¡Haz lo correcto!

Es importante mantener una cultura ética y legal.
¡Se trata de hacer lo que es correcto!

- Actuar de manera justa y honesta
  Cumplir con la carta y el espíritu de la ley
- Adherirse a los estándares de ética más altos en todo lo que haces
- Reportar sospecha de violaciones

Conflicto de Interés

- Se deben evitar aquellas situaciones en las que sus intereses personales puedan causar un conflicto o parecer un conflicto con los intereses de la empresa.

- Si se encuentra en una situación en la que cree que puede existir un conflicto de intereses, debe comunicarlo a su Supervisor y/o al Oficial de Cumplimiento

Política de Conflicto de Interés

Ejemplos:

- Regalos y Entretenimiento;
  - No puede aceptar regalos o favores inusuales de clientes, competencia o suplidores.
  - Regalos a clientes-valor nominal de $15
- Supervisar a un familiar;
- Realizar negocios con un familiar empleado por un Proveedor o Suplidor;
- Relaciones financieras con entidades que actualmente tienen o que en un futuro puedan tener relación con la compañía;
- Pertenecer a la Junta de Directores de otra compañía;
- Realizar alguna función u ofrecer servicios para la competencia o suplidores, sin el consentimiento de la compañía.

Programa de Integridad

Fraude, Desperdicio y Abuso ("FWA", por sus siglas en inglés)

¿Por qué es importante recibir adiestramiento sobre fraude, despilfarro y abuso?

- Eres parte de la solución.
- Debe estar atento a cualquier actividad que pueda parecer sospecha.

¿Cómo puedo prevenir el FWA?

- Asegúrate de mantenerte al día con las leyes, regulaciones y políticas establecidas;
- Asegúrate de que los datos y la facturación sean precisos y que estén a tiempo;
- Verifica la información que se te provee;
- Mantente atento a cualquier actividad que pueda aparentar sospechosa. Como patrones, esquemas o tendencias que presentan los Proveedores, Beneficiarios, Entidades Delegadas y/o Suplidores.

Definiciones

Fraude

Engaño o declaración falsa, hecha intencionalmente, para obtener algún beneficio para el que no está autorizado.

Desperdicio

Sobreutilización de los recursos, u otras prácticas que resultan en gastos innecesarios. Estos gastos pueden ser reducidos, aumentando la calidad del cuidado.

Abuso

El abuso es una acción que puede resultar en costos médicos innecesarios. Es cuando una persona o entidad ha tergiversado los hechos para obtener el pago, pero no a sabiendas y / o intencionalmente.

MMM multihealth

Diferencia entre Fraude, Desperdicio y Abuso

La diferencia principal es la intención y el conocimiento.

El fraude requiere que la persona tenga la intención de obtener un pago y el conocimiento de que la acción es incorrecta.

Desperdicio y Abuso pueden incluir obtener un pago indebido o inapropiado, pero no requiere la intención y el conocimiento.

Leyes y Regulaciones Aplicables

"False Claims Act" (por su nombre en inglés):

- El Acta de Reclamaciones Falsas prohíbe que cualquier persona conscientemente presente al Gobierno Federal una reclamación falsa para pago y aprobación;
- Utilice información falsa como apoyo a un reclamo falso;
- Conspire para defraudar al Gobierno al someter reclamaciones falsas

Penalidades:

- En virtud de la Ley Federal de Reclamaciones Falsas, quienes presenten a sabiendas o hagan que otra persona presente reclamaciones falsas para que el gobierno las pague, son responsables del triple de los daños del gobierno más sanciones civiles de $21.563 por reclamación falsa.

Leyes y Regulaciones Aplicables

Estatuto: "Anti-Kickback" (por su nombre en inglés)

Prohíbe a profesionales de la salud, entidades y vendedores solicitar, recibir, ofrecer o pagar una remuneración (incluyendo cobro de comisiones, sobornos o rebates) a cambio de referidos por servicios pagados en parte o en su totalidad, por un programa de salud federal

La recompensa puede ser aceptable en algunas industrias, pero no para los programas federales de salud. Consecuencias: Sobreutilización, competencia desleal y otras. Por ejemplo, una empresa farmacéutica enviaba tarjetas de regalo a domicilio y renunciaba continuamente a los copagos de los beneficiarios para generar remisiones. Esta empresa tuvo que pagar 5 millones de dólares por daños y perjuicios.

Leyes y Regulaciones Aplicables

Protecciones bajo la ley "Whistleblower", (por su nombre en inglés)

Cualquier persona que tenga pruebas de que se está cometiendo fraude contra el gobierno está autorizada a actuar como denunciante en virtud de la Ley de Reclamaciones Falsas

La ley federal prohíbe que un empleador discrimine contra un empleado porque el empleado denuncie una sospecha de fraude de buena fe o inicie o asista en una acción de reclamos falsos en nombre del gobierno.

Leyes y Regulaciones Aplicables

Penalidad del Estatuto Anti-kickback

- Las penas civiles pueden incluir multas de hasta $ 73,588 por cada acto cometido y hasta tres (3) veces la cantidad del "kickback".
- Las penas criminales pueden incluir multas, encarcelamiento, o ambos.

Estatuto Stark o Ley de Auto-Referido

- Prohíbe; Que un Médico refiera pacientes para ciertos tipos de Servicios de Salud a una entidad de la cual el Médico (o un miembro de su familia inmediata) sea propietario o tenga algún interés financiero o un acuerdo de compensación (aplican excepciones).

Leyes y Regulaciones Aplicables

Daños y Penalidades de Ley Stark:

Las penalidades por violar la ley "Stark" incluyen,

- Hasta $23,863 de multa por cada servicio provisto.
- Recobro de las reclamaciones y,
- La posibilidad de Exclusión de los programas Federales de Salud

Exclusión:

Ningún pago del programa de salud Federal puede ser realizado por algún artículo o servicio realizado, ordenado o prescrito por un individuo o entidad excluida por la Oficina del Inspector General.

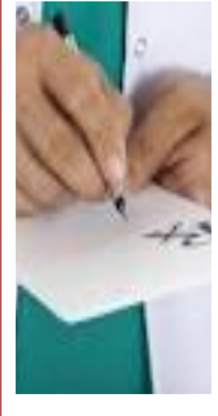
- 42 U.S.C. § 1395 (e) (1)
- 42 C.F.R. § 1001.1901

Leyes y Regulaciones Aplicables

Contrato con ASES

Este contrato se estableció entre MMM MH Vital y ASES para definir los requisitos y responsabilidades adquiridos al formar parte de los planes de salud seleccionados por Medicaid para administrar los servicios de Salud de los beneficiarios que le sirven. Disponen de requisitos estatales y federales que cada Plan Médico debe cumplir.

Lista de Individuos y Entidades Excluidas
("LEIE", por sus siglas en inglés)



Los médicos excluidos no pueden cobrar directamente para el tratamiento de pacientes de Medicare y Medicaid, ni pueden facturar sus servicios indirectamente a través de un empleador o un grupo médico.

Los proveedores también son responsables de no emplear o contratar a personas o entidades excluidas, ya sea en una clínica, o en cualquier escenario de atención médica en el que se reciban pagos de fondos federales. Esto requiere que se evalúe a todos los empleados y contratistas actuales y potenciales contra la lista de personas y entidades excluidas de la OIG, antes de establecer cualquier relación de empleo o de negocio y un proceso continuo de verificación mensual.

Ejemplos de sospechas de “FWA”:

“Upcoding”

Los Proveedores facturan un código de mayor nivel que representa un tratamiento, equipo o pruebas más costosas, para recibir un pago mayor.

“Unbundling”

Ocurre cuando se factura por separado servicios que están cubiertos en un código global, por ejemplo, en pruebas de laboratorio o servicios dentro de un código de cirugía que cubren los procedimientos pre- y post-operatorio.

Fraude de inscripción de Beneficiarios:

Los Beneficiarios pueden cometer fraude presentando información de elegibilidad fraudulenta de Medicaid (por ejemplo, subestimar los ingresos o los niveles de activos, o reclamar incorrectamente que es un residente del Estado).

Falsificación de Credenciales de Proveedores de Servicios de Salud:

La falsificación de las Credenciales de los Proveedores puede poner a los pacientes en riesgo porque pueden estar recibiendo tratamiento de un Proveedor no cualificado, o sin licencia. Y resultar en pagos indebidos por servicios de un Proveedor que no cumple con las calificaciones profesionales requeridas.

Ejemplos de sospechas de "FWA":

Falsa Representación:

- Un proveedor somete reclamaciones falsas haciendo representación falsa de la persona que realmente proveyó el servicio. En estos casos el que brindó el servicio está impedido de recibir el pago, por ejemplo, porque no tiene licencia, o porque está excluido por OIG.

Servicios No Medicamente necesarios:

- Por ejemplo, facturar por terapias costosas, cirugías, servicios de salud en el hogar o equipos que el paciente no necesita.

Fraude y Abuso de los Beneficiarios:

- Los beneficiarios pueden abusar del sistema mediante la utilización inapropiada de servicios, como la venta de medicamentos recetados o equipos médicos. Otras formas de fraude pueden incluir prestar la tarjeta del plan médico a una persona inelegible para que esa persona reciba servicios de Salud a los que no tiene derecho.

Indicadores Claves de FWA:

Una orden médica, nota de progreso, solicitud de pre-autorización, resultado, u otro documento que parece estar alterado o falsificado;

Los servicios no están sustentados por el historial médico del beneficiario;

Un proveedor que factura servicios en mucha mayor cantidad que otros Proveedores de su misma especialidad y/o región;

Un proveedor que prescribe principalmente medicamentos controlados;

Un beneficiario con varias órdenes médicas para narcóticos, en dosis altas y de diferentes prescriptores;

Los expedientes médicos no tienen evidencia de los resultados de estudios facturados;

Un proveedor con un patrón de uso incorrecto de modificadores, entre otros.

Medidas de Prevención de FWA

Requisitos de Inscripción y Contrato del Proveedor.

- Se han establecidos procesos para validar que los proveedores contratados cumplan con los requisitos del estado, licenciatura, declaraciones de interés en propiedad y condenas criminales, entre otros.

Extensión y Educación de los Beneficiarios y Proveedores:

- Debemos asegurarnos de que los Beneficiarios, los Proveedores y sus empleados sean educados de manera efectiva sobre fraude y abuso, y cómo y dónde denunciarlo.

Mecanismos para denunciar sospechas de una posible actividad fraudulenta:

- Contamos con varios mecanismos para denunciar situaciones sospechosas de manera confidencial "hotline", "Ethics point" (por su nombre en inglés), correo electrónico y correo postal. En MMM MH Vital están prohibidas las represalias en contra de cualquier empleado que de buena fe, refiera un caso de posible FWA.

Identificación Individuos Excluidos:

- MMM MH Vital ha implementado políticas y procedimientos para revisar las listas de individuos o entidades excluidas por OIG/SAM antes de contratar a un proveedor, empleado o contratista y luego, mensualmente.

¿Qué pueden hacer los Beneficiarios para evitar FWA?

- Proteger la información de la tarjeta de plan médico;
- Nunca ofrecer información del plan a personas desconocidas o personas que lo llamen por teléfono;
- Relacionarse con los términos de su cubierta;
- Guardar copia de los resultados de laboratorios y estudios para evitar duplicidad;
- Verificar la información antes de firmar cualquier solicitud de seguro o reclamación de servicios de Salud.
- Revisar el resumen de los servicios recibidos por el Beneficiario;
- No dar dinero a alguna persona que le ofrezca realizar o acelerar alguna gestión en ASES o la oficina de Medicaid.

¡Debes Recordar!

Reportar FWA

No es necesario que usted defina si la situación es fraude, desperdicio o abuso. **Reporte cualquier inquietud al Departamento de Cumplimiento de la organización.**

El Departamento de Cumplimiento investigará y tomará la determinación que corresponda.

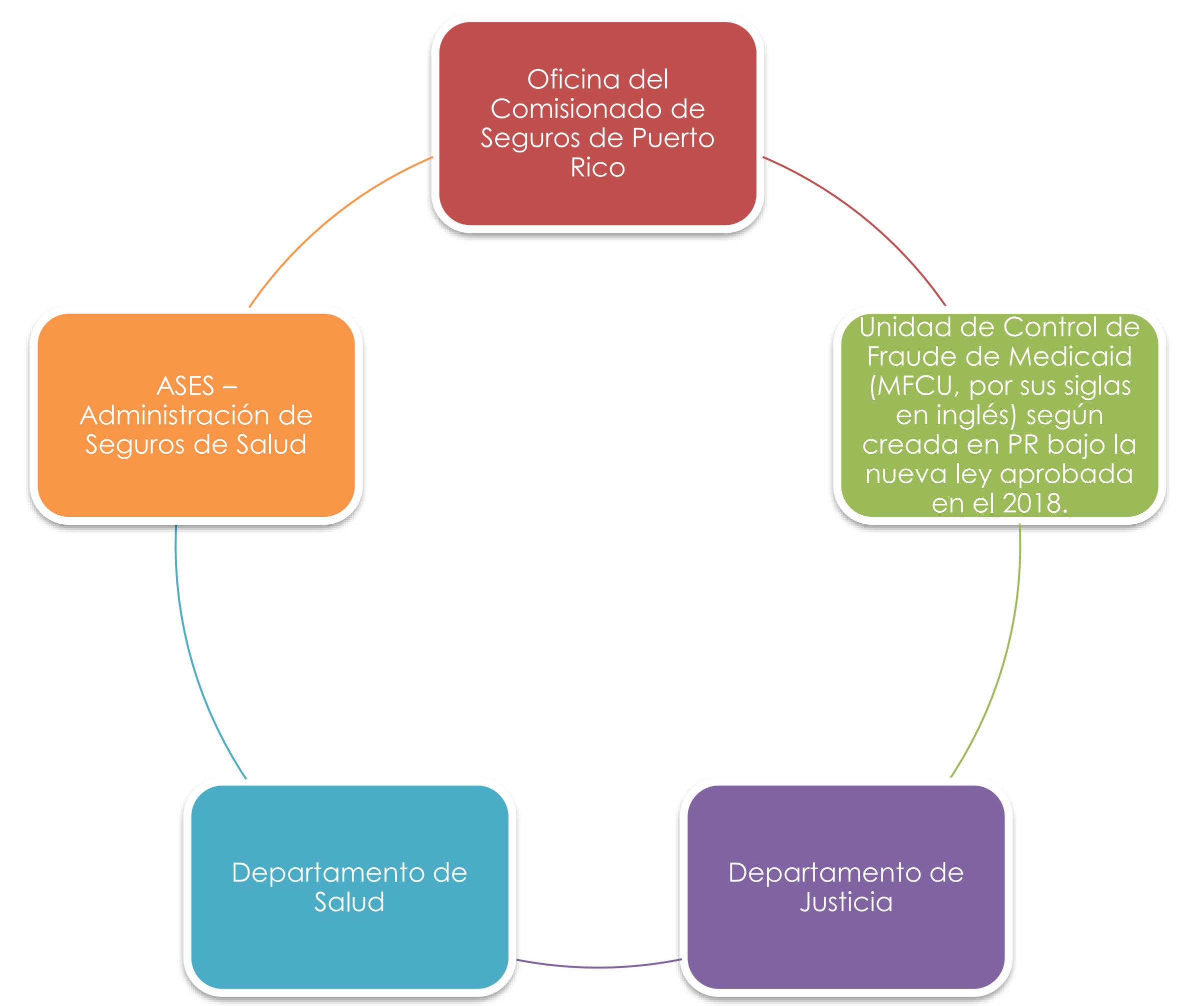
Consecuencias de cometer FWA:

- Las siguientes son penalidades potenciales. Las consecuencias actuales dependerán de la violación.
  - Penalidad monetaria civil;
  - Convicción/penalidades criminales;
  - Demanda civil;
  - Encarcelación;
  - Pérdida de licencias;
  - Exclusión de Programas Federales de Salud.

¿Cómo Reportar cualquier situación de no cumplimiento si eres beneficiario, proveedor o FDRs ?

- Por Internet a través de la página "Ethics Point" (por su nombre en inglés): www.psg.ethicspoint.com
- Línea telefónica de "Ethics Point": 1-844-256-3953
- Refiere a través de correo electrónico: : VitalSIU@mmmhc.com

Agencias Regulatorias atentas con el FWA



Privacidad y Seguridad
Ley HIPAA

Health Insurance Portability and Accountability Act, 1996", (por su nombre y siglas en inglés).

Ley HIPAA

- La Ley HIPAA es una ley federal que todos los planes de Salud y Proveedores del cuidado de la Salud tienen que cumplir para proteger la **Privacidad y Seguridad** de toda la información de Salud de cada individuo.

- HIPAA es supervisada por el Departamento de Salud y Servicios Humanos (HHS) y aplicada por la Oficina de Derechos Civiles (OCR).

¿Qué significan sus siglas?

Health - Salud

Insurance - Seguro

Portability and - Portabilidad

Accountability - Responsabilidad

Act of 1996 – Ley de 1996

H I P A A

Se creó para otorgar mayor acceso a los seguros de cuidado de Salud, proteger la Privacidad de la información de Salud, y promover la estandarización y eficiencia en la Industria del cuidado de Salud.

La sección de **Privacidad** consiste en **establecer salvaguardas** para prevenir el acceso no autorizado a información protegida de cuidado de Salud y establece los derechos del individuo con respecto a su información de salud protegida.

Como individuo que tiene acceso a información protegida de cuidado de salud, **usted es responsable de adherirse a los requerimientos establecidos por la Ley HIPAA**.

HIPAA

- Firmada el 21 de agosto de 1996;
- Vigencia total a partir del 14 de abril del 2003;
- Aplica tanto para información de salud en formato en papel, electrónico y verbal;
- Tiene tres (3) componentes: Simplificación Administrativa, Seguridad y Privacidad;
- Buscan mejorar la eficiencia y la efectividad del sistema de atención médica uniformando, protegiendo la información médica;
- Promueve el desarrollo de un sistema de información mediante la adopción de estándares para la transmisión electrónica de cierta información médica;
    - Estándares uniformes para reclamos y otras transacciones financieras y administrativas,
    - Estándares de privacidad y seguridad para el manejo de información médica y personal identificado.

Regla de Privacidad de HIPAA

Propósito:

Protege la confidencialidad de la PHI en todos los formatos (papel, verbal y electrónico)

Otorga a los individuos el entendimiento y control de cómo su PHI es utilizada.

Se asegura que la PHI sea utilizada solamente para propósitos de salud.

Establece la información protegida de salud (PHI) solo puede divulgarse para tratamiento, pago u operaciones de cuidado de salud (TPO) o con el consentimiento (autorización válida) del individuo.

Establece los derechos de los individuos respecto su información de salud.

Establece el proceso de notificación por violaciones a HIPAA.

Relación de la Ley HIPAA con las leyes de Puerto Rico

- Por disposición expresa del Congreso de los Estados Unidos, la Ley aplica a los estados y a los territorios; incluidos Puerto Rico. "*State means any of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands and Guam*".

- Dispone que solamente cualquier legislación local presente o futura que sea más estricta y provea mayores derechos a los individuos en relación a su información de salud puede prevaler sobre HIPAA.

- Ocupa el campo estatal; desplaza, sustituye y prevalece sobre cualquier ley local que sea contraria a HIPAA.

HIPAA

Entidades cubiertas por HIPAA:

- Planes de Salud;
- "Healthcare Clearinghouses" (son instituciones centrales que establecen transacciones);
- Proveedores de Cuidados de Salud (médicos, hospitales, farmacias, etc).

Estándar de Mínimo Necesario:

- HIPAA requiere que la entidad cubierta use o divulgue la PHI de manera limitada, solo la información necesaria para cumplir con el propósito de la divulgación a la persona que lo solicite. (Estándar del Mínimo Necesario).

Privacidad en la genómica (Genetic Information Nondiscrimination Act)

- La Ley de No Discriminación por Información Genética (GINA) -se convirtió en ley el 21 de mayo de 2008.
- GINA protege a las personas contra la discriminación basada en su información genética en la cobertura de salud y en el empleo.
- GINA se divide en dos secciones o títulos. El Título I de GINA prohíbe la discriminación basada en información genética en la cobertura de salud. El Título II de GINA prohíbe la discriminación basada en información genética en el empleo.

- En la regla propuesta emitida el 1 de octubre de 2009, el OCR propone modificar la Regla de privacidad para aclarar que la información genética es información de salud y prohibir el uso y la divulgación de información genética por parte de los planes de salud cubiertos para fines de suscripción, que incluyen determinaciones de elegibilidad, cálculos de primas. , solicitudes de exclusiones de condiciones preexistentes y cualquier otra actividad relacionada con la creación, renovación o reemplazo de un contrato de seguro médico o beneficios médicos.
- El OCR publicó esta regla propuesta con un período de 60 días para comentarios públicos.

"PHI" (por sus siglas en inglés), es Información Protegida de Salud:

PHI debe ser vista sólo por personas autorizadas a ver la información.

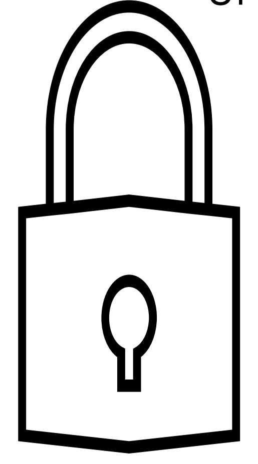
PHI debe ser escuchada sólo por personas autorizadas a escuchar la información divulgada.

PHI debe ser transmitida o compartida sólo con las personas autorizadas a recibir o compartir la información.

"PII"(por sus siglas en inglés)– Información Personal Identificable: La información personal identificable también debe ser protegida y limitada sólo a personas autorizadas.

"PHI" (por sus siglas en inglés), es Información Protegida de Salud:

PHI es ***información individual de salud identificable*** coleccionada de un individuo, creada o recibida por una entidad cubierta **y**



- Que está relacionada a la salud o condición física o mental de la persona pasada, presente o futura; o a la provisión de cuidado de salud de un individuo; o al pago pasado, presente o futuro por servicios médicos del individuo **y**
- Que **identifica a un individuo** o puede identificar a un individuo.
- Que puede ser transmitida o mantenida electrónicamente, así como por cualquier otro medio.

¿Qué protege la Ley HIPAA?

Ejemplos de Información de Salud Protegida o "PHI/PII"

- Nombre
- Género
- Religión
- Estado Civil
- Número de Seguro Social
- Raza
- Licencia de Conducir
- Dirección Postal o Física
- Resultados de Exámenes Médicos
- Reclamaciones
- Tratamiento
- Expedientes Médicos
- Datos Financieros
- Condición Médica

MMM multihealth

Diferencia entre uso y divulgación

- **Uso**

El compartir, aplicación, examen o análisis de PHI dentro de la entidad cubierta.

- **Divulgación**

La liberación, transferencia, suministro de acceso a o divulgación de cualquier otra forma PHI fuera de la entidad cubierta.

Autorización para la divulgación de “PHI”:

No se necesita la autorización del Individuo para usar y/o divulgar su “PHI” para **Tratamiento, Pago y/u Operaciones de Salud.**

En ciertas instancias **la ley permite** divulgar “PHI” **sin** autorización del Individuo, ej. Para propósitos de auditoría por entidades estatales o federales, para evitar amenaza grave para la salud pública, a familiares y amigos, etc.

Cualquier otro uso requiere autorización

MMM MH Vital tiene un formulario de autorización de “PHI” disponible para que los Beneficiarios añadan a las personas de su preferencia a recibir su “PHI”.

Divulgación de PHI a Parientes y/o Guardianes de Menores Emancipados y No Emancipados:

- Los padres o tutores legales de los menores no emancipados tienen derecho a que se les divulgue la información protegida de Salud ("PHI") de dichos menores.
- El padre o tutor legal designado por una corte será el representante personal del menor, sin necesidad de requerirles una autorización de "PHI" para divulgar su información.
- Los representantes legales de los menores de edad, que no sean sus padres (ej. tutores legales) deben presentar evidencia de su autoridad al plan, antes de cualquier divulgación de información.

Divulgación de PHI a Parientes y/o Guardianes de Menores Emancipados y No Emancipados:

Si el menor está emancipado: (por motivo de matrimonio, porque los padres o un tribunal lo emancipó) entonces, el menor podrá escoger a quien le divulga su "PHI".

Cuando la ley lo permite, los padres o tutores legales no podrán obtener "PHI" del menor no emancipado cuando:

el servicio médico no requiere el consentimiento de los padres o tutores y;

el menor y una corte u otra persona autorizada por ley consienten a dicho servicio médico.

También el padre o tutor legal podrá consentir a un acuerdo de confidencialidad entre un Proveedor de Salud y el menor sobre un servicio médico.

Notificación de Prácticas de Privacidad (NPP)

- Es un documento que explica los derechos de las personas a su PHI, los deberes legales y prácticas de privacidad de la entidad cubierta (ej. MMM MH) con respecto a la información de salud de las personas y las formas en que la entidad cubierta puede usar o divulgar dicha información.
- Un plan de salud debe distribuir su aviso de prácticas de privacidad a cada nuevo afiliado al momento de la inscripción y enviar un recordatorio a cada afiliado al menos uno cada tres años de que el aviso está disponible a solicitud.

AVISO DE PRÁCTICAS DE PRIVACIDAD DE HIPAA

La fecha original de efectividad de este aviso fue el 14 de abril de 2003. Este aviso fue revisado por última vez en mayo de 2023.

ESTE AVISO DESCRIBE CÓMO PUEDE UTILIZARSE Y DIVULGARSE SU INFORMACIÓN MÉDICA Y CÓMO PUEDE ACCEDER A ELLA. POR FAVOR, LÉALO DETENIDAMENTE.

La información sobre su salud y sus beneficios de salud es privada. La ley establece que tenemos que mantener este tipo de información, llamada PHI (por sus siglas en inglés), segura para nuestros afiliados. Esto significa que, si usted es o ha sido afiliado, su información está segura.

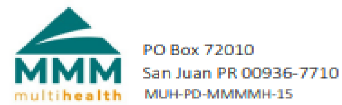
Obtenemos información sobre usted de las agencias estatales de *Medicaid* y del Programa de Seguro Médico Infantil (CHIP, por sus siglas en inglés) después de que se hace elegible y se afilia a nuestro plan de salud. También la obtenemos de sus médicos, clínicas, laboratorios y hospitales para poder autorizar y pagar su cuidado de salud.

La ley federal dice que tenemos que informarle de lo que tenemos que hacer para proteger PHI que se nos provee por teléfono, impresa en papel o guardada en una computadora. También tenemos que decirle cómo la mantenemos segura. Para proteger PHI que está:

- Impresa en papel, nosotros:
  - Cerramos con llave / seguro nuestras oficinas y archivos
  - Destruimos el papel con información de salud para que otros no puedan obtenerla
- Guardada en una computadora, nosotros:
  - Utilizamos contraseñas para que solo puedan accederla las personas indicadas
  - Utilizamos programas especiales para monitorear nuestros sistemas
- Utilizada o compartida por personas que trabajan para nosotros, médicos o el estado, nosotros:
  - Establecemos reglas para mantener segura la información (llamadas políticas y procedimientos)
  - Enseñamos a las personas que trabajan para nosotros a seguir las reglas

¿Cuándo está bien el que podamos utilizar y compartir su PHI?

Podemos compartir su PHI con su familia o con una persona de su elección que le ayude con o pague su cuidado médico si usted nos da su consentimiento. A veces, podemos utilizarla y compartirla **sin** su consentimiento:



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Definición de “’Breach” 45 CFR 164.402

Una violación (“*breach*”) es una adquisición, acceso, uso o divulgación no autorizada de PHI no protegida que compromete la privacidad y la seguridad de la PHI. El uso y la divulgación de PHI no autorizada por HIPAA se presume que es una violación a menos que la entidad cubierta o socio de negocio demuestre que hay una baja probabilidad de que la PHI ha sido comprometida.

Toda violación a HIPAA debe reportarse a los individuos afectados en un termino de 60 días contados a partir del descubrimiento de la violación o desde la fecha en que la violación debió ser descubierta.

En adición, la compañía debe notificar al HHS, y a la prensa de dicha violación. La fecha de esa notificación dependerá de la cantidad de individuos que se vieron afectados por la violación.

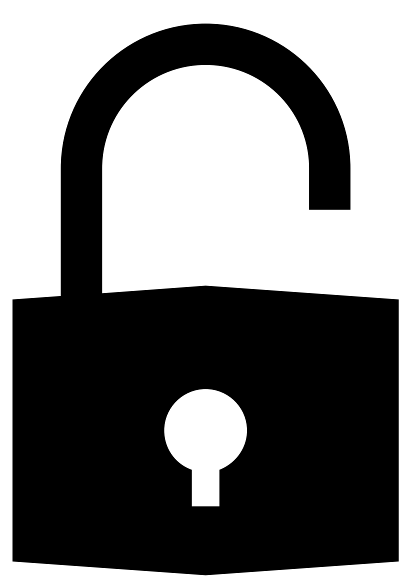
- 500 o más individuos afectados: la notificación a la prensa y al HHS debe ser dentro de los 60 días de haberse descubierto la violación o debió ser descubierta.
- 499 o menos individuos afectados: las violaciones se deben notificar al HHS el próximo año calendario.

Regla de Seguridad de HIPAA

Propósito:

- La Regla de Seguridad requiere que las entidades cubiertas protejan la PHI en forma electrónica (ePHI).
- Establece controles para salvaguardar la confidencialidad, integridad y disponibilidad de la ePHI.
  - *Confidencialidad*: asegurarse de que la ePHI no esté disponible o divulgada a personas no autorizadas.
  - *Integridad*: asegurarse de que la entrada de ePHI de hoy, sea la ePHI que se recupere en el futuro (ePHI) no se haya alterado o destruido de manera no autorizada)
  - *Disponibilidad*: asegurarse que la ePHI esté disponible para aquellos que la necesiten, cuando la necesiten.
- Tiene la intención de proteger la ePHI contra cualquier amenaza o peligro razonablemente anticipado, y al uso o divulgación indebida.

Incidentes de Seguridad



Los incidentes de seguridad deben reportarse de inmediato

Ejemplos de incidentes de seguridad:

- Infecciones de “malware” (virus/troyanos)
- Descubrimiento de una cuenta de usuario no autorizada
- Robo / pérdida de equipo
- Uso inadecuado de sistemas
- Abuso de privilegios en un entorno de red.

Considera que…

El almacenamiento, la transmisión o el manejo inadecuado de "PHI" puede ocasionar hurto o pérdida de la información y acceso a individuos no autorizados denominado como una ruptura o ("breach" por su nombre en inglés).

Si advienes en conocimiento sobre un acceso no autorizado de "PHI", debes comunicarte **inmediatamente** la Oficina de Cumplimiento de MMM.

Para cumplir con la ley, todo acceso no autorizado a "PHI" debe ser notificado a las personas afectadas, ASES y a la Oficina de Derechos Civiles dentro de los términos requeridos.

Todo Beneficiario tiene derecho a presentar quejas sobre incumplimiento con Ley HIPAA si siente que su información no ha sido manejada apropiadamente.

Considera que…

- La querella puede ser radicada en MMM MH Vital, en la Oficina de Derechos Civiles del Departamento de Servicios Humanos y de Salud Federal, ASES, o la Oficina del Procurador del Paciente.

- Existen sanciones por violaciones a los estándares establecidos por HIPAA que incluyen pero no se limitan a;
  - Multas
  - Encarcelamiento

- Este adiestramiento no solo aplica a los empleados de MMM MH Vital, si no que a sus Proveedores contratados, Contratistas y Subcontratistas, incluyendo los empleados de estos.

Recuerda…

- Sigue el procedimiento para la eliminación adecuada de la información sensitiva utilizando las cajas cerradas de reciclaje.
- Mantén laptops, teléfonos inteligentes, USB y cualquier otra memoria o documento que contenga PHI en un lugar seguro.
- Asegúrese de no dejar documentos que contengan PHI en impresoras o máquinas de fax.
- Nunca dejes PHI a simple vista en tu escritorio.
- Use contraseñas seguras. Mantén tu ID y contraseña confidencial y segura. Nunca compartas tu contraseña o nombre de usuario (ID de Usuario).
- No accedas PHI que no necesitas acceder.
- Nunca compartas tu identificación corporativa con nadie.

Recuerda…

- Informe inmediatamente a su supervisor si pierde o le roban su identificación corporativa.
- Los visitantes deben tener una identificación de visitantes antes de ingresar a las instalaciones de la empresa y deben ser escoltados por un supervisor o gerente en todo momento.
- Si observa una persona desconocida o sospechosa en su área de trabajo, notifíquelo a su supervisor de inmediato.
- No dejes documentación con PHI, la computadora portátil, teléfono celular, USB o cualquier dispositivo de almacenamiento portátil en el automóvil.
- No abras correos electrónicos con archivos adjuntos de contactos no identificados.
- Antes de dejar su computadora desatendida, presione *Ctrl* + *Alt* + *Supr* y bloquéela.
- No instales aplicaciones a menos que lo apruebe el Departamento de IT de MMM.
- No navegues por internet para uso personal.

¿Cómo Reportar cualquier situación de no cumplimiento y/o de FWA si eres beneficiario, proveedor o FDRs ?

- Por Internet a través de la página "Ethics Point" (por su nombre en inglés): www.psg.ethicspoint.com
- Línea telefónica de "Ethics Point": 1-844-256-3953
- Refiere a través de correo electrónico: : VitalSIU@mmmhc.com

¡Gracias!

Adiestramiento Corporativo sobre Regulaciones Aplicables a la Industria de la Salud

Revisión Noviembre 2023

Agenda

En el Adiestramiento Corporativo sobre Regulaciones Aplicables a la Industria de la Salud se cubrirán los siguientes temas:

1. Plan de Competencia Cultural
2. Declaración Previa de Voluntad Sobre Tratamiento Médico (Ley 160 del 17 de noviembre de 2001), mejor conocido como "Directrices Avanzadas"
3. Carta de Derechos de los Pacientes (Ley 194 del 25 de agosto de 2000, según enmendada)
4. Ley 57 para para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores",.
5. Ley sobre la violencia de género, 54
6. Protocolo de Prevención y Detección de Posibles Casos de Explotación Financiera a Personas de Edad Avanzada o Adultos con Impedimentos

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Plan de Competencia Cultural

¿Qué es Competencia Cultural?

Es el conjunto de destrezas interpersonales que permiten a individuos incrementar su entendimiento, aceptación y respeto por las diferencias culturales y similitudes entre grupos, y la sensibilidad para saber que esas diferencias influyen en las relaciones con los beneficiarios. Es la capacidad de comprender, interactuar y colaborar bien con diferentes personas.

Plan de Competencia Cultural

- Los empleados y asociados del plan deben proveer servicio a todos los beneficiarios de cualquier cultura, raza, raíces étnicas, identidad de género, expresión de genero u orientación sexual real o percibida (lesbiana, gay, bisexual, transgénero, queer, queer/ questioning, intersexual, asexual, "two-sprit") conocido como LBGTQIA2S+ y religión; en orden de reconocer los valores, respetar, proteger y preservar la dignidad de cada individuo.

- El propósito es asegurar que se consideren las diversas necesidades de los beneficiarios.

Objetivos del Plan de Competencia Cultural

- Identificar beneficiarios que tienen limitaciones culturales o barreras de lenguaje o idioma.
- Asegurar que se cuentan con los recursos necesarios para cumplir con los requisitos de comunicación contemplando posibles barreras de lenguaje.
- Asegurar que los proveedores de salud entiendan y reconozcan las necesidades de acuerdo a las diferencias culturales.
- Asegurar que todos los empleados y asociados están adiestrados para valorar las diferencias culturales, religiosas y de lenguaje.

Metas del Plan de Competencia Cultural

- Aumentar la comunicación con los beneficiarios que tengan competencias culturales o barreras lingüísticas.
- Utilizar materiales educativos apropiados y culturalmente sensibles para cada tipo de limitaciones culturales, incluidas la raza, religión, identidad de género, expresión de genero u orientación sexual real o percibida (LGBTQIA2S +), origen étnico o el idioma.
- Disminuir las discrepancias en la atención médica recibida.
- Aumentar el entendimiento de nuestros empleados, contratistas, proveedores de salud, sobre las diferencias culturales y religiosas.

Componentes del Plan de Competencia Cultural

- **Análisis de Datos:**
  - Realizar periódicamente evaluaciones de nuestra población en las regiones contratadas.
  - Realizar periódicamente análisis de reclamaciones y encuentros para identificar las necesidades de salud.
  - Como parte del proceso de matrícula, identificar necesidades específicas en cuanto a raza, religión, origen étnico y lenguaje.

Componentes del Plan de Competencia Cultural

- **Servicios Lingüísticos o de Intérprete:**
  - Los proveedores ayudan a identificar beneficiarios con posibles barreras lingüísticas.
  - En coordinación con el Departamento de Servicios al beneficiario, estos reciben servicios de intérpretes libre de costo para acceder a los servicios cubiertos.
  - Los servicios de intérprete incluyen interpretación para beneficiarios con limitaciones en el idioma español o impedimentos auditivos.
  - Los contratistas que brinden servicio a nuestros beneficiarios deben cumplir con el Plan de Competencia Cultural aprobado.
  - Los materiales escritos están disponibles tanto en español como en inglés.
  - Tendrán un lenguaje entendible por un menor de cuarto grado de escuela-opcional

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Componentes del Plan de Competencia Cultural

- **Creencias Religiosas:**
  - Asegurar que todos los empleados traten con respeto los beneficiarios conforme a sus creencias religiosas.
  - Los proveedores deben cumplir con respetar las creencias religiosas de los beneficiarios al momento de brindar servicios de tratamiento médico.

Componentes del Plan de Competencia Cultural

- Anti Discrimen Población LGBTQIA2S+:
  - Existe una guía básica a proveedores para manejo sensible y adecuado al brindar servicios de salud a beneficiarios LGBTQIA2S+ y que es distribuida a los proveedores.
  - Respetar las leyes relacionadas aplicables en Puerto Rico tal y como lo es la Ley 22-2013- primera legislación contra el discrimen por orientación sexual.
  - El proveedor es responsable de adiestrar a su personal sobre sensibilidad a la población LGBTQIA2S+.
  - La aprobación y despachos de medicamentos, así como de los servicios médicos, no deben tener restricción por razón de sexo.

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Componentes del Plan de Competencia Cultural

- **Educación a los Proveedores:**
  - El proveedor debe educarse acorde al Plan de Competencia Cultural.
- **Medios Electrónicos:**
  - Los beneficiarios tienen acceso a línea TTY/TDD para servicios audio-impedidos
  - Servicios al beneficiario brindará los servicios de seguimiento necesarios adicionales a la llamada.

Componentes del Plan de Competencia Cultural

- Encuesta sobre el Plan de Competencia Cultural:
  - Para crear conciencia y aumentar la creencia, valores y actitudes que promuevan el entendimiento de las diferencias culturales, de religión, preferencias sexuales y lenguaje e identificar áreas de necesidad de adiestramiento los empleados que proveen servicio directo a los beneficiarios deben participar de una autoevaluación.
  - Esta autoevaluación es acorde o similar a la autoevaluación del *“National Center for Cultural Competence”* (por su nombre en inglés).

Beneficiarios de las Islas Municipio

Beneficiarios Vieques y Culebra

- Existe una política de turnos preferenciales para exigir a los proveedores dar prioridad a los beneficiarios residentes de Vieques y Culebra, de modo que sean atendidos en un tiempo razonable después de llegar a la oficina.
- Este tratamiento preferencial es necesario debido a la ubicación de estas islas municipios, considerando el mayor tiempo de viaje necesario de sus residentes para obtener atención médica.

Declaración Previa de Voluntad Sobre Tratamiento Médico
(Ley 160 del 17 de noviembre de 2001)

Definición

- **Directriz Anticipada:** Una instrucción escrita, como un testamento en vida o un poder legal, otorgando responsabilidad sobre la atención médica de un individuo mayor de 21 años de edad, según se define en 42 CFR 489.100, y según lo reconoce la Ley de Puerto Rico Número 160 del 17 de noviembre de 2001, según enmendada, a la provisión de atención médica cuando el individuo está incapacitado.

Ley de Declaración Previa de Voluntad

- Reconoce el derecho de toda persona mayor de edad, en pleno uso de sus facultades mentales, declarar previamente su voluntad sobre lo referente a tratamiento médico en caso de sufrir una condición de salud terminal y/o de estado vegetativo persistente.
- El declarante podrá nombrar un mandatario o representante para que en caso de una eventualidad que le impida tomar decisiones y de no haber dispuesto sobre alguna situación médica en la declaración de voluntad, este tome las decisiones, según los valores e ideas del declarante.

Ley de Declaración Previa de Voluntad

- Recae bajo la responsabilidad del declarante el notificar a su Médico y/o a la Institución de Salud sobre la existencia de una directriz anticipada y proveerle a estos una copia de dicho documento.
- La directriz anticipada puede ser firmada en presencia de un Notario Público y dos testigos que sean mayores de 21 años de edad.
- También el beneficiario puede firmar la directriz anticipada en la presencia de un Médico y dos (2) testigos que sean mayores de 21 años de edad.
- El beneficiario puede modificar el documento de directivas anticipadas, en parte o totalmente; en cualquier momento.
- La revocación del documento solo puede solicitarse por escrito.

Ley de Declaración Previa de Voluntad

- En caso de las mujeres embarazadas, quedará sin efecto cualquier declaración previa, hasta que termine el estado de embarazo.
- El declarante no podrá prohibir que se le administre tratamientos para alivio de dolor, hidratación y alimentación.
  - Excepto, cuando la muerte ya sea inminente o su cuerpo no pueda absorber alimentos y/o hidratantes. **Solo el médico tendrá la autoridad para tomar una decisión.**
  - Esta ley no autoriza la práctica de la eutanasia ni de la misericordia.

Carta de Derechos de los Pacientes (Ley 194 del 25 de agosto de 2000, según enmendada)

Carta de Derechos de los Pacientes

“Ley 194 del 25 de agosto del 2000

Fue creada para establecer la “Carta de Derechos y Responsabilidades del Paciente”. Dispone los derechos y responsabilidades de los pacientes y usuarios de servicios de salud médico-hospitalarios en Puerto Rico, así como de los Proveedores de tales servicios y sus aseguradores.

Su propósito es definir términos, fijar procedimientos de solución de querellas, imponer penalidades y otros fines relacionados.

Los padres, hijos mayores de edad, custodio, encargado, cónyuge, parientes, representante legal, apoderado o cualquier otra persona designada por los tribunales o por el paciente, podrá ejercer estos derechos si el paciente carece de la capacidad de tomar decisiones, es declarado incapaz por ley o es menor de edad.

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Derechos de los Pacientes

- Obtener información del Plan sobre el cuidado coordinado, facilidades, profesionales de la salud, servicios y los accesos de servicios.
- Recibir servicios de salud de la más alta calidad
- Ser tratado con respeto, igualdad y consideración ante la dignidad y privacidad.
- Obtener información sobre opciones y alternativas de tratamiento.
- No ser discriminado por ninguna razón.
- Participar en decisiones sobre su cuidado de salud, incluyendo el derecho a rehusar tratamiento.
- Recibir servicios de emergencia las 24 horas al día, siete días a la semana.

Derechos de los Pacientes

- Continuidad de servicios de salud.
- Solicitar y recibir copia de sus expedientes médicos.
- Confidencialidad de su información y expedientes de salud.
- Radicar una queja, querella o apelación libremente y sin afectar adversamente la manera en que es tratado(a).
- Poder ejercer todos sus derechos sin represalias.
- Recibir información sobre la ***Declaración Previa de Voluntad sobre Tratamiento Médico.***

Responsabilidades del Paciente

- Debe mantenerse informado sobre su cubierta del plan, sus límites y exclusiones.
- Informar a su médico sobre:
  - Cambios en su salud
  - Información que no haya entendido
  - Razones por las cuales no pueda cumplir con el tratamiento recomendado
- Proveer a su médico toda la información sobre su salud.
- Seguir los tratamientos recomendados por sus médicos.
- Llevar un estilo de vida saludable.

Responsabilidades del Paciente

- Comunicar su ***Declaración Previa de Voluntad sobre Tratamiento Médico.***
- Mantener un comportamiento adecuado que no perjudique, dificulte o evite que otros pacientes reciban la atención médica necesaria.
- Proveer la información requerida por su plan.
- Notificar sobre cualquier actividad posiblemente fraudulenta o acción inapropiada relacionada a servicios, proveedores o facilidades de salud.

Penalidades y Rol de la Oficina del Procurador del Paciente (OPP)

- Todo asegurador, plan de cuidado de salud, profesional de la salud o Proveedor de servicios de salud médico-hospitalarios o persona o entidad que incumpla con cualquiera de las responsabilidades u obligaciones que le impone esta Ley, incurrirá en una falta administrativa y será sancionada con pena de multa no menor de quinientos (500) dólares ni mayor de cinco mil (5,000) dólares por cada incidente o violación de ley.
- La Oficina del Procurador del Paciente (OPP) fue creada en el 2001 para garantizar el cumplimiento de los derechos y las responsabilidades del paciente. Está facultada por la Ley para investigar y dirigir cualquier querella relacionada con la violación de las disposiciones legales consignadas en la **Carta de Derechos y Responsabilidades del Paciente.**

MMM
Holdings

Contactos OPP

Dirección Postal: PO Box 11247 San Juan , Puerto Rico 00910-2347

Dirección Física: Edificio Mercantil Plaza piso 9 Hato Rey, Puerto Rico.

Cuadro Telefónico: 787-977-1100 (metro) 1-800-981-0031 (Isla) ;

Para radicar querellas: 787-977-1100

Fax: 787-977-0915

info@opp.pr.gov

www.opp.pr.gov

“Ley 57 para para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores”, antes conocida como la Ley Núm. 246, “Ley para la Seguridad, Bienestar y Protección de Menores” del 16 de diciembre de 2011.

Ley Núm. 57 del año 2023- Ley para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores.

- Esta ley derogó la Ley Núm. 246, conocida como **Ley para la Seguridad, Bienestar y Protección de Menores" del 16 de diciembre de 2011.**

- Busca establecer la "Ley para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores," a los fines de garantizar cumplimiento con las partes B y E del Título IV de la Ley del Seguro Social, según enmendada por la Family First Prevention Services Act, 42 USC §§621-629m y 42 USC §§670-679c;

- Esta ley incorpora varios términos y conceptos nuevos en nuestra jurisdicción, necesarios para la modificación del paradigma programático del sistema de protección de menores. Uno de los términos más importantes lo es el de "menor en riesgo a ingresar a cuidado sustituto", el cual se refiere a un menor de edad y a su familia que pueden beneficiarse de tratamiento y servicios dirigidos a la preservación de la unidad familiar ante una situación de riesgo de maltrato o negligencia y para evitar que dicho menor ingrese a cuidado sustituto.
- El término se utiliza también para distinguir situaciones donde los esfuerzos de preservación sean viables de aquellas donde se requiera la remoción de un menor de su hogar, su ubicación en cuidado sustituto, y el comienzo de la acción judicial correspondiente"

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Ley Núm. 57 del año 2023- Ley para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores

- Tiene el propósito de garantizar el bienestar de los niños y niñas, y asegurar que los procedimientos en los casos de maltrato de menores se atiendan con diligencia.
- Para la ley, el abuso infantil significa cualquier tipo de daño; humillación; abuso físico o psicológico; descuido; omisión o trato negligente, maltrato, explotación sexual; incluyendo la agresión sexual y el comportamiento obsceno; y cualquier tipo de agresión violenta dirigida a un niño o joven por sus padres, tutores legales o cualquier persona

Ley Núm. 57 del año 2023- Ley para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores

- La ley incorpora la frase “mejor interés del menor” para referirse de forma universal al conjunto de acciones y procesos tendentes a garantizarle a un menor su desarrollo integral y una vida digna, así como las condiciones materiales y afectivas que le permitan vivir plenamente y alcanzar su máximo potencial, incluyendo, pero sin limitarse a factores que afecten la seguridad, bienestar físico, mental, emocional y otros.
- De esta manera se recogen todos estos factores en un solo término y así se elimina la utilización de varias expresiones que pueden causar confusión, ya que pueden significar lo mismo como “mejor bienestar del menor”, “bienestar del menor”, entre otros.
- Un término importante cuyo significado cambia en la ley es “persona responsable del menor”, el cual ahora incluye a toda persona que esté a cargo de este de forma temporal o permanente, como a los progenitores, un familiar, entre otros.

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Ley Núm. 57 del año 2023- Ley para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores

- Esta ley también esclarece las prerrogativas y límites que tiene el Departamento de la Familia en cuanto a la determinación administrativa de donde ubicar a un menor. Asimismo, se aclara, con bastante especificidad, lo que se espera de los manejadores de casos de dicha agencia en cuanto a la preparación de diferentes planes dirigidos a preservar la unidad familiar a través de fomentar el regreso del menor a su hogar, en caso de ser removido, su ubicación permanente con algún recurso familiar o mediante el mecanismo de la adopción.

- En cuanto a las acciones judiciales la presente ley detalla con bastante especificidad los diferentes pasos a seguir en todas las etapas de los procesos de protección de menores ante nuestros tribunales. Ello incluye los términos de tiempo para la celebración de diferentes vistas críticas, el lenguaje que debe utilizarse en las órdenes, resoluciones y sentencias, entre otros. Los términos de tiempo para llevar a cabo esfuerzos razonables de reunificación también se revisaron ante la necesidad y posibilidad de proveer servicios de esta índole a las familias por más de seis (6) meses. Todo esto se hace con el objetivo de fomentar la implementación de esta ley de una manera uniforme a través de todos los tribunales de Puerto Rico.

Ley Núm. 57 del año 2023- Ley para la Prevención del Maltrato, Preservación de la Unidad Familiar y para la Seguridad, Bienestar y Protección de los Menores

Responsabilidades del Departamento de Salud

- Proporcionar servicios de diagnóstico y tratamiento médico a los niños maltratados y a sus familias;
- Proporcionar formación a los profesionales médicos y no médicos sobre los aspectos médicos del maltrato infantil;
- Proporcionar evaluación y atención médica prioritaria a los niños bajo la custodia del Departamento, y suministrar los medicamentos prescritos;
- Garantizar los servicios sanitarios a los niños bajo el cuidado del Departamento, independientemente del lugar en el que se encuentren;
- Coordinar la prestación de servicios de adicción y salud mental con el Plan de Servicios del Departamento.
- Establecer programas de servicios para niños maltratados con necesidades especiales de atención sanitaria; y
- Proporcionar asesoramiento experto en cuestiones de salud y experiencia en situaciones de abuso institucional y/o negligencia institucional en instituciones educativas;
- Garantizar que los proveedores o entidades privatizadoras de servicios y establecimientos de salud mental ofrezcan atención inmediata a las situaciones de maltrato, así como a los medicamentos, y que cumplan con las obligaciones aquí impuestas al Departamento de Salud.
- Desarrollar acuerdos de colaboración con las entidades gubernamentales obligadas por esta Ley a proveer servicios de salud mental o de adicción a menores, padres, madres o persona responsable de un menor que haya incurrido en una conducta abusiva.

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Contactos del Programa de ADFAN del Departamento de la Familia

Dirección Física

- Roosevelt Plaza Building
  185 Avenida Roosevelt
  Hato Rey, Puerto Rico 00918

Dirección Postal

- P.O. Box 194090
  San Juan, PR 00919-4090

Teléfono:

- 787-625-4900

Línea de ADFAN
Hotlines
787-749-1333/ 1-800-981-8333

- **Líneas directas de orientación**
  787-977-8022 1-888-359-7777

“Ley para la Prevención e Intervención con la Violencia Doméstica” Ley Núm. 54 de 15 de agosto de 1989, según enmendada

¿Qué establece la ley?

Ley 54 de 15 de agosto de 1989, según enmendada

- Establecer un conjunto de medidas dirigidas a prevenir y combatir la violencia doméstica en Puerto Rico; definir los delitos de Maltrato, Maltrato Agravado, Maltrato por Amenaza, Maltrato por Restricción de la Libertad y Agresión Sexual Conyugal, y establecer sanciones;
- Facultar a los tribunales a emitir Órdenes de Protección para las víctimas de violencia doméstica y establecer un procedimiento fácil y expedito para la tramitación y adjudicación de las mismas; establecer medidas dirigidas a la prevención de la violencia doméstica y ordenar a la Oficina de la Procuradora de las Mujeres la divulgación y orientación a la comunidad sobre los alcances de esta Ley y la asignación de fondos.
- En 2022 se incluyó la amenaza de maltrato o abuso de animales domésticos dentro de las conductas delictivas que forman parte de la definición de violencia doméstica.

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¿Qué es violencia doméstica?

Es un tipo de violencia de género que se da en personas que son o fueron pareja y entre las que hubo una relación consentida. No es necesario que vivan juntos o que hayan tenido hijos juntos.

La violencia doméstica incluye:

- la violencia física,
- psicológica,
- intimidación o amenazas,
- la agresión sexual y
- privación de libertad

A veces, el agresor no causa daño directamente a la superviviente, sino que daña las cosas de la superviviente o de otras personas con el fin de causar un daño emocional a la superviviente.

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Información de Contacto de la Oficina de la Procuradora de las Mujeres

Dirección Física

- 161 Avenida Juan Ponce de León
  San Juan, 00917

Dirección Postal

- Box 11382
  Fernández Juncos Station
  San Juan, PR 00910-1382

Teléfonos:

- Tel: (787) 721-7676
- Libre de costo: 1-877-722-2977
  Fax: 787-721-7711
  TTY: 787-725-5921
- **Email:** **intercesoraslegales@mujer.pr.gov**.

Ley del Programa de Prevención y Seguridad para las Víctimas de la Violencia de Género. Ley núm. 3 del 18 de enero de 2022

Programa de prevención y seguridad para las víctimas de la violencia de género

- La violencia de género se produce cuando una persona muestra comportamientos que causan daño físico, sexual o psicológico a otra persona motivados por los estereotipos de género creados por la sociedad.
- Estadísticamente, en la mayoría de estos casos las víctimas son mujeres en situaciones de violencia ejercida por hombres. Esto incluye a mujeres de diversas edades y contextos sociales, educativos y económicos. Sin embargo, cualquier persona puede verse afectada por la violencia de género
- El concepto de violencia incluye amenazas, agresiones, persecución y aislamiento, entre otras acciones similares. Estas acciones pueden ocurrir en lugares públicos y privados, y manifestarse en el trabajo, la comunidad, la familia, las amistades, las relaciones, los profesores e incluso por parte de desconocidos.

¿Qué establece la ley?

- Para adoptar y crear la "Ley del Programa de Prevención y Seguridad para las Víctimas de Violencia de Género" para proteger a las víctimas de violencia de género que tengan una orden de protección, mediante la integración de servicios y alianzas entre la Policía de Puerto Rico, la Policía Municipal y la Rama Judicial; y para otros fines.
- Esta Ley no excluye cualquier otra iniciativa de la Rama Ejecutiva que pueda unir esfuerzos para brindar seguridad a las víctimas de violencia de género al amparo de la declaración de emergencia emitida en la Orden Ejecutiva del Boletín Administrativo Núm. 2021-013.
- Cualquier protocolo o proceso aprobado bajo dicha Orden Administrativa se incluirá como parte del programa de vigilancia y seguridad ordenado en esta Ley, sin perjuicio de las facultades constitucionales de la Asamblea Legislativa de Puerto Rico.

Protocolo de Prevención y Detección de Posibles Casos de Explotación Financiera a Personas de Edad Avanzada o Adultos con Impedimentos

¿Qué es Explotación Financiera?

- La *Explotación Financiera* es una modalidad de maltrato hacia las personas de edad avanzada o un adulto con impedimento en la que incurren familiares, amigos, vecinos, personas encargadas del cuidado, entre otros.

- La Ley Núm. 121-1986 define la explotación financiera como el uso impropio de los fondos de una persona de edad avanzada capacitada o un adulto con impedimento, de su propiedad o recursos por otro individuo, incluyendo, pero no limitándose a fraude, falsas representaciones, malversación de fondos, conspiración, falsificación de documentos, falsificación de récords, coerción; transferencia de propiedad mediante fraude o negación de acceso a bienes.

Explotación Financiera - Razones

Algunos factores que contribuyen a que ocurra la Explotación:

- La situación económica de hijos e hijas
- El uso y abuso de substancias controladas por familiares cercanos
- Confiar u ofrecer información de asuntos económicos a terceras personas
- Condiciones de salud que limitan la capacidad mental del adulto de edad avanzada o adulto con impedimento
- Cambios en los patrones tradicionales de manejo de las cuentas bancarias
- Riñas entre hijos(as) por los recursos de los padres.

Indicadores de Explotación

Algunos indicadores de Explotación Financiera en personas de edad avanzada son:

- Reducción significativa de los balances en cuentas de ahorros o cuentas corrientes de forma súbita o atípica
- Cancelación de certificados de depósitos antes de la fecha de maduración
- Pagos por débito directo de cuentas de terceras personas
- La víctima carece de atención a sus necesidades básicas en comparación con sus recursos económicos
- Falsificación de firmas
- Cuentas sin pagar
- Suspensión de servicios de agua, luz y teléfono
- Notificaciones de embargo
- Retiro en efectivo de cantidades significativas de sus cuentas o cambios en los patrones de consumo
- Solicitudes o firma de préstamos
- La compra de vehículos o propiedades sin el consentimiento de la víctima
- Venta de vehículos o propiedades
- Compra o cancelación de pólizas de seguros

Factores que aumentan el riesgo

- Aislamiento
- Soledad
- Miembros de la familia con problemas de acción a drogas, alcohol o al juego
- Incapacidad física o mental de la víctima que la hace dependiente de la ayuda de otro
- Falta de destrezas para manejar asuntos financieros o tecnológicos
- Muerte del cónyuge que se encargaba de los asuntos financieros o de los hijos que le ayudaban en esta área

¿Cómo evitar la Explotación Financiera?

Información que nuestros Beneficiarios deben conocer:

- Identifique y seleccione cuidadosamente a la persona con quien compartirá sus asuntos financieros
- Proteja su chequera, tarjetas de crédito o ahorros, estados financieros, y cualquier otro documento sensitivo, en un lugar seguro
- No comparta su número de Seguro Social o número secreto del cajero automático (ATH) con ninguna persona, especialmente vía teléfono

Penalidades

La Ley Núm. 146-2012, establece las siguientes penalidades:

- En los casos en que la cantidad de los fondos, activos o propiedad mueble o inmueble envueltos en la explotación financiera de la persona de edad avanzada o con impedimentos, sea de hasta $2,500.00, el ofensor incurrirá en delito menos grave. En los casos mayores de esta cantidad , incurrirá en delito grave.

- En todos los casos, el Tribunal impondrá la pena de restitución en adición a la pena establecida.

Leyes Aplicables

Las siguientes leyes protegen a las personas de edad avanzada de la Explotación Financiera:

- Ley Núm. 121-1986, según enmendada, conocida como la *"Carta de Derechos de las Personas de Edad Avanzada".*
- Ley Núm. 206-2008, la cual ordena al Comisionado de Instituciones Financieras, a la Corporación Pública para la Supervisión y Seguro de Cooperativas de Puerto Rico y a la Oficina del Comisionado de Seguros a implantar aquellos reglamentos necesarios, a fin de requerirle a las instituciones financieras, cooperativas o de seguros que operan en Puerto Rico a que establezcan un protocolo de prevención y detección de posibles casos de explotación financiera a personas de edad avanzada o con impedimentos. Estas entidades están obligadas a referir situaciones en las que se sospecha explotación financiera.
- Ley Núm. 146-2012, según enmendada, conocida como el *"Código Penal de Puerto Rico"*, en sus Artículos 127-C y D Explotación Financiera de Personas de Edad Avanzada, exponen modalidades y penas, entre otros, para personas que cometen este delito.

Información de Contacto

Todo proveedor o entidad delegada tiene la responsabilidad de referir cualquier potencial situación de Explotación Financiera a:

Departamento de Cumplimiento Medicaid

Liza Rivera-Ortiz, Oficial de Cumplimiento Medicaid

MMM Holdings, LLC

P.O. Box 71114

San Juan, PR 00936-8014

Cel. 787-918-7332

Correo electrónico: liza.rivera@mmmhc.com

Por Internet a través de la página "Ethics Point" (por su nombre en inglés): www.psg.ethicspoint.com

Línea telefónica de "EthicsPoint": 1-844-256-3953

Refiere a través de correo electrónico: VitalSIU@mmmhc.com

Departamento de Cumplimiento Medicare Advantage

Myra Plumey, Chief Compliance Officer

MMM Holdings, LLC

P.O. Box 71114

San Juan, PR 00936-8014

Tel. 787-622-3000, Ext. 2061

Cel. 787-379-3327

Correo electrónico: myra.plumey@mmmhc.com

Por Internet a través de la página "Ethics Point" (por su nombre en inglés): www.mmmpr.ethicspoint.com

Línea telefónica de "EthicsPoint": 1-877-307-1211

Refiere a través de correo electrónico: SIU@mmmhc.com

MMM Holdings

Información de Contacto

Todo **empleado de MMM** tiene la responsabilidad de reportar cualquier situación de conducta inapropiada :

- Sospechas u observas cualquier conducta inapropiada, incluyendo violaciones al Código de Conducta, políticas y procedimientos de la compañía, leyes y regulaciones o alguna otra situación, usted debe reportar a través de;
  1. Hablar con su supervisor inmediato
  2. Completar la solicitud a través de la web:**elevancehealthethicshelpline.com**
  3. Llamar a la línea de ayuda de Ética & Cumplimiento: (877-725-2702)
  4. Enviar un correo electrónico a: **ethicsandcompliance@elevancehealth.com**
  5. Enviar una carta a la siguiente dirección:

Ethics Department
VP, Chief Ethics and Privacy Officer
220 Virginia Avenue
Indianapolis, IN 46204 United States

Gracias por su atención

MMM Multihealth, LLC.

Compliance Program Addendum for the Government Health Plan Program in Puerto Rico (Vital Plan)

This Compliance Program Addendum applies to all employees, directors, contractors, Providers, enrollees, subcontractors, and delegated entities that work with the Puerto Rico Government Health Plan Program, Vital Plan.

PO Box 72010 San Juan PR 00936-7710

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PO Box 72010 San Juan PR 00936-7710

I. Compliance Program Preface

The legal entity MMM Multihealth, LLC, who contracts with the Puerto Rico Health Insurance Administration (*Administración de Seguros de Salud de Puerto Rico*, hereinafter referred to as ASES) is governed by a separate Code of Conduct, Compliance Program, and Fraud Waste and Abuse (FWA) Prevention Plan from the parent organization, Elevance Health. In addition, MMM Multihealth established this Addendum of the Compliance Program to assure the integration of all requirements established by ASES detailed in the contract between both parties in the administration and delivery of services for the Puerto Rico Government Health Plan Program (Plan Vital).

MMM Multihealth has built a strong Compliance Program to assure that patient care and services are provided consistent with all applicable Federal and State laws. The Compliance Program has been designed in accordance with relevant and applicable requirements of the Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General (OIG), Medicaid Program Integrity Office, Health Insurance Portability and Accountability Act (HIPAA), ASES, the Office of the Advocate for Patient Bill of Rights of the Commonwealth of Puerto Rico, the Offices of State Insurance Commissioners, among others.

The main objective is to comply with reporting requirements, identify risk areas, prevent FWA, misconduct and operational inefficiencies, enhance operational functions, improve the quality of healthcare service, and decrease the cost of healthcare.

The Compliance Program is intended to provide a framework for compliance efforts on an individual, departmental and enterprise-wide basis and to apply to all personnel and functions. Detailed policies and procedures and work plans developed by individual departments shall fit within the scope of this Program. PI and Compliance oversight responsibilities and functions aren't delegated to any vendor and all of our program integrity activities are performed by our organization's employees locally in Puerto Rico. A Medicaid Compliance Officer (CO) leads MMM Multihealth Program Integrity operations for Plan Vital and has the overall responsibility and accountability for compliance matters. However, every MMM Multihealth employee or agent remains responsible and accountable for their compliance with applicable laws and regulations as well as MMM Multihealth policies and procedures.

II. Compliance Program Summary

This Compliance Program manual is intended to provide guidance and support all employees in the day to day operation to comply with Federal and State laws, and serve as a mechanism for preventing and reporting any violation to those laws and regulations.

Our Program incorporates the following requirements:

- Implementing written policies, procedures, and standards of conduct
- Designation of a Medicaid Compliance Officer, a Compliance Committee, and a Fraud, Waste and Abuse Committee
- Conducting effective training and education (to members, providers, employees, and subcontractors)
- Developing effective lines of communication
- Conducting internal monitoring and auditing
- Enforcing standards through well-publicized disciplinary guidelines
- Responding promptly to detected offenses and undertaking corrective action
- Implementing a process to check for services not rendered
- Implementing a process for payment suspension and excluded providers/

It is the policy of MMM Multihealth that:

1) Board members, all employees, subcontractors, providers, and delegated entities are instructed regarding applicable laws and trained in matters of compliance;
2) There is periodic auditing, monitoring, and oversight of compliance with those laws;
3) An atmosphere exists that encourages and enables the reporting of non-compliance without fear of retribution;
4) Responsibility is not delegated to persons with tendencies to act in a non-compliant manner, and;
5) Mechanisms exist to investigate, discipline, and correct non-compliance.

The Compliance Program contains policies and procedures relative to the business of Vital Plan and all its beneficiaries. This Compliance Program is not intended to serve as the Compliance Program for clients or contractors of MMM Multihealth, they should adopt their own program in compliance with all ASES' requirements. MMM Multihealth doesn't assume the responsibility of developing a Compliance Program for their clients. However, it is the responsibility of clients, providers, contractors, subcontractors, and delegated entities to report any non-compliance issue, FWA incidents, and violations of law to MMM Multihealth in a timely manner.

As required by ASES, MMM will present any changes to the Compliance Plan and Fraud, Waste, and Abuse policies and procedures to the Medicaid Program Integrity Office and ASES for approval within fifteen (15) calendar days of the date MMM will implement any change to the Program. Those changes shall not go into effect until ASES provides prior

written approval. A paper and an electronic copy of the Compliance Plan will be provided to the Medicaid Program Integrity Office and ASES annually. The Medicaid Program Integrity Office and ASES shall provide notice of approval, denial, or modification to MMM within thirty (30) calendar days of receipt. MMM will make any necessary changes required by the Medicaid Program Integrity Office and ASES within an additional thirty (30) calendar days of the request.

III. Compliance Program Applicability

Everyone employed and/or contracted by MMM Multihealth and its affiliated companies are required to comply with the Medicaid Compliance and Integrity Programs. The agreements established with contractors, providers, and subcontractors should have certain provisions of this Compliance Program and all the instances or issues related with FWA, misconduct, or violations must be reported to MMM Multihealth.

IV. Your Role

This Compliance Program is only effective if everyone takes it seriously and commits to comply with all aspects. It is important that you not only understand and comply with the words written in this Compliance Program, but that you also understand and appreciate the spirit and purpose of this Compliance Program. When in doubt, ask your supervisor, review the appropriate section of this Compliance Program, call your Compliance Officer, or take other steps to ensure that you are following the Compliance Program. Compliance requirements are ever-changing. We must all keep this Compliance Program current and useful. You are encouraged to let your supervisor know when you become aware of changes in any law or MMM Multihealth policy that might affect this Compliance Program.

V. Compliance Program Components:

1. *Board of Directors (BOD)*

The Board of Directors (BOD) must exercise reasonable oversight with respect to the implementation and effectiveness of MMM Multihealth Compliance and Integrity Programs.

The BOD may delegate compliance program oversight to a specific committee of the governing body, but the BOD remains accountable for reviewing the status of the compliance program. The BOD is responsible of conduct reasonable oversight of the Compliance Program. This includes, but is not limited to:

1. Approving the Standards of Conduct (this should be performed by the full governing body and not a committee);
2. Understanding the compliance program structure;
3. Remain informed about the compliance program outcomes, including results of internal and external audits;
4. Remain informed about governmental compliance enforcement activity such as Notices of Non-Compliance, Warning Letters and/or more formal sanctions;
5. Receives regularly scheduled, periodic updates from the Compliance Officer and Compliance Committee;
6. Reviewing the results of performance and effectiveness assessments of the Compliance Program.

Also, the BOD may be involved in the following activities or may delegate some or all of these activities to Senior Management or to the Compliance Committee:

- Development, implementation, and annual review of compliance policies and procedures;
- Approval of compliance policies and procedures;
- Review and approval of Compliance and FWA Training;
- Review and approval of Compliance and FWA Risk Assessment;
- Review of internal and external Audit Work Plans and audit results;
- Review and approval of Corrective Actions Plans (CAPs) resulting from audits;
- Review and approval of appointment of the CO;
- Review and approval of performance goals for the CO;
- Evaluation of the senior management team commitment to ethics and the compliance program; and
- Review of dashboards, scorecards, self-assessment tools, etc., that reveal compliance issues.

2. ***Medicaid Compliance Officer (CO):***

MMM Multihealth has a CO who serves as the primary supervisor of this Compliance Program. MMM CO occupies a high-level position within the organization and has authority to carry out all compliance responsibilities set forth in this Compliance Program. The CO is responsible for assuring that the Compliance Program is administered to ensure that MMM Multihealth and its affiliates, and their respective personnel, at all times maintain business integrity and that all applicable laws, regulations, rules, and guidelines are followed. The CO provides frequent reports to the Board of Directors about the Compliance Program and compliance issues.

The CO reports to the Board of Directors on compliance issues. The Board of Directors is ultimately responsible for supervising the work of the CO and maintaining the standards of conduct set forth in the Compliance Program. The CO also prepares routine reports

for the CEO. Any significant findings in the interim are reported immediately to the CEO. The report includes:

- Level of compliance/non-compliance found because of monitoring and auditing;
- Training and Education efforts;
- Corrective or Disciplinary Action(s);
- Communication between the CO and employees, contractor, subcontractors, and Delegated Entities.

The Board of Directors oversees all of MMM Multihealth' compliance efforts and shall take whatever actions appropriate and necessary to ensure that MMM conducts its activities in compliance with the law and sound business ethics.

The CO and Board of Directors shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

<u>CO Responsibilities:</u>

The CO 's specific responsibilities include the following:

- Develop compliance policies and standards for MMM Multihealth;
- Achieve and keep compliance with relevant laws, regulations, and other applicable requirements;
- Appoint employees to serve in various roles, to complete any tasks as needed to promote and conform the applicable requirements under law, regulation or other authoritative guidance;
- Ensure that Medicaid compliance reports are provided regularly to the plan's Corporate CO (if any), Governing Body, CEO, and Compliance Committee. Reports should include the status of the plan's Medicaid Compliance Program implementation, the identification and resolution of suspected, detected or reported instances of noncompliance, and the plan's compliance oversight and audit activities;
- Be aware of daily business activity by interacting with the operational units of the plan;
- Create and coordinate, by appropriate delegation, if desired, educational training programs to ensure that Officers, Governing Body, Managers, Employees, Providers, Beneficiaries, FDR's, and other Individuals working in the Medicaid Program are knowledgeable about the plan's Compliance Program, its written Standards of Conduct, compliance policies and procedures, and all applicable statutory and regulatory requirements;
- Develop and implement methods and programs that encourage Managers and Employees to report Medicaid program noncompliance and potential FWA without fear of retaliation;
- Maintain compliance reporting mechanisms;

- Respond to reports of potential FWA, including the coordination of internal investigations with the FWA Department and the development of appropriate corrective or disciplinary actions, if necessary. To that end, the CO should have the flexibility to design and coordinate internal investigations;
- Ensure that DHHS OIG and Government Services Administration ("GSA") Exclusion lists have been checked with respect to all Employees, Governing Body Beneficiaries, and Delegated Entities, monthly and coordinating any resulting personnel issues with the plan's Human Resources, Security, Legal or other departments as appropriate;
- Maintain documentation for each report of potential noncompliance or potential FWA received from any source, through any reporting method (e.g., hotline, mail, ethics point, email or in-person);
- Oversees the development and monitoring of the implementation of CAPs;
- Coordinate potential fraud investigations and prompt referrals to the appropriate government and/or law enforcement agencies. This includes, facilitates in a timely manner any documentation or procedural requests received;
- Collaborate with other health plans, State Medicaid programs, Medicaid Fraud Control Units (MCFUs), the Office of Inspector General (OIG), and other organizations, where appropriate, when a potential FWA issue is discovered that involves multiple parties.

The Medicaid Compliance Officer has the authority to:

- Interview or delegate the responsibility to interview employees and other relevant individuals regarding compliance issues;
- Review company contracts and other documents pertinent to the Medicaid Program;
- Review or delegate the responsibility to review the submission of data to regulatory agencies to ensure that it is accurate and in compliance with the applicable reporting requirements;
- Independently seek advice from legal counsel;
- Report potential FWA to ASES, Medicaid Program Integrity Office, HHS-OIG, MFCU, or law enforcement;
- Conduct and/or direct audits and investigations of any FDR;
- Conduct and/or direct audits of any area or function involved with Medicaid Program and;
- Recommend policy, procedure, and process changes.

Also, the CO has authority to review all documents and other information relevant to compliance activities, including, but not limited to: patient records, billing records, records concerning marketing efforts, and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents, and physicians.

3. *Compliance Committee (CC) and FWA Compliance Committee (FWAC):*

MMM MH has established a Compliance Committee to advise the CO and assist in the monitoring of this Compliance Program. The CO provides the perspectives of individuals with varying responsibilities in MMM Multihealth, including Finance, Human Resources, Legal, and Information Technology, as well as Employees and Managers of key operating units.

The status of all Program Integrity and Compliance activities is reported on a quarterly basis to the Compliance Committee, or during ad hoc meetings as needed. The Committee provides a forum for health plan leadership to review and discuss emerging issues and upcoming activities, regulatory reporting, and contract changes; assess potential compliance risks; and provide input into mitigation activities. MMM Compliance Program is approved on an annual basis by the Compliance Committee.

Members of the CC:

The Compliance Committee is comprised at a *minimum* of the following executive leadership:

- MMM Multihealth CO
- President
- Chief Medical Officer (CMO)
- Chief Operational Officer (COO)
- Security Officer (IT)
- Chief Financial Officer (CFO)
- Pharmacy Department Vice President
- Legal Counsel
- Others, as assigned

The Chief Compliance Officer serves as the chairperson of the Compliance Committee. The CC serves in strictly an advisory role and shall have no authority to adopt or implement policies or procedures. The CO will consult with the CC on a regular basis and may call meetings of all or some members of the CC.

The CC also reports on a quarterly basis to the Board of Directors subcommittee of the CC.

Functions of the Compliance Committee CC:

The CC's functions include the following:

- Meet at least on a quarterly basis, or more frequently as necessary to enable reasonable oversight of the compliance program;

- Develop strategies to promote compliance and the detection of any potential violations;
- Review and approve Compliance and FWA training, ensuring that training and education are effective and appropriately completed;
- Assist with the creation and implementation of the Compliance Risk Assessment and of the Compliance Monitoring and Auditing Work Plan;
- Assist in the creation, implementation and monitoring of effective corrective actions;
- Develop innovative ways to implement appropriate corrective and preventative action;
- Review effectiveness of the system of internal controls designed to ensure compliance with Medicare/Medicaid regulations in daily operations;
- Supporting the CO's needs for enough staff and resources to carry out his/her duties;
- Ensure that plan has appropriate, up-to-date compliance policies and procedures;
- Distribute written standards, including policies, that are readily understandable by all members and Employees (including policies that have been translated into other languages, if necessary) to members of the workforce with a need to know the applicable MMM MH Vital standards; and,
- Ensure that plan has a system for Employees and related entities to ask compliance questions and report potential instances of Medicaid program noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation;
- Ensuring that the plan has a method for enrollees to report potential FWA
- Reviewing and addressing reports of monitoring and auditing of areas in which the plan is at risk for program noncompliance or potential FWA and ensuring that corrective action plans are implemented and monitored for effectiveness; and
- Oversees the compliance program and the effectiveness of the program and the CO.
- Providing regular and ad hoc reports on the status of compliance with recommendations to the plan's governing body.
- Performs other functions as necessary to carry out the objectives of the Corporate Compliance Program.

The tasks listed above are not intended to be exhaustive. The CC may also address other compliance related issues as they evolve.

<u>FWA Committee (FWAC):</u>

The FWAC is a subcommittee of the CC. It was created to evaluate FWA investigations and collaborate in the decision making of actions to be taken regarding completed investigations resulting in FWA findings. The FWAC meetings consist of a discussion of FWA

investigations reports, case status, and cases that were closed and discharged since no actual FWA was identified.

4. **Training and Education**

MMM Multihealth acknowledges that the Compliance Program can only be effective if communicated and explained to personnel on a routine basis and in a manner that clearly explains its requirements. To that end, MMM requires all personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by MMM and each of its affiliates based on the needs and requirements of each affiliate. Employees are trained early in their employment and annually thereafter.

Training Programs include appropriate training in Federal and State statutes, regulations, guidelines, the policies and procedures set forth in this Compliance Program, and Corporate Ethics. Training Programs also include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards. All formal training undertaken as part of the Compliance Program is documented.

In general, the General Compliance Program and Fraud, Waste and Abuse (FWA) training, include information regarding the following:

a) A description of the compliance program, including a review of the compliance policies and procedures, the Standards of Conduct, and the organization's commitment to business ethics and compliance with all statutory, regulatory, and Medicaid program requirements.
b) An overview of how to ask compliance questions, request compliance clarification or report suspected or detected non-compliance or potential FWA. Training emphasizes confidentiality, anonymity, and non-retaliation for compliance-related questions, or suspected or detected non-compliance or potential FWA.
c) The requirement to report to the plan actual or suspected Medicaid program noncompliance or potential FWA.
d) Provide examples of reportable non-compliance that and Employee might observe and report.
e) A review of the disciplinary guidelines for non-compliant or fraudulent behavior which results in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported.
f) Attendance and participation in formal training programs are a condition of continued employment, and a criterion to be included in Employee evaluations.

g) A review of policies related to contracting with the government, such as the laws addressing fraud and abuse or gifts and gratuities for Government Employees.
h) A review of potential conflicts of interest and the Plan's disclosure/attestation system.
i) An overview of HIPAA and the importance of maintaining the confidentiality of Personal Health Information.
j) An overview of the monitoring and auditing work plan of the organization.
k) A review of laws that govern the Employee conduct in the Medicaid Program.

The following is a list of laws and regulations that may be discussed in the training:

- Title XVIII of the Social Security Act;
- Social Security Act, Title XIX;
- Social Security Act, Sections 1128, 1128A, 1156, 1842(j)(2), 1902(a)(68),1903(i)(2)(C) & 1909;
- 42 CFR 438.608, and the U.S. Department of Justice's Federal Sentencing Guidelines;
- 42 CFR 455.436, 456.3, 456.4, 456.23;
- Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119);
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191);
- The False Claims Act (31 U.S.C. 3729-3733);
- Federal Criminal False Claims Statutes (18 U.S.C. 287, 1001);
- Federal Anti-Kickback Statute (42 U.S.C 1320a-7a (a)(5));
- Civil Monetary Penalties of the Social Security Act (42 U.S.C. 139w-27 (g));
- Physician Self-Referral ("Stark") Statute (42 U.S.C. 1395nn);
- Prohibitions against employing or contracting with individuals or entities that have been excluded from doing business with the Federal Government (42 U.S.C. 1395w-27 (g)(1)(G);
- Fraud Enforcement and Recovery Act of 2009;
- The Deficit Reduction Act of 2005;
- Article 13 of the Contracts between ASES and MMM MH Vital. All sub-regulatory guidance produced by ASES, CMS and HHS such as manuals, trainings materials, memos, and guides;
- Medicare regulations governing Parts C and D found at 42 C.F.R. §§ 422 and 423 respectively;
- Medicaid Director Letter #09-001, January 16, 2009.
- Civil Monetary Penalties of the Social Security Act (42 U.S.C. § 1395w-27 (g));
- All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos, and guides.

Also, the training should address the following FWA topics:

- Laws and Regulations related to Medicaid, MA and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

- Definitions of FWA;
- Examples of Provider, Enrollee, Employee and subcontractor FWA;
- How to access FWA policies and procedures;
- Information regarding state and federal laws, including but not limited to the False Claims Act, Protection afforded to those who report FWA, how to report FWA, incorporates all CMS training curriculum standards listed in 42 C.F.R. §422.503(b)(4)(vi)(C)(3) (2014).
- Obligations to have appropriate policies and procedures to address FWA;
- Processes for plans and Employees to report suspected FWA to the plan (or, as to Employees, either to the plan directly or to their employers who then must report it to the plan);
- Protections for plan and Employees who report suspected FWA and;
- Types of FWA that can occur in the settings in which plan and Employees work.

Specific training for appropriate Corporate Officers, Managers, and other Employees may include areas such as:

- Restrictions on marketing activities;
- General prohibitions on paying or receiving remuneration to induce referrals;
- Proper claims processing techniques;
- Monitoring of compliance with this Compliance Program;
- Methods for educating and training Employees;
- Duty to report misconduct;
- Fraud, Waste and Abuse.

Training is provided upon hiring and annually thereafter. Attendance and participation in compliance and FWA training programs is a condition of continued employment or contracted. Failure to comply with training requirements will result in disciplinary action, including possible termination.

Adherence with the provisions of this Compliance Program, including training requirements, is a factor in the annual evaluation of each MMM employee. Outside contractors will be afforded the opportunity to participate in or required to develop (where applicable) their own compliance training and educational programs, to complement MMM Multihealth standards of conduct, compliance policies, and procedures. The CO will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions are maintained.

The Compliance and FWA trainings are in addition to any periodic professional education courses that may be required by statute or regulation for certain personnel. MMM expects that its board members, employees and contractors will comply with applicable education requirements and failure to do so could result in disciplinary action, including termination of contract or employment.

MMM MH is also responsible for developing and providing annual general compliance and fraud waste and abuse training or the appropriate training materials to delegated entities and ensuring that the training has been distributed and taken at the time of contracting and annually thereafter.

MMM delegated entities are also required to complete an annual FWA training. The entity may choose to use MMM training or their own if it satisfies Medicaid contractual requirements.

The Medicaid Compliance Department reviews and updates all education and training material on an annual basis, and as needed, to ensure it remains relevant and up to date with current laws, rules, and regulations. Training records are maintained for a minimum of ten (10) years.

Training for Network Providers and Subcontractors:

MMM offers providers initial and ongoing Compliance and FWA trainings per year. Education includes definitions and examples; reporting and investigation procedures; possible actions and outcomes; prevention (member verification, proper documentation, and bill accurately); and where to find more information. The annual training provided to all providers outlines our FWA Program (PIP) and provide detailed reporting instructions. The Provider Manual and our provider website also offers information about reporting FWA. All providers, contractors, subcontractors, and delegated entities contracts includes a requirement of collaborating with MMM Compliance Department with the Medicaid Compliance and Integrity Program initiatives.

Members Education on FWA Prevention:

We use multiple methods to engage and educate members on FWA prevention. We rely on collaboration of all stakeholders to have the most meaningful impact. Upon enrollment, we provide a welcome packet with a welcome newsletter, ID card that includes telephone number to report FWA, and instructions on how to access the member's handbook and MMM website, which includes orientation about how to report suspicious FWA events, provides the enrollee with examples of reportable issues, and the methods to report them.

5. **Lines of Communications and Reporting:**

The CO establishes and maintains effective lines of communication between the Medicaid Compliance Department, Contractors, provider, Subcontractor and Delegated Entities. This may include, but is not limited to, the use of a confidential hot line

(**1-844-256-3953)**, compliance drop boxes, e-mails: compliance_medicaid@mmmhc.com or VitalSIU@mmmhc.com, or web address www.psg.ethicspoint.com, so that, beneficiaries, contractors, subcontractors, and delegated entities may seek answers to compliance questions or report suspected acts of non-compliance, misconduct, and FWA.

For employees: Every employee has the responsibility to report Misconduct and Ethics : Suspected or observed misconduct, including violations of the code, company policies and procedures, laws and regulations, or other ethical concerns, should be reported to Ethics Departments. There are various channels to submit reports or ask questions; 1. Speak with an immediate supervisor or manager; 2. Fill out the online form at elevancehealthethicshelpline.com 3. Call the Ethics and Compliance HelpLine (877) 725-2702 4. Send an email to ethicsandcompliance@elevancehealth.com 5. Send a letter to; Ethics Department VP, Chief Ethics and Privacy Office 220 Virginia Avenue, Indianapolis 46204 United State

All employees, contractors, subcontractors, and delegated entities have the responsibility to comply with applicable laws and regulations and report any real or perceived acts of non-compliance. Any employee, contractors, subcontractor, and delegated entities who know of a non-compliant act and fail to report them will be subject to discipline. Reports can be made anonymously through the help line if the caller desires, although a name and phone number generally make investigating easier and more effective.

No employee or agent shall retaliate in any way against another employee for reporting an act of non-compliance. Written reports may be submitted in person, fax, or mailed to the attention of the CO at the corporate address:

350 Chardón Avenue **Suite 500 Torre Chardón** **San Juan, PR 00918-2101**	**MMM Multihealth** **PO BOX 71114** **SAN JUAN PR 00936-8014**

If mailed, the envelope should be marked **CONFIDENTIAL**.

It is recognized that questions will arise regarding compliance issues that employees want to have answered in a safe environment. Employees, beneficiaries, providers, contractors, subcontractors, and delegated entities may call the help line to receive answers in a confidential manner or may come to the Medicaid Compliance Department in person.

6. Standards, Policies, and Procedures and Enforcement:

Policies

MMM has written policies, procedures and standards of conduct that;

- Articulate the organization's commitment to comply with all applicable Federal and state standards;
- Describe compliance expectations as embodied in the Standards of Conduct;
- Implement the operation of the compliance and FWA program;
- Provide guidance to Employees and others on dealing with suspected, detected or reported compliance and potential FWA issues);
- Identify how to communicate compliance issues to appropriate compliance personnel;
- Describe the operation of the hotline and other reporting mechanisms;
- Describe how suspected, detected or reported compliance and FWA issues are investigated and resolved by the organization;
- Describe methods to detect potential noncompliance or FWA issues;
- Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials;
- Establish the process to collect overpayments as results of the audits process;
- Describe the Compliance and FWA trainings requirements; and
- Describe the process for recipient verification of claims billed.

It is the policy of MMM to render appropriate discipline for failure of any company personnel to comply with the Code of Ethics and Business Conduct, policies, and procedures set forth in, or adopted pursuant to Elevance Health and MMM Compliance Program, or any federal or state laws or regulations.

The guiding principles underlying MMM policies include the following:

- Intentional or reckless noncompliance should subject personnel to significant sanctions, which may include verbal warnings, suspension, or termination of employment, depending upon the nature and extent of the noncompliance;
- Failure to comply with the policies and procedures set forth in this Compliance Program, or with other applicable laws, should also result in sanctions;
- Disciplinary action should be taken where a responsible Employee fails to detect a violation, where such failure can be attributed to their negligence or reckless conduct;
- Internal audit or review may lead to discovering violations and could lead to disciplinary action;

- All levels of employees are subject to the same disciplinary action for the commission of similar offenses. Because MMM takes compliance seriously, MMM must respond to personnel misconduct.

Compliance as an Element of Performance:

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all MMM Multihealth employees, contractors, subcontractor, and delegated entities. Employees, contractors, subcontractors, and delegated entities will be periodically trained regarding the Compliance Program, and new compliance policies and procedures that may, from time to time, be adopted. All Managers and Supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following.

- Discuss, as applicable, the compliance policies and procedures and legal requirements set forth in this Compliance Program with all supervised personnel and all contractors and agents.
- Inform all supervised personnel that strict compliance with this Compliance Program is a condition of continued employment. Disclose to all supervised personnel and contractors that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and provided MMM with the opportunity to take corrective action.

Discipline Procedures

Any Employee found that have violated any provision of this Compliance Program or the Organization's policies and procedures can be subject to discipline, including termination of employment if deemed appropriate by MMM. Any disciplinary action taken shall be fair and equitable and within the sole discretion of MMM.

In severe and/or repeated cases, coordination with the responsible Department Director and Director of Human Resources shall take place to discuss progressive discipline including the possibility of immediate termination. The Human Resources Department is a key element in this process. Human Resources policies establish the degrees of disciplinary actions that may be imposed upon corporate officers, managers, and

employees, for failing to comply with the Organization's policies and applicable statues and regulations.

Upon determining that an Employee from MMM or any of its affiliates has committed a violation of this Compliance Program, said employee shall meet with their supervisor to review the conduct that resulted in violation of the Compliance Program.

The employee and supervisor will discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Human Resource Department and/or the CO during the investigation of any violation. Legal counsel must be consulted prior to final actions or punitive measures.

7. Auditing and Monitoring

The CO is responsible for periodic monitoring of compliance with applicable laws, regulations, and policies. If the CO or their designee discovers that a department or individual level of compliance is unacceptable, they may require a corrective action plan (CAP), which includes future monitoring of the process until identified issues have been resolved.

Annually, the CO develops an auditing and monitoring plan, identifying the areas that will be focus of auditing and monitoring based on an Annual Risk Assessment conducted by the CO. The risk assessment tool will be used to identify and analyze where noncompliance could potentially result in a significant risk or penalty to MMM Multihealth. The Work Plan is submitted on an annual basis to the Compliance Committee for feedback and approval and they are updated at least quarterly to incorporate new program policies or requirements and to reflect emerging issues or evolving best practices.

Audits will be conducted to ensure compliance with Federal and State regulations and performance standards. The performance standards used will be consistent with the contract agreement with ASES for the Government Health Plan, as well as any other Federal and State regulation. The scope and frequency of audits may vary depending on prior findings and compliance rate improvement.

The periodic review process may include the following techniques:

- Interviews with personnel involved in management, operations, claim development and submission, and other related activities;
- Questionnaires developed to solicit impressions of personnel;
- Review of claims to identify red flags (e.g. Under/over utilization, outliers or suspicious billing patterns;
- Reviews of medical records, case files, financial records, and any other source

documents that support claims for reimbursement and claims submissions, including enrollment and reconciliation date;
- Review of enrollee's complaints and trends regarding Providers;
- Reviewers will present a written report on compliance activities to the CO. The report shall specifically identify areas, if any, where corrective actions are needed. In certain cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.
- 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 MMM MH Vitals' compliance efforts.

Compliance Program Effectiveness:

On an annual basis, the Compliance Department completes an annual evaluation and report of the effectiveness of the previous year's auditing and monitoring activities, including:
- Summary of key goals and corresponding audit, monitoring, and reporting activities;
- Analyses of audit, monitoring and reporting effort and commentary regarding changes to the initial plan;
- Brief description of critical issues identified;
- Projects planned but not executed due to change in priorities and resources;
- Update on staffing levels, experience, and training.

Opportunities identified during the execution of the Annual Work Plan and lessons learned from previous years are considered to stablish best practices that will guide the development of the Work Plan for the next year.

The Medicaid Compliance Department will use fewer formal measures to monitor the compliance program effectiveness such as self - assessment tool, dashboards, or scorecards in support of the Compliance Program effectiveness audit. The CO will share results with the Compliance Committee and Senior Management.

Fraud, Waste and Abuse (FWA) Issues:

A potential FWA incident could be identified internally by the Medicaid Compliance Specialist, through data analysis, also, external referrals of suspicious activities could be received from other MMM employee or through external referrals, from enrollees, providers, local and federal agencies, or any other Individual. Once the issue is identified the Compliance Specialist performs an initial screening. The screening consists in conducting an overview of the allegation received and the merits of the referral, to

assess if the situation consists of a systematic, operational or informational error. If the issue involves an operational or informational error, it will be referred to the applicable area for correction. However, If the result of the initial screening includes elements of suspicious of fraud, waste or abuse, the case will be referred to the FWA Investigator to conduct a preliminary investigation. If the preliminary investigation leads to a potential FWA, or it is determined that there is enough basis to continue investigating, a full investigation is conducted. A full investigation consists of detailed data analysis, evaluation of utilization or billing patterns, desk or onsite audits, interviews, record reviews, among other research activities regarding the investigated individual or entity. Depending on the results of the full investigation, the case may be referred to the corresponding law enforcement and/or regulatory agencies. See more information on MMM Medicaid Program Integrity Plan.

Delegation Oversight:

MMM remains ultimately accountable for all services provided to Plan Vital membership by other entities, although functions may be delegated. MMM oversees and evaluates the performance of its delegated entities by:

- Reviewing routine periodic reports submitted by the entity;
- Conducting periodic and annual reviews of systems, staff, and policies and procedures;
- Tracking and analyzing complaints, and other performance indices.

Delegated entities are expected to comply with all Federal and State regulatory requirements for their delegated functions. Delegated entities must also ensure that its downstream entities and sub-delegates adhere to the processes outlined in their agreement with MMM Multihealth.

Our Delegation Oversight Program includes multiple touchpoints to monitor and discuss subcontractor performance:

Timing	Subcontractor Monitoring Activity
Daily	• Delegation Oversight staff are available as needed to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns
Monthly	• Delegation Oversight staff review subcontractor performance against standards, including trends and report submissions
Quarterly	• Delegation Oversight staff review performance with subcontractor during Joint Operations Committee (JOC) meetings

	• Report to the Delegation Oversight Committee any subcontractor update including additions, terminations, and performance issues • Report to the Quality Management Committee any quality issues with subcontractor performance • Discuss performance standards and metrics of subcontractors as well as new subcontractor additions, terminations, CAPs, and overall risk during the Compliance Committee
Annually	• Perform audits or reviews to confirm that subcontractor meets operational, financial, legal, compliance, regulatory, and ethical requirements • Present audit findings to the Delegation Oversight Committee and to the Compliance Committee

Pre-Delegation Audits:

Prior to selecting a subcontractor, MMM evaluates each prospective subcontractor's ability to perform activities to be delegated. Through pre-delegation audits, MMM documents that it has reviewed the entity's policies and procedures with respect to the delegated function and verifies that the contractor has devoted sufficient resources and appropriately qualified staff to perform the function(s). MMM will only delegate functions to a vendor capable of performing the delegated activities within the standards established by the organization, including compliance with all applicable Medicaid laws, Federal and Local regulations, and instructions. A formal report is developed and distributed to Executive Management, which are ultimately responsible for approving the entity to perform the delegated function(s) and executing an agreement. All delegation determinations are presented at MMM Delegation Oversight Committee.

8. Corrective Action Plan (CAP):

Violations to the Compliance Program, failure to comply with applicable Federal or State laws, and other types of misconduct threaten MMM Multihealth status as a reliable, honest, and trustworthy, MMM might prompt a request for a corrective action plan (CAP). Detected but uncorrected misconduct can seriously endanger MMM and its affiliates' reputations. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the CO to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. If a violation has occurred, prompt steps will be taken to correct the problem. As appropriate, such steps may include an immediate referral to criminal or civil law enforcement authorities, an establishment of a CAP, a report to the appropriate government organization, or submission of any overpayments. The specific steps that are

appropriate in any given case will be determined after consultation with the Legal Counsel.

Depending upon the nature of the alleged violations, the CO internal investigation could include interviews with relevant staff and a review of relevant documents. Legal Counsel, auditors, or subject matter experts may be engaged by the CO to assist in an investigation where the CO deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed, and the documents reviewed, results of the investigation (e.g. any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the CO believes the integrity of the investigation may be at risk because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the CO will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

A CAP will be also requested for internal audit findings. The performance of internal departments and delegated entities is also measured by the timely and accurate development and implementation of CAPs when performance falls below set expectations. Failure to develop and implement corrective actions may result in disciplinary action as recommended by the Compliance Committee and Senior Management. Disciplinary action may include sanctions, penalties, non-renewal of contract or termination. The corrective actions must be tailored to address the deficiency identified and must include timeframes for specific achievements.

9. Reporting

If the CO, Director, or any Manager discovers credible evidence of fraud, waste, abuse or misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported to the appropriate governmental authority or Federal or State law enforcement agency having jurisdiction over such matter. Said reports will be submitted in a timely manner. The CO will also report the results of any case investigation with possible fraudulent activities to ASES, Medicaid Program Integrity Office (MFCU), OIG, or other regulatory or law enforcement agencies, as necessary.

VI. Compliance Policies and Procedures:

The policies in this section are those applying to MMM Multihealth, Vital Plan. Additional

policies may be developed to supplement these policies to reflect the activities of MMM.

The following policies are included in this section:

- False Claims Act
- Anti-kickback and Self-Referral Laws
- Billing and Coding
- Employee and Contractor Screening
- Confidentiality of Healthcare Information
- Labor Laws

False Claims Act

The False Claims Act allows people **to** bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against groups or other individuals that are defrauding the government through programs, agencies, or contracts. The False Claims Act applies when a company or person:

- Knowingly presents a false or fraudulent claim for payment,
- Knowingly uses a false record or statement to get a claim paid,
- Conspires with others to get a false or fraudulent claim paid,
- Knowingly uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
- "Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information. An example would be if a health care Provider, such as a Hospital or a Physician knowingly "up codes" or overbills, resulting in overpayment of the claim using Medicaid or Medicare dollars.
- The time for a claim to be brought under the False Claims Act is the later of:
  - ✓ Within six (6) years from the date of the illegal conduct, or;
  - ✓ Within three (3) years after the date the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.
- It is the policy of MMM Multihealth to detect and prevent any activity that may violate the federal False Claims Act or the State Medicaid fraud laws. If any employee, provider, delegated entity, subcontractor, or agent has knowledge or information that any such activity may have taken place, they should contact the Medicaid Compliance Department. In addition, Federal and State law and MMM policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Medicaid Compliance Department.

- MMM also communicates the protections in place for its employees and enrollees in the applicable handbooks respectively.

Anti-Kickback and Self-Referral Laws:

Federal law, commonly known as the Medicare/Medicaid "Anti-kickback statute" (42 U.S.C. Section 1320a-7b(b)), prohibits giving anything of value, directly or indirectly, to any person to induce that person to refer, order or arrange for goods or services for which payment may be made under a federal healthcare program. Federal law also prohibits any person from offering or transferring anything of value to any person eligible for benefits under Medicare, Medicaid, or other federal healthcare program that such person knows or should know is likely to influence the person to order services from a particular Provider (Section 1128A(a)(5) of the Social Security Act).

Another federal law, commonly known as the "Stark Law" (42 U.S.C. Section 1395nn) generally prohibits physicians from referring Medicare or Medicaid patients to an entity for certain designated health services which are specifically listed when a physician has a financial relationship with that entity, unless the specific requirements of an exception under the Stark Law are satisfied. A financial relationship is any ownership interest or compensation arrangement.

- *The Penalties:* The penalties for violating these laws are severe. Violations of the federal anti-kickback statute include fines of up to $25,000 and imprisonment of up to 5 years. Violations of the Stark Law may result in denial of claims payment and civil monetary penalties of up to $15,000 for each violation.
- Many states have statutes like the federal anti-kickback statute and the Stark Law, which may apply to referrals for any patient, not just patients covered under federal healthcare programs. MMM General Counsel and Compliance Officer are familiar with State laws and should be consulted before entering into any agreement or arrangement with a referral source.
- Many people mistakenly believe that these laws apply only to doctors, hospitals, and other Providers of healthcare services. This is not the case. For example, payments to a marketing company to develop business can implicate the federal ant-kickback statute. Furthermore, even if a law appears to apply only to healthcare Providers, a non-provider involved in wrongful conduct could still be viewed, and prosecuted, as aiding or assisting in the violation of the law. Regardless of whether MMM MH Vital can ultimately be held liable under a law, Elevance Health Code of Ethics and Business Conduct requires that all personnel conduct themselves at all times in accordance with all laws. Conduct to the contrary places MMM, its personnel and its clients at risk.

Examples of how these laws might apply to MMM MH:

- ***Physician Compensation Systems:*** MMM MH Vital is engaged by a large, multi-specialty medical group to develop software for handling income distributions

to Physicians of the group based on factors such as productivity and profit benchmarks. If the formula developed rewards medical group members for ordering Medicare or Medicaid reimbursed laboratory services or X-rays performed by the group, the Stark Law could be implicated. MMM and its personnel must not attempt to act as legal counsel for their clients. MMM acknowledges that its personnel may be limited in their ability to detect and prevent potentially illegal arrangements between clients and third parties. The goal of MMM is to ensure that all personnel are acting in compliance with the law and making their best efforts to assist our clients in complying with the law. This Compliance Program is prepared with this goal in mind.

- ***Federal "Safe Harbors" and Exceptions to the Stark Law:*** The federal government has created "safe harbor" regulations under the anti-kickback law. A transaction that fully satisfies a safe harbor will not be subject to civil or criminal sanctions. There are also a number of exceptions to the Stark Law's general prohibition. Arrangements that satisfy the requirements of a particular exception are permitted under the Stark Law. The requirements of these safe harbors and exceptions are often complex and difficult to interpret. Personnel should not attempt to analyze arrangements under the anti-kickback safe harbors or Stark Law exceptions without the assistance of MMM MH Vitals' General Counsel or other legal counsel approved by MMM. Only MMM Legal Counsel may determine whether a particular arrangement complies with an anti-kickback law safe harbor or Stark Law exception.
- ***Common Issue: Physician Compensation:*** MMM, whether acting as a consultant or manager, is sometimes involved in establishing formulas and systems for physician compensation. If physicians in a medical group internally refer Stark Law covered services to the medical group (e.g., lab, X rays, and ultrasounds) the compensation they receive can implicate the Stark Law. An exception to the Stark Law that is commonly available in this situation is the exception for in-office ancillary services. This exception includes many elements, and only MMM Legal Counsel can determine whether a arrangement fully satisfies those requirements. However, when developing physician compensation systems, one fundamental element of the in-office ancillary services exception should be kept in mind. No physician in the group can either directly or indirectly receive compensation which varies with the volume or value of referrals by the physician for Medicare/Medicaid covered ancillary services. In other words, compensation systems must treat revenues derived from Stark Law covered Medicare/Medicaid services in a referral-neutral manner, and the referring physician's compensation may in no manner be connected to such referrals.

<u>Examples of Arrangements Commonly Covered by the Anti-Kickback Law or the Stark Law:</u>

- Physician Compensation Plans that include Medicare/Medicaid receivables

as a factor in determining compensation;
- Professional Service Agreements between Providers and entities to which those Providers refer;
- Space and Equipment Leases between Providers and entities to which they refer;
- Management Agreements that include marketing and promotional services;
- Joint ventures between hospitals and medical groups;
- Any other agreements between parties that are actual or potential sources of referrals for each other.

Other Policies:

MMM Vital has established the following policies to promote compliance with federal and State anti-kickback and self-referral statutes and regulations. Additional polices may be adopted by MMM based on the specific needs and activities.

- All contracts and other arrangements that in any way involve or relate to the referral of patients, or arranging for the referral of patients, to which MMM is a party must comply with all applicable anti-kickback and self-referral statutes and regulations.
- Company personnel cannot assist clients in negotiating or entering into contracts or arrangements that its personnel suspect may violate the anti-kickback or self-referral laws unless the client has been informed in writing of the concern and the client advises MMM that the client has received legal advice indicating the arrangement is permissible.
- In the event MMM personnel, while acting as a consultant or manager for a client, become aware that a contract or arrangement contemplated by the client potentially violates the anti-kickback or self-referral laws, the client shall be informed of the potential violation and advised to consult with qualified legal counsel. Personnel shall also inform MMM CO and General Counsel.
- No free gifts or services shall be provided by MMM personnel to beneficiaries of any government program (e.g. Medicare or Medicaid) to influence such beneficiaries' choice of Provider, nor shall personnel encourage or assist clients of MMM to offer such free gifts or services to such beneficiaries, unless such free gifts or services are offered in strict compliance with applicable laws as determined in advance by MMM General Counsel.
- No compensation, gift or gratuity of any kind may be provided in exchange for, or to induce, the referral of clients or customers to MMM, and personnel cannot solicit, offer or receive any payment or remuneration of any kind in exchange for referring or recommending the referral of clients or customers to MMM or to any hospital, physician or medical facility that is a client of MMM.
- In the event personnel are involved on behalf of clients in negotiating agreements with Providers who are able to make referrals to the client, the personnel shall recommend to the client the agreement be reviewed by the client's legal counsel.

- In the event MMM personnel encourage a client to have a particular contract or arrangement reviewed by legal counsel for compliance purposes, but the client fails or refuses to do so, MMM General Counsel or CO shall be contacted to determine the proper course of action to be taken.
- When engaged to negotiate contracts between healthcare clients and their referral sources or entities to which they refer, all negotiations shall be conducted in a manner consistent with high ethical standards and based on the concept that all such agreements should involve the exchange of services for payment that is consistent with fair market value for the goods or services being provided, without accounting for the volume or value of referrals between the parties.
- No personnel shall provide any item, service or other benefit to any patient, physician, payer or other customer at less than fair market value in order to induce referrals to, or for recommending or arranging for referrals to, MMM or any of its clients, unless approved in advance by MMM Legal Counsel.
- No discount shall be offered or given by personnel to any patient, physician, payer or other referral source of MMM or its clients, unless approved in advance by MMM Legal Counsel.
- Only MMM Legal Counsel, or other designated legal counsel, is authorized to determine whether a particular arrangement to be entered into by MMM or any of its subsidiaries satisfies a federal antikickback law safe harbor or a Stark Law exception. MMM personnel must consult with MMM Legal Counsel before entering into arrangements.
- When hiring personnel or entering into arrangements with outside contractors to perform services or provide goods that are in any way related to the Medicare, Medicaid, CHAMPUS, or any other government healthcare program – whether such arrangements are for the benefit of MMM or a client – the person or entity to be hired or contracted must not be subject to exclusion from participation in federal healthcare programs.
- MMM personnel, whether acting as managers or consultants for clients, shall not provide legal advice to clients as to whether an arrangement complies with or violates any law or regulation. All personnel shall encourage clients to seek legal advice.

Policies Specific to Marketing Activities:
In addition to marketing its own products and services, MMM is often engaged to market the products and services of clients. MMM reputation, integrity and the ability to generate demand for its products and services, as well as the products and services of its clients, are paramount to its success.

It is in the best interests of MMM and its clients that the recipients of marketing information accurately understand the products and services being promoted. To that end, MMM shall maintain policies and procedures for marketing activities that are specific to the activities of that subsidiary. All marketing activities must be compliant with applicable

regulatory requirements.

The guiding principles underlying those policies are as follows:

- All agreements that involve advertising and other marketing services to be performed by MMM for clients that are engaged in rendering healthcare services must be in writing and approved by MMM Legal Counsel prior to such services being performed.
- All marketing activities are to be performed in accordance with the highest ethical standards.
- All marketing information shall be clear, correct, non-deceptive and fully informative as to the subject matter of the information.
- All marketing information, materials and methods created by MMM for generating business for clients engaged in rendering healthcare services shall be approved by MMM Medicaid CO prior to use.
- Marketing materials shall only use the plan logo as notified and approved by ASES and the logo applicable to the Government Health Plan (GHP).

VII. Billing & Coding:

Background

Although MMM Multihealth is not always a direct provider of healthcare services, it is engaged by clients to manage and oversee coding and billing procedures, as well as to train and supervise clients' personnel. This section of the Compliance Program will help ensure that MMM Multihealth personnel are familiar with applicable billing and codes laws and policies.

All claims submitted for payment from third party payers, including government programs, must be submitted in accordance with complex rules and regulations. Claims for payments must be for items and services that are (a) medically reasonable and necessary; (b) of a quality that meets recognized standards of care; and (c) supported by documentation of medical necessity, quality, and all other standards applicable to the claim. Claims submitted for services that are not medically necessary or not supported by adequate medical record documentation may violate state and federal laws. For example, the federal False Claims Act and the Civil Monetary Penalties law both prohibit any person from submitting or causing to be submitted to a government payment program a claim for payment if the person submitting the claim or causing it to be submitted knows that the claim is false or fraudulent.

Penalties:

The penalties for violating the statutes are severe and include civil penalties of $11,000 per claim and damage of three times the total amount paid (under the False Claims Act)

or $10,000 for each item or services improperly billed and triple damages (under the Civil Monetary Penalties law), for violations that occurred on or before November 2, 2015. (As of August 1, 2016, False Claims Act civil penalties increased between $10,781.40 and $21,562.80 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. These adjusted amounts will apply only to civil penalties assessed after August 1, 2016; whose violations occurred after November 2, 2015). In addition, a person or entity violating these laws can be excluded from participation in federal payment programs such as Medicare Advantage, Medicaid or PDP.

In addition to the federal laws mentioned above, other federal laws as well as numerous state laws may be implicated. For example, wire and mail fraud (for submitting a false claim by mail or by modem) and criminal conspiracy (working in concert with another) to submit a false claim. Also, the Health Insurance Portability and Accountability Act (HIPAA) expressly prohibit activities to defraud any healthcare benefit program, including private health plans and insurance companies. Many states have laws prohibiting false or fraudulent submission of claims to state Medicaid programs and to private insurance companies. Health maintenance organizations (HMO) are subject to additional laws that require that a Provider not provide substandard care or deny medically necessary care for HMO patients and dictate that all patients should receive the same level of care regardless of the financial or insurance status of the patient.

The Office of the Inspector General (OIG) of the Department of Health and Human Services has issued compliance guidelines for third party medical billing companies. The OIG has also issued guidelines for physician practices. To the extent that MMM and its subsidiaries provides billing services, consults with physician practices regarding billing issues, or creates information systems related to billing, it is imperative that MMM employees understand billing and coding policies and procedures.

Some of the billing and coding issues the OIG has identified, which are applicable to MMM Vital Program clients include:

- Presumptive or Default Billing: Billing at the same level of procedure code in all cases without regard to the actual services provided.
- Evaluation and Management ("E&M") Services: Billing for E&M services at a level higher than that supported by the medical record.
- "Cheat Sheets": Coding performed using "cheat sheets" that provide diagnostic information that has triggered reimbursement in the past.
- Computer Coding: Using a computer program that automatically inserts diagnosis codes without receipt of diagnostic information from the physician.

Examples of how this might apply to MMM Vital Program:

- MMM Multihealth provides coding and billing consulting services to a physician practice and becomes aware of improper billing practices, for example, upcoding. MMM can't merely "stick its head in the sand." To do so submits MMM to potential liability.
- MMM provides management services to a medical group. As manager, MMM is responsible to train and oversee the group billing personnel. Such training and supervision must include adequate knowledge and awareness of proper billing procedures.

Regardless of whether MMM and its personnel can ultimately be held liable under laws, MMM Compliance Program requires compliance with all applicable laws, as well as ethical conduct. MMM goal is to ensure that its employees and contractors are acting in compliance with the law and making their best efforts to help our clients comply with the law.

General Principals when MMM is Involved with Coding and Billing:

MMM and its subsidiaries may be involved directly or indirectly in coding and billing processes. Sometimes we act as an outside consultant providing limited and general information. In other circumstances, we act as a consultant or manager responsible for creating systems and supervising personnel directly involved in coding and billing. The following general principals should be applied, as applicable, in each of these circumstances and all other circumstances in which MMM or its subsidiaries are involved with coding and billing.

- Both MMM and Ccient personnel involved with billing or coding shall receive adequate education and training, including legal requirements and billing procedures.
- Proper coding and billing policies and procedures shall be established and maintained by each subsidiary engaged in activities that are in any way related to coding and billing.
- Only properly trained and qualified personnel shall be permitted to render consulting or management services related to coding and billing.
- Coding or billing methods that are known to violate proper coding and billing standards shall not be used.
- All claims shall be submitted using accurate and current codes, including the most current ICD-10, CDT and CPT codes.
- No claim should be submitted to any payer or patient for items or services not actually provided or rendered.
- No claim should be submitted to any payer or patient for services which are not medically necessary, that is services which are not warranted by the patient's current and documented medical condition.

- All services, including physician and other professional services, should be reviewed prior to billing to ensure that only accurate and properly documented services are billed to payers and patients.
- The diagnosis and procedures reported on claims should be based on the medical record and other appropriate or required documentation.
- Any form of "upcoding," meaning the use of a billing code that provides for a higher payment rate than the billing code that accurately reflects the services furnished to the patient, or "code creep," meaning the practice of using a code that provides a higher payment rate than the code that accurately reflects the patient's diagnosis and treatment, is strictly prohibited.
- Any form of "unbundling," or submitting bills in a piecemeal or fragmented fashion for tests or procedures which are required to be billed together for increasing reimbursement, is strictly prohibited.
- Under no circumstances should compensation for billing and coding personnel or consultants provide any financial incentive whatsoever to improperly code claims.
- Computer software systems used for coding and billing shall be monitored and reviewed to assure compliance with applicable laws and such software shall not automatically insert diagnosis codes without receipt of diagnostic information from the physician.
- Processes shall be in place to recognize overpayments and to assure prompt repayment when warranted.
- Adequate clarification shall be obtained when documentation is confusing or lacking adequate justification.
- The integrity of computerized systems shall be maintained and shall assure adequate protection from invasion (i.e., viruses, hackers, etc.).

In addition to the policies set forth above, employees are encouraged to refer to and rely upon appropriate billing and coding references and recognized guidelines approved by MMM, including those produced by the American Health Information Management Association, the Centers for Medicare and Medicaid Services, and the National Corporation for Health Statistics.

VIII. Employee and Contractor Screening

Background

The effectiveness of this Compliance Program depends in large part on the integrity of company personnel and their commitment to compliance. It is incumbent upon MMM to employ and contract with individuals and organizations that meet high standards of conduct. To that end, MMM has adopted the following policies.

- It is the policy of MMM not to hire as Employees or contractors or continue the employment or contract of individuals who have been convicted of a criminal

offense related to healthcare or who are debarred, excluded, or otherwise become ineligible for participation in federal healthcare programs.

- MMM shall investigate the background of all Employees and Contractors prior to hiring by checking with all applicable licensing and certification authorities to verify that any requisite licenses and certifications are in order.
- MMM shall require that all potential Employees certify on their employment application that they are not excluded from participation in any federal or state health programs.
- All personnel are required to report to their supervisor if, after their employment or contract, they are convicted of an offense that would preclude employment by a healthcare or contracting facility or are excluded from participation in any federal or state healthcare program.
- Pending the resolution of any federal criminal charges or proposed debarment or exclusion of a current Employee, that Employee shall be removed from the direct responsibility for or involvement in any coding or billing processes, and any other activity related to a federal healthcare program.

Exclusion Lists Screening:

MMM and each of its affiliated entities will review the names of all employees, contractors and subcontractors, against the Office of Inspector General's list of excluded individuals/entities (LEIE) and/or the General Services Administration (GSA) exclusion lists, on upon hiring and, at least, monthly thereafter, to ensure no current employees, independent contractors, related entities, or vendors have being included in this list. Individuals or Entities included on the LEIE and/or GSA are not considered for employment or contracting. Verified inclusion on the list of presently hired individuals or entities shall constitute grounds for termination. The discovery of any individuals or entities on the LEIE and/or GSA shall immediately be reported to the CO. Verification must include social security number verification.

IX. Confidentiality of Healthcare Information

Background

Comprehensive Federal and State laws exist to protect the confidentiality of medical records and other personal information obtained by healthcare providers when delivering medical services. Failure to comply with these laws can result in significant penalties and a breach of patient trust.

Although MMM and its subsidiaries are not direct providers of healthcare services, they work closely with healthcare providers in ways that result in MMM and its subsidiaries having access to confidential healthcare information. As a result, many laws that apply

to the confidentiality of medical records and related health information apply to MMM and its subsidiaries.

> **Important:** *Do not assume that confidentiality of medical information is solely our clients' problem. Many of the services performed by MMM and its affiliates are directly covered by laws that regulate the use of confidential information*.

Maintaining the confidentiality of medical records and related information is a fundamental rule in the delivery of quality healthcare services. Patients trust our clients to maintain confidentiality. Clients must be able to trust that MMM and its personnel will perform their services in a manner that complies with all applicable laws related to confidentiality of medical records and healthcare information.

HIPAA/HITECH:

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) with the intent to improve the portability and continuity of individual and group health insurance, to combat fraud, waste, and abuse in health insurance and healthcare delivery, to improve access to long term care services and coverage, and to simplify the administration of health insurance. HIPAA/HITECH is a very comprehensive law that applies to many aspects of MMM business in different ways. Depending on the type of services being provided, different rules and regulations will apply.

CMS has developed extensive regulations related to HIPAA/HITECH. Those regulations include three general categories:

- The Transactions Regulations. The standards for administrative simplification, including the standards for electronic transactions, the national standard healthcare Provider identifier, and the national standard employer identifier (these are commonly referred to as the "Transactions Regulations")
- The Security Regulations. The standards for electronic signatures and the security of individually identifiable health information (these are commonly referred to as Security Regulations)
- The Privacy Regulations. The standards for the privacy of individually identifiable health information (these are commonly referred to as Privacy Regulations).

The regulations also include extensive provisions to determine which types of business entities are covered by the various regulations and which parts of the law apply to each type of entity. The test to determine whether a business is subject to the law is based upon the actual activities and operations of the business. In other words, if an organization performs a service or function that falls within the scope of the law, then that organization is subject to the requirements of the law even if the rest of its business has nothing to do with healthcare or HIPAA/HITECH.

In some cases, state laws are more restrictive than HIPAA/HITECH regarding security and privacy of medical records.

> **Important:** *Do not assume that compliance with HIPAA/HITECH means compliance with state laws. You should check with the CO and MMM General Counsel to ensure that activities follow all applicable privacy laws.*

MMM has developed written policies and procedures specific to compliance with State laws related to confidentiality of medical information. You may consult with your supervisor or the appropriate MMM MH Vitals' department if you have any questions about state laws.

It is the policy of MMM to comply with their legal obligations arising under federal and state laws and regulations that relate to the security and privacy of medical records and related patient information, including but not limited to, applicable HIPAA/HITECH requirements, and regulations promulgated there under.

MMM has developed a comprehensive program, including written policies and procedures, for purposes of ensuring compliance with HIPAA/HITECH and similar state laws. Since most states maintain their own laws related to the privacy of medical records and information, these policies and procedures will vary by state. You will receive information and training regarding the HIPAA policies and procedures applicable to you. You should consult with your supervisor or CO if you have any questions about these policies and procedures, and how they apply to you.

<u>Policies of Preserving the Confidentiality of Medical Records and Related Patient Information:</u>

In addition to MMM policies and procedures related to HIPAA and similar state privacy laws, MMM has adopted the following general policies in furtherance of preserving the confidentiality of medical records and related patient information.

- All personnel, whether acting in a management, consulting, or other capacity, shall exercise the utmost caution to maintain the confidentiality of patient medical records and related patient information in strict accordance with MMM policies, procedures, and applicable laws.
- MMM shall encourage clients to adopt policies and procedures for complying with HIPAA/HITECH and applicable state privacy laws.
- All contracts between clients and MMM shall clearly define the responsibilities of each party regarding the protection of medical records and other patient information that is subject to HIPAA/HITECH and state privacy laws.
- Except when required as part of your job and done in accordance with MMM policies and procedures, the discussion, use, or transmission of patients' medical or personal information is forbidden.

- Temporary placement of patients' medical records and personal information in unattended areas should be avoided and all such records shall be maintained in the proper designated locations.
- Faxes or electronic transmissions of patient medical records or other personal information must be done in strict accordance with adopted policies and procedures.
- All computer workstations must be positioned in a manner such that the public cannot see the monitor.
- All conversations relating to patient medical information shall be conducted in areas that are not easily overheard by the public.
- All fax machines, computer printers, and copy machines shall be in areas that are not readily accessible to the public.
- The shredding of patient medical records and personal information shall only be done in strict accordance with MMM MH Vitals' policies and procedures.
- All software and computer databases used by MMM that contain patient medical record information or other personal information shall be password protected.
- All MMM offices shall maintain physical security in a manner intended to limit access by unauthorized personnel to areas of the office that contain medical records and personal information.
- The violation of these policies or any other policies or procedures adopted for securing the confidentiality of medical records or other patient information is a serious offense that could result in Employee sanctions, including termination of employment.

X. Labor Laws

Non-Discrimination Policy:

MMM believes the fair and equitable treatment of employees, clients, patients, and other persons is critical to fulfilling our goals. It is our policy to recruit, hire, train, promote, assign, and, where necessary or appropriate transfer, layoff, recall and terminate employees based on their own ability, achievement, experience and conduct without regard to race, color, religion, gender, ethnic origin, age or disability, or any other classification prohibited by law. No form of harassment or discrimination against anyone based on gender, race, color, disability, age, religion or ethnic origin or disability or any other classification prohibited by law will be tolerated.

Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resource policies. MMM also understands that numerous federal and state labor laws apply to its business and that compliance with such laws is crucial to MMM growth and success. However, due to the complexity of the labor laws and issues related thereto, and MMM desire to prepare and organize its policies and procedures in a manner that is both functional and practical, MMM has not

included its labor compliance policies and procedures in this Compliance Program. Rather, a separate compliance manual has been established for labor law compliance.

XI. Definitions

The following definitions apply for purposes of this document:

- **Abuse** - means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
- **Agent** - means any person who has been delegated the authority to obligate or act on behalf of a Provider.
- **Anonymous** – Given without name or other identifying information.
- **Act** refers to the Social Security Act.
- **ASES** - Puerto Rico Health Insurance Administration
- **Audit** is a formal review of compliance with a set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
- **Confidential** – Revealed in the expectation that anything done or revealed will be kept private. Reported concerns are kept private to the extent permitted by law.
- **Corrective Action Plan (CAP)** – A written notification outlining the mandatory steps to be implemented to maintain compliance with state, federal, NCQA, URAC and/or MMM MH Vital designated requirements.
- **Contract** - means the written agreement between ASES and MMM MH Vital for the GHP; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.
- **Contractor** - means the Managed Care Organization that is a Party of this Contract, licensed as an insurer by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP program for the provision of Covered Services and Benefits to Enrollees on the basis of PMPM Payments.
- **Conviction or Convicted** - means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

- **Deemed Provider Deemed Provider or Supplier** means a Provider or Supplier that has been accredited by a national accreditation program (approved by CMS) as demonstrating compliance with certain conditions.
- **DHHS** is the Department of Health and Human Services. CMS is the agency within DHHS that administers the Medicaid and Medicare programs.
- **DOJ** is the Department of Justice.

- **Downstream Entity** is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicaid benefit, below the level of the arrangement between a MCO or applicant or a plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).
- **Employee(s)** refers to those persons employed by MMM MH Vital or related entities who provide health or administrative services for an enrollee.
- **Enrollee** means a Medicaid beneficiary who is enrolled in the Government Health Plan.
- **External Audit** means an audit conducted by outside auditors, not employed by or affiliated with, and independent of, MMM MH Vital
- **Exclusion** - means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.
- **Ethics** – The discipline of dealing with what is good and bad and with moral duty and obligation.
- **False Claims Act** – This act permits individuals to help reduce fraud against the federal government by allowing them to bring "whistleblowers" lawsuits on behalf of the government (known as "qui tam" suits) against groups or other individuals that are defrauding the government through programs, agencies, or contracts.
- **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- **FWA** means fraud, waste and abuse.
- **FWA reporting mechanisms** – Ways an Employee, Provider, Enrollee/Member or other may report allegations of FWA to MMM MH Vital. Reports can be made anonymously and are kept confidential to the extent permitted by law. HIPAA – Health Insurance Portability and Accountability Act.
- **Furnished** - refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a Provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)
- **Governing Body** means that group of individuals at the highest level of governance of the sponsor, such as the Board of Directors or the Board of Trustees, who formulate policy and direct and control the sponsor in the best interest of the organization and its enrollees. The governing body does not include C-level management such as the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, etc., unless persons in those management positions also serve as directors or trustees or otherwise at the highest level of governance of the sponsor.

- **GSA** means General Services Administration.
- **Integrity** – The adherence to a moral code, reflected in honesty and harmony in what one thinks, says and does.
- **Immediately** - means within twenty-four (24) hours.
- **Indirect ownership interest** - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
- **Internal Audit** means an audit of MMM MH Vital conducted by auditors who are employed or affiliated by MMM MH Vital.
- **List of Excluded Individuals and Entities ("LEIE")** is a database of individuals and entities excluded from Federally funded health care programs maintained by the Department of Health and Human Services Office of the Inspector General.
- **Medicaid** is a program through which the federal government contributes with the states and territories for the provision of medical services to certain low-income individuals.
- **Medicaid Compliance Officer (CO)** – The Medicaid CO oversees the compliance, Program Integrity, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization.
- **Monitoring Activities** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
- **OIG** is the Office of the Inspector General within DHHS. The Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare and Medicaid programs.
- **Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
    - Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
    - Any Medicare intermediary or carrier; and
    - Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
    - Person with an ownership or control interest means a person or corporation that;
        - Has an ownership interest totaling 5 percent or more in a disclosing entity;
        - Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

- Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or
- Is a partner in a disclosing entity that is organized as a partnership.

- **Provider** refers to any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.
- **Provider Contract** - means any written contract between MMM MH Vital and a Provider that requires the Provider to order, refer, provide or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.
- **Program Integrity Plan (PIP)** - means the program, processes and policies that each Contactor has implemented to comply with integrity requirements. The PIP shall be developed in accordance with federal regulations and these guidelines.
- **Related Entity** means any entity that is related to a MCO sponsor by common ownership or control and;
  1. Performs some of the MCO plan sponsor's management functions under contract or delegation;
  2. Furnishes services to Medicaid Enrollees under an oral or written agreement; or
- **Retaliation**– A negative consequence for something done in good faith. This can include things like demotion, hostility, adverse changes in job requirements or other undesirable actions by an Employer, Supervisor or Coworker. Retaliation against an Employee for a good faith action is strictly prohibited.
- **Subcontractor:**
  - An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
  - An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
- **Stakeholder** - means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid beneficiaries.
- **Suspension** - means that items or services furnished by a specified Provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

- **Unbundling** – A fraudulent practice in which Provider services are broken down to their individual components, resulting in a higher payment by the payor.
- **Upcoding** – A practice of assigning a billing or diagnosis code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive right to access their medical records, request an amendment to their records and receive a list of individuals and/or entities to whom MMM MH Vital has disclosed their information.
- **Termination**;
    a. Medicaid or CHIP Provider, a State Medicaid program or CHIP has taken an action to revoke the Provider's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
    b. Medicare Provider, supplier or eligible professional, the Medicare program has revoked the Provider or supplier's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
        i. In all three programs, there is no expectation on the part of the Provider or supplier or the State or Medicare program that the revocation is temporary.
        ii. The Provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
        iii. The requirement for termination applies in cases where Providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to;
            1. Fraud, Integrity; or Quality.
            2. Wholly owned supplier means a supplier whose total ownership interest is held by a Provider or by a person, persons, or other entity with an ownership or control interest in a Provider
- **Waste** - occurs when someone makes careless or extravagant expenditures, incurs unnecessary expenses, or grossly mismanages resources. This activity results in unnecessary costs. It may or may not provide the person with personal gain. Waste is almost always a result of poor management decisions and practices or poor accounting controls.
- **Whistleblower** – A person that files an action under the False Claims Act is informally called a whistleblower. A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public.

MMM Multihealth, LLC.

Program Integrity Plan

Government Health Plan Program in Puerto Rico (Vital Plan)

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Proprietary

I. Introduction:

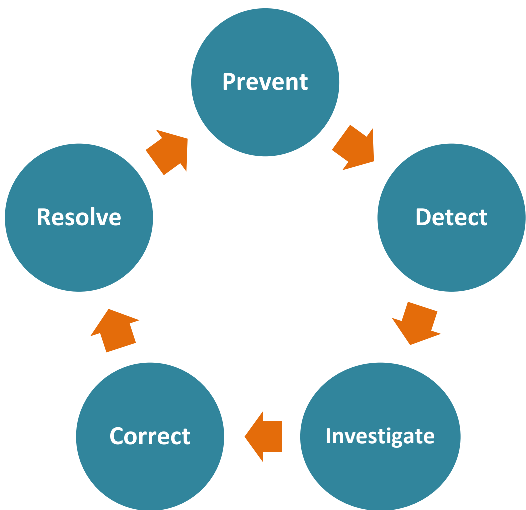
The legal entity MMM Multihealth, LLC (MMM), who contracts with the Puerto Rico Health Insurance Administration (*Administración de Seguros de Salud de Puerto Rico*, hereinafter referred to as ASES) is governed by a separate Code of Conduct, Compliance Program, and Fraud Waste and Abuse (FWA) Prevention Plan from the parent organization, Elevance Health. In addition, MMM Multihealth established this Program Integrity Plan to assure the integration of all requirements established by ASES detailed in the contract between both parties in the administration and delivery of services for the Puerto Rico Government Health Plan Program (Plan Vital).

MMM comply with its responsibility to implement and manage a Medicaid Program Integrity Plan (PIP) for the Government Health Plan (GHP). MMM has developed a Compliance and Program Integrity Plan (Fraud, Waste and Abuse/FWA) as well as policies and procedures with the purpose of establishing guidelines to reduce FWA, enhance healthcare Provider operations, and improve quality of services.

The Medicaid PIP will assist MMM in fulfilling its legal duty to provide quality care, refrain from submitting false and inaccurate claims or cost information to ASES, the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), Health Insurance Portability and Accountability Act (HIPAA), Office of the Advocate for Patients' Bill of Rights of the Commonwealth of Puerto Rico, the State Insurance Commissioner's Office, among others. MMM complies with all the federal and state regulations regarding FWA, which include but are not limited to:

- Social Security Act, Title XIX;
- Social Security Act, Sections 1128, 1156, 1902,1903 & 1909;
- 42 CFR 438.608 and the U.S. Department of Justice's Federal Sentencing Guidelines;
- 42 CFR 455.436, 456.3, 456.4, 456.23;
- Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119);
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191);
- The False Claims Act (31 U.S.C. 3729-3733);
- Federal Criminal False Claims Statutes (18 U.S.C. 287, 1001);
- Federal Anti-Kickback Statute (42 U.S.C 1320a-7a (a)(5));
- Civil Monetary Penalties of the Social Security Act (42 U.S.C. 139w-27 (g));
- Physician Self-Referral ("Stark") Statute (42 U.S.C. 1395nn);
- Prohibitions against employing or contracting with individuals or entities that have been excluded from doing business with the Federal Government (42 U.S.C. 1395w-27 (g)(1)(G);
- Fraud Enforcement and Recovery Act of 2009;
- The Deficit Reduction Act of 2005;
- Article 13 of the Contracts between ASES and MMM Multihealth. All sub-regulatory guidance produced by ASES, CMS and HHS such as manuals, trainings materials, memos, and guides.

MMM PIP is focus on:



MMM has established;

- Methods for the identification, investigation and referral of suspected cases;
- Procedures to perform Preliminary Investigations and Full Investigations;
- Procedures to address the resolution of Full Investigations;
- Procedures to comply with reporting requirements; and
- Policies for assessing provider's statements and attestations, such as those included in any reports, claims or other submissions.

The above policies and practices must also address cooperation with the Puerto Rico Government and the Medicaid Fraud Control Unit (MFCU), as well as procedures to withhold payments in cases of credible allegations of Fraud. The identification, investigation, and referral of suspected cases, guaranteeing the use of a consistent and objective approach to address FWA.

As required by ASES, MMM will present any changes to the Compliance Plan and Fraud, Waste, and Abuse policies and procedures to the Medicaid Program Integrity Office and ASES for approval within fifteen (15) business days of the date MMM will implement any change to the Program. Those shall not go into effect until ASES provides prior written approval. A paper and an electronic copy of the Compliance Plan will be provided to the Medicaid Program Integrity Office and ASES annually. The Medicaid Program Integrity Office and ASES shall provide notice of approval, denial, or modification to MMM within twenty (20) business days of receipt. MMM will make any necessary changes required by the Medicaid Program Integrity Office and ASES within an additional twenty (20) business days of the request.

The PIP and Compliance Program are designed to prevent, identify, and correct inappropriate payments and to comply with the Medicaid Program Integrity as well as with regulatory agencies' requirements. The programs apply to all businesses, contractual arrangements with providers (including healthcare facilities), i.e. Physicians, Vendors, Subcontractors, Delegated Entities, and any other person subjected to federal, state laws and regulatory oversight in relations to FWA.

II. Definitions:

- **Fraud** - means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- **Waste** – Waste occurs when someone makes careless or extravagant expenditures, incurs unnecessary expenses, or grossly mismanages resources. This activity results in unnecessary costs. It may or may not provide the person with personal gain. Waste is almost always a result of poor management decisions and practices or poor accounting controls.
- **Agent** - means any person who has been delegated the authority to obligate or act on behalf of a Provider.
- **Abuse** - means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
- **Anonymous** – Given without name or other identifying information.
- **Confidential** – Revealed in the expectation that anything done or revealed will be kept private. Reported concerns are kept private to the extent permitted by law.
- **Medicaid Compliance Officer (CO)** – The Medicaid CO oversees the compliance, Program Integrity, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization.
- **Corrective Action Plan (CAP)** – A written notification outlining the mandatory steps to be implemented to maintain compliance with state, federal, NCQA, URAC and/or MMM designated requirements.
- **Downstream Entity** - Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between a MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
- **InnovaU**– A term to describe web-based learning system.
- **False Claims Act** – This act permits individuals to help reduce fraud against the federal government by allowing them to bring "whistleblowers" lawsuits on behalf of the government (known as "qui tam" suits) against groups or other individuals that are defrauding the government through programs, agencies, or contracts.
- **Ethics** – The discipline of dealing with what is good and bad and with moral duty and obligation.
- **FWA reporting mechanisms** – Ways an Employee, Provider, Enrollee/Member or other may report allegations of FWA to MMM. Reports can be made anonymously and are kept confidential to the extent permitted by law. HIPAA – Health Insurance Portability and Accountability Act.
- **Integrity** – The adherence to a moral code, reflected in honesty and harmony in what one thinks, says and does.
- **Retaliation**– A negative consequence for something done in good faith. This can include things like demotion, hostility, adverse changes in job requirements or other undesirable actions by an Employer, Supervisor or Coworker. Retaliation against an Employee for a good faith action is strictly prohibited.

- **Unbundling** – A fraudulent practice in which Provider services are broken down to their individual components, resulting in a higher payment by the payor.
- **Upcoding** – A practice of assigning a billing or diagnosis code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive right to access their medical records, request an amendment to their records and receive a list of individuals and/or entities to whom MMM has disclosed their information.
- **Whistleblower** – A person that files an action under the False Claims Act is informally called a whistleblower. A person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public.
- **Contract** - means the written agreement between ASES and MMM for the GHP; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.
- **Contractor** - means the Managed Care Organization that is a Party of this Contract, licensed as an insurer by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP program for the provision of Covered Services and Benefits to Enrollees on the basis of PMPM Payments.
- **Conviction or Convicted** - means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
- **Disclosing Entity** - means a Medicaid Provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
- **Exclusion** - means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.
- **Furnished** - refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an Employee or in his or her own capacity), a Provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)
- **State Medicaid Agency (SMA)** – as defined by the Medicaid Integrity Manual, the single state agency administering or supervising the administration of a state Medicaid plan. Each SMA establishes and administers their own Medicaid programs; they determine the type, amount, duration, and scope of benefits within broad federal guidelines. While all state Medicaid programs have financial responsibility for any improper payments identified through program integrity activities, the scope and execution of program integrity activities varies by state. State entities that may be involved in the program integrity oversight include the SMAs, Medicaid fiscal agents, MFCUs, State, State Attorney General offices, and other agencies with program integrity missions, such as Medicaid Inspector General and State Comptroller offices.
- **Group of practitioners** - means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
- **Medicaid Fraud Control Unit ("MFCU"):** The Unit created by the Puerto Rico Department of Justice under Administrative Order 2018-002 to investigate and prosecute Medicaid Provider Fraud as well as patient abuse and neglect in health care facilities, as defined in Section 1903(q) of the Social Security Act, found at 42 USC 1396b(q).
- **Immediately** - means within twenty-four (24) hours.
- **Indirect ownership interest** - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

- **Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
    a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
    b. Any Medicare intermediary or carrier; and
    c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.
    d. Person with an ownership or control interest means a person or corporation that;
        i. Has an ownership interest totaling 5 percent or more in a disclosing entity;
        ii. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
        iii. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
        iv. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
        v. Is an officer or director of a disclosing entity that is organized as a corporation; or
        vi. Is a partner in a disclosing entity that is organized as a partnership.
- **Program Integrity Plan (PIP)** - means the program, processes and policies that each Contactor has implemented to comply with integrity requirements. The PIP shall be developed in accordance with federal regulations and these guidelines.
- **Provider Contract** - means any written contract between MMM and a Provider that requires the Provider to order, refer, provide or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.
- **Subcontractor:**
    a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
    b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
- **Stakeholder** - means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid beneficiaries.
- **Suspension** - means that items or services furnished by a specified Provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.
- **Termination**;
    a. Medicaid or CHIP Provider, a State Medicaid program or CHIP has taken an action to revoke the Provider's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

b. Medicare Provider, supplier or eligible professional, the Medicare program has revoked the Provider or supplier's billing privileges, and the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
   i. In all three programs, there is no expectation on the part of the Provider or supplier or the State or Medicare program that the revocation is temporary.
   ii. The Provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
   iii. The requirement for termination applies in cases where Providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to;
      - Fraud, Integrity; or Quality.
      - Wholly owned supplier means a supplier whose total ownership interest is held by a Provider or by a person, persons, or other entity with an ownership or control interest in a Provider.

III. Fraud, Waste and Abuse Laws and Standards:

State Plan Requirements:
MMM PIP is strictly adhered to the Puerto Rico State Plan requirements, considered by Medicaid and ASES.

1. The single state agency and sub-grantee acknowledge the need to adhere to a Medicaid Integrity Program as defined in the state plan.
2. The grantee and sub-grantee agree to establish a structure to manage Program Integrity Plan (PIP) activities.
3. The organization structure to perform above mentioned activities is furnished with a Program Integrity Plan (PIP) of members representing the single state agency, the sub-grantee, and each contracted organization.
4. The PIP leads the efforts toward achieving compliance with state plan requirements regulation by establishing the minimum criteria of required PI program policies and procedures.
5. The PIP monitors MMM PIP compliance on regular basis.
6. The PIP chairman develops the meeting calendar each year, develops the committee agenda, and keeps minutes of all meetings and call for meetings.
7. Sub-grantee facilitates the development and update of the Program Integrity Plan guidelines, reports and notification to guarantees its distribution and final acceptance among contracted companies and regulatory agencies.
8. Sub-grantee review performance of each organization, level of adherence to policies and recommend corrective action plan development for areas that must be improved.
9. Sub-grantee develops an annual report that is to be submitted to the Medicaid Integrity Group and to the CMS Region 2. The report will include the areas and companies reviewed during the period and the findings of each company, if any.
10. The PIP provides guidance and guarantees that each contracted company develop and implement policies and procedures in their organizations.
11. The PIP guidelines are integrated into each MMM Program Integrity Plan Policies and Procedures; and are assumed as a standard operating procedure to prevent FWA in the management of Medicaid funds and health plan benefit coverage for the indigent population.

- **The False Claims Act** allows people to bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against groups or other individuals that are defrauding the government through programs, agencies or contracts. The False Claims Act applies when a company or person:
    - Knowingly presents a false or fraudulent claim for payment,
    - Knowingly uses a false record or statement to get a claim paid,
    - Conspires with others to get a false or fraudulent claim paid,
    - Knowingly uses a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property.
    - "Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information. An example would be if a health care Provider, such as a Hospital or a Physician knowingly "up codes" or overbills; resulting in overpayment of the claim using Medicaid or Medicare dollars.
    - The time for a claim to be brought under the False Claims Act is the later of:
        - Within six (6) years from the date of the illegal conduct, or;
        - Within three (3) years after the date the Government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.
    - It is the policy of MMM to detect and prevent any activity that may violate the federal False Claims Act or the state Medicaid fraud laws. If any Employee, Provider, Delegated Entity, Subcontractor or Agent has knowledge or information that any such activity may have taken place, they should contact the Medicaid Compliance Department. In addition, federal and state law and MMM policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to the Medicaid Compliance Department.

- **Federal Anti-Kickback Statute**. This law prohibits the payment or receipt of any "remuneration" that is intended to induce the purchasing, leasing or ordering of any item or service that may be reimbursed, in whole or in part, under a Federal health care program, such as Medicare or Medicaid. It also prohibits the payment or receipt of any remuneration that is intended to induce the recommendation of the purchasing, leasing or ordering of any such item or service. The Federal Anti-Kickback Statute also prohibits receipt of remuneration that is intended to induce purchases, or recommendations of purchases, of goods or services. For example, payment received by MMM from pharmaceutical companies that are intended to induce MMM purchase of drugs or MMM recommendation of drugs to plans could violate the Federal Anti-Kickback Statutes. The Federal government has created several regulatory "Safe Harbors" under the Federal Anti-Kickback Statute. If a transaction, relationship, or payment is structured in a manner that meets all the requirements of a safe harbor, it can be protected from civil or criminal penalty under the Federal Anti-Kickback Statute.

- **Stark Act/Physician Self-Referral -** Prohibits a Physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation) unless an exception applies. It prohibits the entity from

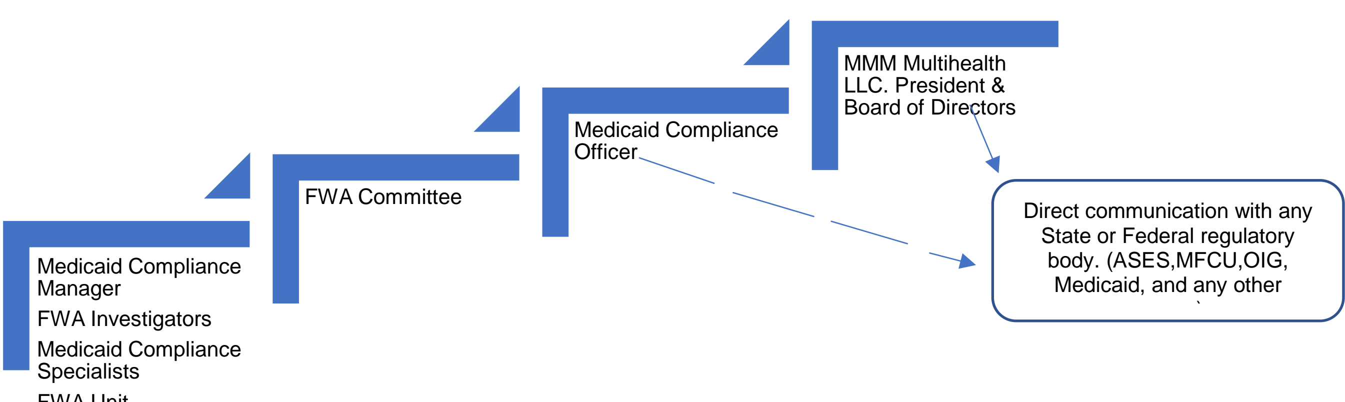
presenting or causing to be presented claims to Medicare or Medicaid (or billing another individual, entity or third-party payer) for those referred services. It established several specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

- **Exclusion Provisions -** Federal health care programs should not be billed for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity. 42 U.S.C. § 1395 (e) (1) 42 C.F.R. § 1001.1901

IV. Program Integrity Plan and Compliance Structure:

A Medicaid Compliance Officer (CO) is assigned to MMM Multihealth operations for the Government Health Plan Program. The CO duties include the implementation, administration, and day-to-day oversight of the Compliance and Integrity Programs. The status of all Program Integrity and Compliance activities is made known on a monthly basis to the FWA Committee and on a quarterly basis to the Compliance Committee, or at ad hoc meetings as needed. MMM President, Executive Management from core operational areas, Chief Compliance Officer, and the Medicaid Compliance Officer participate in these Committees and provide guidance and assistance when dealing with noncompliance matters. The Medicaid Compliance Officer supply regular reports to the Board of Directors, Compliance, and FWA Committees, which includes discussion on specific provider or member investigative activities, Integrity Program activities and investigation results. FWA investigations are primarily done by the FWA investigators with the oversight of the FWA Director, Medicaid Compliance Manager, and Compliance Officer. The FWA Committee provides a forum for health plan leadership to review and discuss emerging PI issues and upcoming activities, regulatory reporting, and contract changes; assess potential compliance risks; and provide input into mitigation activities. The PIP is approved on an annual basis by the Committees.

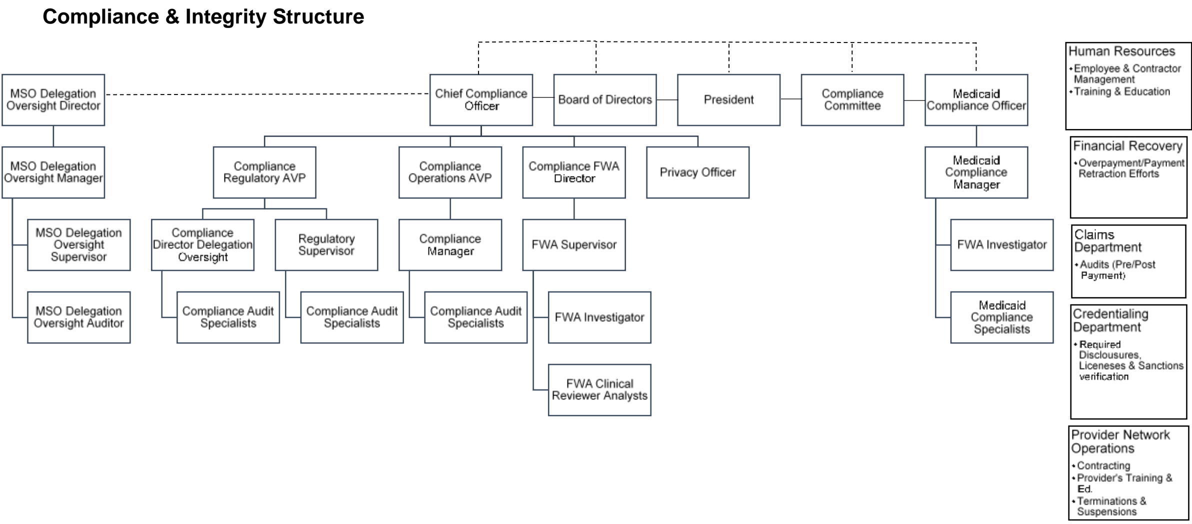
The following structure is the reporting line in the event of a suspicious instance. There's a direct communication by the Medicaid Compliance Officer with regulators that can impact the reporting line based on the severity of the allegations and the reporting mechanisms agreed in contract.



MMM Multihealth has a designated Medicaid Compliance Department who performs compliance and integrity (FWA) responsibilities for the Medicaid Program. In addition, the Medicaid Compliance Program operations is supported by:

- Chief Compliance Officer: Leads Compliance and FWA Corporate efforts within the Organization.
- FWA Director: Leads FWA initiatives and Department operations
- Delegation Oversight: Audit and monitors delegated entities that provides services for the Medicaid Program
- Human Resources: Administrates regulatory trainings and performs employees screening.
- Financial Recovery Unit: Conducts post payment audits and leads overpayment recovery efforts
- Credentialing Department: Performs screening of providers and compile required credentials
- Claims Department: Conducts pre-payment audits

The following diagram illustrates the main administrative and management structure of the Compliance Department.



Medicaid Compliance Department:
The Medicaid Compliance Department has the responsibility to detect, prevent and mitigate fraud, waste, and abuse in MMM Multihealth in accordance to State, Federal and legal regulatory requirements, conduct preliminary and full FWA investigations and comply with reporting requirements from regulatory and government agencies. Medicaid Compliance Department's staff receives and complies with new hire, annual FWA general and specialized trainings which will include at least skills for preventing, identifying, and investigating FWA, laws and regulation, examples of FWA trends in the healthcare industry.

Responsibilities:

- **Medicaid Compliance Officer (CO):** Responsible for reviewing and approving Integrity Plan (FWA), policies and procedures, reviewing investigations performed or in process, presenting FWA reports to the Compliance and FWA Committee, Board of Directors, and overseeing the compilation, maintenance and updates of FWA training materials. Also, the Medicaid Compliance Officer is responsible for ensuring compliance with required reporting to regulatory agencies including but not limited to: ASES, Medicaid Program Integrity Office, OIG, MFCU, Insurance Commissioner Office, or other law enforcement agencies, as required.
- **Medicaid Compliance Manager:** Responsible for revising policies and procedures, reviewing and following up on investigations determinations, recommendations and/or corrective actions, generating, receiving and answering communications to and from Employees, Providers and reporting investigation results and recommendations to the Medicaid Compliance Officer. Develop reporting requirements in compliance with regulatory standards and for compiling and maintaining a log of FWA training provided to staff, including the design of strategies to ensure effective training and education

about Fraud Waste and Abuse for Employees, Directors, Providers, Subcontractors and Enrollees.

- **Medicaid Compliance Specialist(s) /FWA Investigator:** Responsible to receive and track FWA referrals, performs FWA activities as; auditing, monitoring, data analysis, Provider Surveys among other. FWA trainers, internal and external compliance facilitators to Employees. Conduct initial, preliminary and complete FWA investigations. Perform Medical records review. Evaluate and make appropriate recommendations for the prevention of potential FWA or corrective actions as applicable, including referrals to the appropriate department to support overpayments efforts. Perform proactive data analysis to detect patterns, unusual tendencies or billing schemes through the processing and payments of claims, as well as reactive analysis of received complaints (internal or external) of potential FWA. Support Department's staff with the formal referral or delivery to potential FWA issues to ASES; Medicaid Program Integrity Office and/or any other state and federal applicable agency. Collect statistical samples of cases to be audited and reports of the information segregated by Beneficiary, Provider or as needed for the case files, assisting in the preparation of the case files. Select and determine the elements to be audited, criteria, documents to be requested. Create and review training material to educate Employees, Directors, Board of Directors, Providers; and delegated entities on how they can identify and report potential fraudulent and abusive activities.

V. Examples of FWA:

1. **Provider Fraud**
   - **Kickbacks** - Hidden financial arrangements between various health care Providers. There is a variety of improper arrangements where Providers will provide some material benefit in return for other Providers prescribing or using their products or services. In most instances, such arrangements are illegal. Doctors are supposed to decide on the most appropriate treatment for their patients without consideration of their own financial interests. Kickbacks often result in medically unnecessary treatment.
   - **Upcoding** - A pattern of assigning a code that reflects a falsely high level of patient acuity and medical service to generate higher reimbursement than the Provider otherwise would receive.
   - **Billing for services/supplies not provided.**
   - **Billing for medically unnecessary services** – Billing a pattern of services that are not justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care and are used to generate higher reimbursement.
   - **Incorrect coding** – Using an incorrect CPT, CDT, ICD-10, DRG, and HCPCS codes and modifiers to misrepresent the service that was provided to increase revenue.
   - **Double billing** – Submitting a charge more than once, often with a slight modification, for the same service and same patient.
   - **Unbundling** – The practice of separating and billing for the individual components of a medical service to increase revenue, rather than correctly billing with an all-inclusive procedure code.
   - **Misrepresentation of services/supplies** – Providing one service but billing another to obtain reimbursement.
   - **Review of enrollee's complaints and trends regarding Providers.**

- **Substitution of services** – Billing for one type of service or supply but performing or providing another.
- **Submission of any intentionally false documents, addresses, phone numbers, etc.**
- **Overutilization of services –** Overutilizing certain services resulting in medically unnecessary treatment and financial gain.

2. **Pharmacy Fraud**
    - **Prescription drugs not dispensed as written–** Dispensing other drugs than what is prescribed by the Physician (e.g., generic vs. brand name).
    - **Prescription splitting –** Separating prescriptions into multiple orders to seek additional reimbursement, such as dispensing fees.
    - **Expired, fake, diluted or illegal drugs -** Dispensing inappropriate drug types to unsuspecting individuals that could create harmful situations.
    - **Non-dispensed or non-existent prescriptions –** Billing for prescriptions that were not dispensed or picked up by the intended party.
    - **Bait and switch –** Occur when an individual is led to believe that a drug will cost one price, but at the point of sale, the individual is charged a higher amount.
    - **Multiple prescription billing** – Billing multiple payers for the same prescriptions, except as required, for coordination of benefit transactions.
    - **Brand name vs. generic –** Billing for a more expensive brand drug when a less expensive generic prescription is dispensed.
    - **Quantity shortage –** Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fee.

3. **Member Fraud**
    - **Controlled substances -** Obtaining controlled substances from multiple Providers/Pharmacies for non-medically necessary reasons and/or to sell.
    - **Prescription forgery** – Altering and/or forging prescriptions for use or sale.
    - **ID card fraud -** Loaning, sharing, or selling their ID Cards.
    - **Eligibility fraud –** Misrepresenting their eligibility for coverage.

4. **Workforce Member Fraud**
    - **Kickbacks/Stark violations** – Receiving gifts or kickbacks from MMM vendors for goods or services purchased by MMM.
    - **Fraudulent credentials** – Falsify credentials submitted for employment.
    - **Fraudulent enrollment and marketing practices** – Federal and state health program enrollment practices are heavily controlled. An example would be enticing potential members to enroll by presenting incorrect benefit information.
    - **Embezzlement and theft** – The appropriation of company/Medicaid/Medicare monies by a workforce member for his/her own use or benefit.
    - **Underutilization of services/benefits** – Denying or limiting access to Services/Benefits to which the member is entitled.

VI. Methods to perform identification of cases suspected of FWA:

MMM focuses substantial efforts on prevention and prepayment review. While we will continue to pursue recovery of overpayments and recoup payments that stem from instances of FWA, stopping payments before they are made is more efficient and cost-effective. MMM utilizes a claims clearinghouse as the first step in ensuring payment integrity. The system checks for member

eligibility and other billing issues, such as appropriate member sex for the type of surgery, among others edits. We also have a pre-payment claims edits to ensure claim billing codes follow State requirements, medical and claims payment policies, and National Coding Guidelines, including Correct Coding Initiative (CCI) edits and National Coverage Determinations (NCD)/Local Coverage Determinations (LCD) requirements. Prevention processes include adjudication edits, review of identified provider claims, and executing algorithms to look for specific situations. All claims, regardless of entry source (paper or electronic) or provider type (network or out-of-network), pass through the same edits and adjudication processes. In addition to applying industry-standard and payer-defined rules for health care claims coding, we review claims by using a custom internal review and validation tool. We run pre-established reports to apply data analytic algorithms throughout the claim's life cycle during adjudication, after adjudication and before payment, and after payment. After review, claims are paid, partially denied, or denied and a notice to the provider generated with the status or request for additional detail. We also conduct concurrent and retrospective clinical reviews for claims processing. Our Prepayment Review team review providers who are participating in the prepayment program for miscoding issues, such as upcoding, unbundling, high dollar amounts, and inappropriate use of modifiers, among others. Reviewing claims before payment stops unjustified claim payments presented by providers who are under investigation and have a history of submitting claims with miscoding issues and/or medically unnecessary charges.

We employ sophisticated data analytics algorithms for fraud prevention (proactive) and detection (reactive) across the claim life cycle during adjudication and before and after payment. We detect irregular and inconsistent behaviors using coding software.

Anti-Fraud Activities:

A. **Claims Clearinghouse –** MMM utilizes a claims clearinghouse as the first step in ensuring payment integrity. Claims electronically sent from Providers to MMM pass through this system. The system checks for member eligibility and other billing issues like appropriate member sex for the type of surgery.

B. **Claims System Edits –** MMM utilizes, a pre-payment clinical editing software application used to ensure claim billing codes follow state requirements, medical/claims payment policies and national coding guidelines, including Correct Coding Initiative (CCI) edits and National Coverage Determinations (NCD)/Local Coverage Determinations (LCD) requirements. Some or more of these may be applied based on Medicaid specific requirements. Thousands of claim edits are utilized to prevent improper payments to Providers of medical services due to coding errors such as unbundling, inappropriate modifier use, diagnoses mismatch, duplicate claims, etc. The edited data is updated quarterly with CPT/HCPCS and diagnosis codes changes. All claims are processed through this software prior to adjudication.

C. **Provider Claims Statements:**
MMM Multihealth Providers are required to attest in the claim forms that they are agree with the following statement;
    - *"This is to certify that the foregoing information is true accurate and complete".*
    - *"I understand that payment of this claim will be from federal and state funds and that any falsification or concealment of a material fact maybe prosecutes under federal and state laws".*

a. For electronic claims, Providers must attest that they agree with the following statements:
   i. *"This is to certify the truthfulness of the foregoing information and certify that is true, accurate, and complete and that the service was provided"*.

- The statements may be printed above the claimant's signature or, if they are printed on the reverse of the form, a reference to the statements must appear immediately preceding the claimant's signature.
- The Medicaid Compliance Department in collaboration with Claims Department monitors this information in an ongoing basis to ensure compliance.

D. Proactive Data Analysis

We detect irregular and inconsistent behaviors using coding software and our internal, proprietary health care analytics, **Velocity.** Anomaly detection models include algorithm learning techniques that enable analysts to select a confirmed suspect and identify other providers with similar anomalous behavior for further investigation. Predictive modeling tools analyze provider claims and billing practices against peers and detect instances not restricted specifically to CPT codes. Our anomaly detection suite of tools predicts and flags suspicious trends in provider billing patterns. Our models analyze data to identify high-risk areas previously undetected. Provider Education uses anomaly detection models to help identify providers with aberrant billing trends and teach correct use of coding guidelines, billing policies, and claim editing logic.

These algorithms identify atypical behavior patterns through peer comparison and historical trend analysis, analyzing risk populations (provider, member, procedure, and diagnosis) against risk dimensions:

- **Frequency.** Identifies spikes and trends of a particular behavior that can be watched and tracked against norms for that behavior, such as when providers bill a type of service more often than their peers.
- **Intensity.** Calculates a score based on overall measurement of an aberrant behavior; for example, providers who classify a greater percentage of high-level evaluation and management (E&M) services than their peers.
- **Density.** Identifies outlier providers and members whose behavior is flagged by multiple identification algorithms, indicating predictability for aberrant behavior.
- **Velocity.** Qualifies spikes in identified behavior across a timeline, indicating the speed at which the aberrant behavior takes place.

Monthly reporting and analysis support lead generation and verification related to potential provider fraud and abuse. A dashboard for the investigation team displays claims data and supports sorting, filtering, and drill-down analysis on county, city, provider tax ID, and top procedure codes. Viewing a summary of any provider's billing history, including changes and peer comparisons, is a key part of the investigative process and strategy to detect and prevent provider fraud and abuse that have led to the identification of major FWA areas.

We conduct recurring provider profiling and peer comparisons of all provider types and specialties. The data analytic software produces peer comparisons that flag suspicious trends in provider billing patterns. Through peer comparison and historical trend analysis, these models identify atypical behavior patterns using analytic data algorithms that analyze risk

populations (provider, member, procedure, and diagnosis) against risk dimensions. We proactively look for at-risk providers. We accomplish this through comprehensive research based on information obtained from multiple sources, including: anomaly detection algorithms to detect aberrant behavior; Selective data analysis to review vulnerable codes, trends, and peer outliers; Information shared during our quarterly MCOs meetings with MFCU and OIG; Information of providers complaints, suspensions, and terminations; Training opportunities providing information on new schemes and trends; General news, and other professional journal updates on FWA findings and concerns. Our predictive modeling tools can analyze provider claims and billing practices against their peers and detect instances not specifically restricted to CPT codes. Provider profiling also includes a review of the OIG LEIE, the federal LEIE, SAM Excluded Parties List, license verification, and billing history to check for Fraud.

E. Provider Pre-Pay Review:

Providers under an audit or investigation may be placed on a pre-pay review prior to payment of claims. The Medicaid Compliance Department will evaluate various sources of information for risk related practices. Prepayment reviews look for overutilization of services or other practices that, directly or indirectly, result in unnecessary cost to the health care industry. These audits confirm appropriate utilization of cost-effective services and substantiating documentation to support services provided to the member.

F. Post-payment Review:

MMM has established an internal tool utilizing various algorithms and different levels of analysis to detect incorrect payments and potential overpayments. The tool has been programmed with payment rules, as well as tools to identify outliers, and flag transactions for further analysis. This internal tool provides for a knowledge base of known rules to apply to each claim. With this application, we can examine a claim thoroughly against historical data or it can be examined on its own. The application generates multiple reports to complete different type of analysis.

Some of the reports provided by this tool are:

1) Medicare and Medicaid CCI Rules
2) Global Surgery Period Rule
3) Member Cancellation
4) Member Death
5) Add on Code Rule
6) Coordination of Benefits (members with primary health insurance)
7) Duplicate payments
8) Deceased members claims
9) Clinical Rules

Additional data analysis is received from other departments and providers. For example, if a Claim Analyst or Claim Adjuster identifies a possible overpayment during their routine operational process, it is referred to the Financial Recovery Unit with a specific hold code (P3) and a brief description of the finding in order to initiate the payment recovery process.

The data analysis received on these reports is evaluated by the Financial Recovery Auditors on an ongoing basis and after the evaluation of each claim, it is determined if an incorrect

payment was made and if it is needed to proceed with a claim adjustment or overpayment recovery from the provider.

The Financial Recovery Team audit has a three (3) years lookback period from the claim paid date. Reports will be generated to evaluate possible recoveries. The Financial Recovery Auditor (FRA) will evaluate claims flagged with a potential payment issue. If the recovery doesn't proceed, the FRA identifies the claim with a special hold and will document the reason why the recovery process doesn't apply. If a recovery is required, the FRA calculates the total amount to be recovered and the reason for the recovery will have a specific warning or denied hold code attached.

In General, MMM financial recovery process consists of the following steps when no other specific regulation applies:

- Notify a Provider in writing of the requested overpayment
- Wait a minimum of 60 calendar days for the provider to respond to the written request
- When a check for the requested overpayment is not received, perform offsets to future claims

G. Provider Self-Reporting Procedures

If the Provider identifies an overpayment, they can proactively submit a refund check to reconcile the overpayment amount. We include detailed information on our website regarding the steps to take when they want to return an overpayment amount. If a provider identifies an overpayment and submits a refund, our Financial Recovery Unit proceeds to process and reconcile the overpayment in a timely manner, adjust claims, and create claim offsets. We inform providers on how to find information on the provider website when they join our network and include overpayment language in our provider contracts that providers must agree to when they sign. We also make sure that providers know that our Provider Services staff are available to assist in overpayment reporting.

After sixty (60) days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act. MMM also notifies ASES regarding the overpayment. The process is as follows:

- A Provider who has received an overpayment shall notify in writing and return the overpayment.
- The notification shall include the reason for the return of the overpayment.
- Notification and return of an overpayment provided by no later than the later of either of the following, as applicable: sixty days after the date on which the overpayment was identified by the Provider; or the date any corresponding cost report is due.

H. Tools, Training and Available Processes Helping Providers in the Identification and Collection of Improper Payments

MMM has a Performance and Partnership Enhancement Program (PPE) in which we monitor the provider's compliance with our UM criteria and clinical practice guidelines by reviewing and trending performance over a six-month or shorter period. On a quarterly basis, we assist providers identified with utilization patterns, prescribing patterns, and quality or safety of care outside peer norms through training and technical assistance. Our Chief Medical Officer (CMO) and Provider Network Director review identified cases and, if appropriate, develop

an action plan with the provider, referring to our FWA Unit if we identify possible FWA. The action plan begins with a peer-to-peer discussion between the provider and a Medical Director. They discuss pertinent medical policy and clinical guidelines in the context of case examples where we have concerns about potential over-utilization or under-utilization. This way, we give the provider an opportunity to explain circumstances that may be unique to their practice or to the geographical area they serve.

In addition, MMM has an Education Unit that prepares educational material and provides training to Provider Services and Call Center employees in order to prepare our employees to support providers in claims issues, referrals process, overpayments, and authorization process, among others. The dedicated provider Call Center can be accessed during business hours from 7:00am to 7:00pm, Monday through Friday. All MMM internal Call Center representatives have the proper training to fully answer all providers' related questions or concerns. In the instance where an issue cannot be resolved during the initial call, the Provider Issues Resolution Team will manage the instance until final resolution is attained. If the provider needs attention in person, MMM has a robust Network Management Department staffed with External Provider Representatives who can visit them at their office and provide the support they may need.

MMM has a Reconciliation Unit within the Claims Department that assists all providers with their reconciliations, provides them with ongoing feedback, reports, and one on one discussions related to the claims process to close claims periods. MMM also has strategically located regional offices around the Island, already established, with service personnel that can assist providers with claim audits, claims delivery and / or to clarify doubts. Also, all of these services are supported within the Electronic Provider Portal, InnovaMD, that offers its users educational and communication materials and reports, which facilitate their claims processing and reconciliation.

In addition, the Provider Guidelines, available in electronic and paper version, include information regarding to the claims process, utilization and management and pre-authorization processes as well. Additionally, as part of the onboarding process of the providers to our network, MMM provides webinars and/or onsite group training that includes, but is not limited to: claims, pre-authorization, health services, and other pertinent subjects. MMM MH performs periodic PMG and PCP meetings to discuss topics of interest and provide trainings as required.

MMM publishes a monthly newsletter for providers which is posted in InnovaMD, where important information is published related to changes in processes and/or regulations, information relevant to providers related to continued education, regulatory training, changes in claims processes, changes in benefits, among others. Additional communications are also sent to the providers when necessary to inform about changes applicable to a specific group of providers. Also, the provider can directly contact the Financial Recovery Department by phone or email and request any information needed to clarify their doubts.

VII. Investigation and Referrals (FWA):

Our PI Plan provides guidance for the prompt assessment and investigation of detected offenses, ranging from mild offenses that call for provider education to more egregious offenses that potentially require complex investigation. In all instances, our policies and procedures require that allegations be forwarded to the FWA Unit within 24 hours upon recognition of indicators and suspicion of possible fraud and abuse. Information sent to the FWA Unit includes all pertinent provider/member information, claims details, and areas of concern.

The FWA Unit promptly conducts a thorough review of all tips and leads received to determine credibility. All referrals are handled as new allegations, even if a similar complaint has been previously received. Our leads are triaged by the FWA Investigator and if found to be actionable and not an erroneous referral (for example, a billing error), data is pulled relevant to the given information and a preliminary investigation is initiated. Depending on the circumstances specific to each case, the FWA Investigator works to validate the referral through a variety of ways, such as: performing claims data analysis to assure coding guidelines are followed; reviewing medical records from the provider's universe, which may involve sampling; conducting announced and/or unannounced on-site visits to the provider location(s); completing telephone interviews of the provider, staff, and/or member. MMM will follow ASES' established protocols to conduct and notify preliminary and complete investigations of suspicious FWA events.

The detection and prevention of FWA is the responsibility of everyone. MMM has written policies and procedures that address the prevention, detection, and investigation of suspicious noncompliance activity. MMM has implemented mechanisms for the detection of potential FWA. The following steps are considered;

- The FWA Investigator open, registers and has the responsibility to document during the investigation the case until is considered completed/closed.
- A data gathering is considered during the first twenty-four (24) hours to determine if a preliminary investigation is required. An internal check list to cover all the required elements is used.
- Information is analyzed and compared, taking into consideration Enrollee's wellness as the priority, the applicable subject matter experts of departments/operational processes impacted, and the data stored by MMM in its systems;
- Once all the elements of data analysis, documentation, subject matter experts (if applicable) interviews/opinions are satisfied a preliminary investigation report is develop following MMM established protocols and ASES/Medicaid's reporting requirements.
- Case is moved to the next step of reporting, considering ASES reporting requirements, Medicaid Compliance Officer and MMM FWA Committee supporting processes.
- Immediately reporting to ASES, Medicaid Program Integrity Office or any state and federal agency as OIG, MFCU can occur based on the merit of the allegations.

VIII. Training and Education

A comprehensive education and training program have been implemented to combat FWA with knowledge and awareness. By informing Enrollees, Providers, Subcontractors and workforce on what they need to be aware, and their responsibility to report potential issues, expanding fraud detection efforts. FWA education and training includes the following topics:

1. Definitions of FWA;
2. Examples of Provider, Enrollee, Employee and subcontractor FWA;

3. How to access FWA policies and procedures;
4. Information regarding state and federal laws, including but not limited to the False Claims Act, Protection afforded to those who report FWA, how to report FWA, incorporates all CMS training curriculum standards listed in 42 C.F.R. §422.503(b)(4)(vi)(C)(3) (2014).

Throughout the training course, Employees view various FWA scenarios and the appropriate handling of those scenarios. Employees learn their responsibilities for reporting FWA, examples of FWA, as well as how to report concerns. The training reinforces MMM no retaliation policy and outlines the laws and regulations applicable to FWA. Finally, the training educates Employees on the location of FWA resources such as: Compliance Plan, Code of Conduct, FWA Policies and Procedures, Employee Handbook, and the Integrity Plan. The training is required for all MMM workforce members and is tracked for completion by the Medicaid Compliance Department. Non-compliance with this requirement can result in disciplinary action.

MMM delegated entities are also required to complete an annual FWA training. The entity many choose to use MMM training or their own if it satisfies Medicaid contractual requirements for fraud, waste, and abuse training dependent upon the lines of business they support. The Medicaid Compliance Department verifies that delegated entities receive FWA training via an annual attestation through the MMM Delegation Oversight Unit. Staff training begins at hire for the entire MMM workforce, as our formal FWA course is required to be completed within the workforce member's first 90 days. Ongoing training for all workforce members consists of an annual refresher course. The Medicaid Compliance Department reviews and updates all education and training material on an annual basis, and as needed, to ensure it remains relevant and up to date with current laws, rules and regulations. Training records are maintained by MMM for a minimum of 10 years. The Medicaid Compliance Department ensures the information above is included in formal communications such as Enrollee Handbooks, Provider Manuals, Compliance Plan and the Employee Handbook.

IX. Timeframes:

Element	Frequency
FWA Detection (Internal/External)	Must be reported **immediately** to the Medicaid Compliance Department using the reporting mechanisms described in this plan.
MMM Proactive Data Analysis	Daily & Ad hoc
Medicaid Compliance Initial Analysis	Within two (2) business days since is received in the Medicaid Compliance department.
Initial Medicaid Compliance Department Case Documentation Collection	Within two (2) business days since is received in the Medicaid Compliance department.
FWA Committee Initial Intervention	Within two (2) business days since is received in the Medicaid Compliance department.
FWA Substantiated Case – Initial Report with ASES/ Medicaid Program Integrity Office	Within two (2) business days after the FWA Committee initial review determination
Preliminary Investigation	Within ten (10) business days after the case is reported to ASES and Medicaid Program Integrity Office.

Full Investigation directed by ASES Full Investigation notified to ASES/ Medicaid Program Integrity Office but directed by MMM.	Within thirty (20) business days since the preliminary investigation is reported to ASES/ Medicaid Program Integrity Office. Within ninety (90) calendar days since the formal notification to ASES and Medicaid Program Integrity Office.
Claims Audits	On-going
FWA Service Verification Surveys	Monthly
FWA Trainings	New hire within ninety (90) days upon hire and annually.
Referral to HHS-OIG, MFCU and/or US attorney's Field Office	MMM will notify ASES and Medicaid Program Integrity Office about referrals made to the HHS-OIG and/or the US Attorney's Field Office within five (5) days.

X. Preliminary Investigation:

The preliminary investigation consists in conducting an overview of the allegation received and the merits of the referral, to assess if the situation consists of a systematic, operational or informational error. This occurs within ten (10) business days after the case is reported to ASES and Medicaid Program Integrity Office. This phase includes but is not limited to;

1. Reviewing statements from anonymous or identified complainants;
2. Interviewing Providers, Enrollees, others and;
3. Conducting a data analytics review of individual complaints for overall patterns, trends, and errors, among other analysis.
4. Review, identify and determine the following;
   - Source of information;
   - Identification method (how the case was detected);
   - Cause for investigation;
   - Case documentation;
   - Analysis of Data and documents;
   - Report of Findings;
   - Action(s) Taken (Recommended Action(s).

The preliminary investigation is tracked and documented in the Medicaid Compliance Department Internal FWA Log and the reconciliations meetings/communications maintained with the Medicaid Compliance Staff, Medicaid Compliance Officer, FWA Committee and ASES/ Medicaid Program Integrity Office.

XI. Full Investigation:

MMM Medicaid Compliance Department conducts a Full FWA Investigation under the following circumstances:

- To suspect a Provider has engaged in fraud or abuse of the program;
- To suspect a recipient is defrauding the program;
- To suspect a recipient has abused the Medicaid program.

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A full investigation consists of detailed data analysis, evaluation of utilization or billing patterns, desk or onsite audits, and interviews, record reviews, among other research activities regarding the investigated individual or entity. A written report is developed documenting the investigative process and findings.

A full investigation must continue until:

- Appropriate legal action is initiated;
- The case in closed or dropped because of insufficient evidence to support the allegations of FWA;
- The matter is resolved between the organization and the Individual, Entity, Provider, or Enrollee;
- The case is referred to ASES, Medicaid Program Integrity Office, HHS-OIG, MFCU, Department of Justice, US Attorney's Field Office, or applicable law enforcement agency.

The Full Investigations in progress or closed are tracked and documented in the Medicaid Compliance Department Internal FWA Log. Review and discussions for managements and determinations are supported by the Medicaid Compliance Staff, Medicaid Compliance Officer, FWA Committee, MMM Board of Directors and Medicaid/ASES. For any investigation that extends more than ninety (90) calendar days, MMM MH must request, via email, a meeting with ASES.

XII. Case/Investigation Resolutions:

The resolution may include but is not limited to:

- Sending a warning letter to the Individual, Entity, Provider, or Enrollee, giving notice that continuation of the activity in question will result in further action;
- Provider Contract Agreement termination;
- Suspension or termination of the Provider from participation in the Medicaid program (to be determined by regulatory or law enforcement agencies);
- Suspension or termination of Medicaid benefits to the Enrollee (to be determined by regulatory or law enforcement agencies);
- Determination to adopt prepayment edits or flags to the systems configuration;
- Complete overpayment and payment retraction efforts;
- Education on Billing and Guidelines Rules;
- Imposing of other sanctions provided under MMM Performance Improvement Plan (PIP), among others.

All case(s) resolutions are tracked and documented in the Medicaid Compliance Internal FWA Log, and supporting documentation is maintained private and confidential, following HIPAA privacy and security protocols.

XIII. Case Documentation:

The results of any investigations must be thoroughly documented in a report and supported with defined exhibits and submitted to ASES and Medicaid Program Integrity Office through a secure repository. This document is reviewed by the Medicaid Compliance Manager and approved by the Medicaid Compliance Officer. Each investigation must include;

1. Brief overview of the allegation;
2. Action Plan, considering all steps taken during the investigation;

3. Analysis based on reference documentation and facts of the allegation, including details of the investigation in chronological order, and listing of all exhibits and supporting documentation;
4. Detail of findings, including an estimate of dollars involved or overpayment amount identified;
5. Conclusions and recommendations.

XIV. Disclosure of Investigative Results or Interim Results:

The Medicaid Compliance Officer must report the results of any Investigation to the FWA Compliance Committee. If the investigation has not been concluded by the timeframe established, an interim report to the FWA Compliance Committee should be issued. Once findings are identified and reported to the FWA Compliance Committee, the Provider/Entity/Individual subject to investigation is notified about findings, recommendations, and the appeal process. In case the determination is to recover the overpayment, the offender will have the option to request an appeal in writing within sixty (60) days of receipt of the notification. The Medicaid Compliance Officer, in consultation with the Legal Counsel, must determine whether any corrective action applies. The Legal Counsel will advise on matters of attorney/client privilege, disclosure, and whether MMM has any affirmative duties to report the violations or make restitution to Beneficiaries, Providers, ASES, Medicaid Program Integrity Office, MFCU, OIG, CMS or any other government enforcement agency.

XV. Responding to Possible or Detected Violations:

MMM is committed to investigating any incident of noncompliance or significant breach to abide by applicable federal or state law and regulations; and other types of misconduct that threatens or calls into question MMM standing as an honest, reliable, and trustworthy entity. Fraudulent or inappropriate incidents and events detected, but not rectified, can seriously threaten its reputation and jeopardize its legal status. In this regard, MMM has developed internal and external audit procedures to encourage the Employee to voluntary present any FWA situation. If after an investigation, it is determined that the case was unsubstantiated, it is MMM commitment always, even during the investigation, to diligently protect the reporting party or the affected area's reputation.

XVI. Auditing and Monitoring:

a. **Risk Assessment**

MMM develops a Risk Assessment process that identifies vulnerabilities and previews where and how potential fraud, waste, or abuse may originate. The Medicaid Compliance Officer, FWA Compliance Committee, and Medicaid Compliance designated personnel may participate in or contribute to the Annual Risk Assessment process. A general Risk Assessment is conducted on an annual basis and modified as required, considering the current or future OIG Annual Work Plan and previous trends identified by MMM, ASES, Medicaid or the Healthcare Industry. Provider's Utilization History, data mining and analysis, complaints, among others, could be used to modify the Risk Assessment throughout the year. MMM ensures in the internal monitoring and auditing

protocols a 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 MMM compliance efforts. The Medicaid Compliance Department's Annual Audit Work Plan is supported by the Risk Assessment and by the following resources;

- OIG Annual Work plan;
- OIG Audit reports;
- Fraud Alerts;
- Industry Workgroups; E.g. Medicaid Integrity Group, MFCU, and Task Force;
- Claims Data mining and Utilization analysis;
- Monthly Service Verification Surveys;
- Internal and External referrals;
- Trends or patterns previously identified.

On an annual basis, the Compliance Department completes an annual evaluation and report of the effectiveness of the previous year's auditing and monitoring activities, including: Summary of key goals and corresponding audit, monitoring, and reporting activities; Analyses of audit, monitoring and reporting effort and commentary regarding changes to the initial plan; Brief description of critical issues identified; Projects planned but not executed due to change in priorities and resources; and Update on staffing levels, experience, and training. Opportunities identified during the execution of the Annual Work Plan and lessons learned from previous years are considered to stablish best practices that will guide the development of the Work Plan for the next year. When evaluating PI effectiveness, MMM considers:

- Observed changes in billing behavior
- Submission of referrals to federal and State authorities (ASES, MFCU, OIG)
- Total program savings

We also refine and adapt our processes to stay current with industry schemes and issues, participating in national fraud associations and monitoring national "watch lists" to identify common nationwide schemes, as well as irregularities not yet seen in Puerto Rico.

Example of a risk assessment with identification of top three risk vulnerabilities of FWA:

Risk Description	Impact (1-5)	Likelihood (1-5)	Risk Score Impact + Likelihood (1-10)	Impact/Likelihood Assessment	Management Effectiveness (1-10)	Management Effectiveness Assessment
1. Clinical Documentation	5	4	9	Documentation may be incomplete, inaccurate, untimely resulting in over or under-payment and inaccurate quality data reporting. Inaccurate documentation may impact quality of care resulting in increased litigation	6	MMM uses Clinical experts contracted of different specialties, including coding experts to assess and improve clinical documentation. Periodic claims audits are performed to identify trends with the same scenarios

						and billing combinations.
2. Medical Necessity	4	3	7	Evidence of medical necessity is extremely reliant on the quality of documentation. Risk of human error is moderate. Medical necessity regulations are difficult to administer and are inconsistent based MMM Clinical, FWA and Compliance experts' interpretations.	5	Multiples processes are in place and adopted for claims processing management. MMM increased focus and resource deployment on clinical documentation improvement.
3. Billing-Physician	4	3	7	State and federal focus has increased. There are internal controls for coding and documentation methodologies, and risk of human error is moderate to high.	3	MMMhas developed and implemented a systemwide standardized physician billing guide. There is, however, a significant increase in the amount of physician billing activities and disparate controls at the practice level.

XVII. Types of Audits:

- Announce and Unannounced Internal Audits or "Spot checks";
- Examination of the performance of the Medicaid Compliance Program including review of training and education, Compliance Incidents Log (e.g. Ethics Point call log), Investigation files, Code of Conduct Certifications of receipt and Conflict of Interest disclosure/attestation;
- Current and Past Corrective Action Plans monitoring;
- Provider's statements on claims and checks review;
- Proactive Data review based on common red flags;
- Enrollee/Law 114 validation of generation in compliance with the established requirements;
- Service Verification Surveys - Monthly, a random sample of Enrollees who received healthcare services according to claims/encounters submitted to MMM is selected and surveyed. This may be performed through confirmation with Beneficiaries or validating Medical records to identify if services were rendered as per billing or encounters submitted by Providers. A specific form requested monthly and or completed by phone call by the Enrollee/Recipient to confirm if the services were appropriately rendered as billed and paid.

XVIII. Supporting Evidences/Documentation:

1. Referral registration in the specified log;
2. FWA Check List Form;
3. ASES FWA Form (if apply);
4. Request and collection of;
   a. Provider Contract;
   b. Credentialing File;
   c. Member Eligibility information;
   d. Grievances & Appeals history;
   e. Providers/Members Calls history;
   f. Claims/Utilization data;
   g. State and Federal Licenses or Authorized bodies verification;
   h. Medical Records;
   i. Providers, patient progress notes, among others.

XIX. Committees:

Monthly or more often if required, the Medicaid Compliance Officer presents to the FWA Compliance Committee the following information;

- A Summary Report of the Open and Closed FWA cases, considering actions completed or in progress and;
- An update of all the anti-fraud activities handled by the Medicaid Compliance Department in alignment with this plan.
- The Medicaid Compliance Officer also present in writing to the Board of Directors status of MMM FWA Program.

A. FWA Compliance Committee Members (minimum composition)

- President
- Chief Financial Officer (CFO)
- Chief Medical Officer (CMO)
- Chief Operational Officer (COO)
- Pharmacy
- Legal Counsel
- Chief Compliance Officer (CCO)
- Medicaid Compliance Officer
- Medicaid Compliance Manager
- FWA Investigators
- Others, as required

XX. Corrective Actions:

Corrective actions are taken promptly during or immediately following completion of the investigation. If an audit or investigation reveals a material violation of the Compliance Program, Medicaid legal requirements, ASES' contract, Insurance Commissioner's or other State agency requirements, the Medicaid Compliance Officer will draft a corrective action plan and establish a deadline by which the corrective action must be in place. Possible corrective actions may

include, but are not limited to, education, recovering overpayment from the Provider, Employee disciplinary action, which may include official conversations, warning letters, suspension without pay, and proposed termination of contractual agreement, as well as reporting to federal and/or state authorities. All corrective disciplinary actions must be documented and includes corresponding progress reports of each error identified. Disclosure of results of an investigation or audit findings to federal or state authorities must be made by the Medicaid Compliance Officer and notified to the Legal Counsel, in accordance with the FWA Compliance Committee recommendations.

XXI. Overpayment/Payment Retractions Efforts:

MMM has established policies and procedures to withhold/retract payments to any identified Provider or Supplier who committed fraud or willful misrepresentation.

Basis for withholding/retraction. "MMM may withhold capitation or claims payments, in whole or in part, to a Provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. MMM may withhold payments without first notifying the Provider of its intention to withhold such payments. A Provider may request, and must be granted, administrative review where State law so requires."

Notice of withholding/retraction. **"**MMM must send notice of its withholding/retraction of program payments within five (5) days of taking such action. The notice must set forth the general allegations as to the nature of the withholding/retraction action but need not disclose any specific information concerning its ongoing investigation. The notice must:

- State that payments are being withheld in accordance with this provision;
- State that the withholding/retraction is for a temporary period, and cite the circumstances under which withholding/retraction will be terminated;
- Specify, when appropriate, to which type or types of payment (capitation or claims) withholding/retraction is effective; and
- Inform the Provider of the right to submit written evidence for consideration by the agency."

Duration of withholding/retraction. "All withholding/retraction of payment actions under this section will be temporary and will not continue after:

- The agency or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the Provider; or
- Legal proceedings related to the Provider's alleged fraud or willful misrepresentations are completed."
- Documentation will be kept by MMM Medicaid Compliance Department of the actions taken.

XXII. Collaboration with Federal and State Agencies:

MMM comply with requests for information from ASES, the Medicaid Anti-Fraud Unit (MFCUs), the Office of Inspector General (OIG), the Department of Justice (DOJ), Medicaid Office or any other federal or state agency or program divisions in charge of preventing and prosecuting cases related to FWA of services under the Medicaid Program. MMM cooperates fully with Federal and Puerto Rico agencies in FWA investigations and subsequent legal actions, whether administrative,

civil, or criminal. Such cooperation shall include actively participating in meetings, providing requested information, access to records, and access to interviews with Employees and consultants, as well as providing personnel to testify at hearings, trials, or other legal proceedings as needed.

MMM notifies ASES of any participation in meetings with other Managed Care Organizations (MCOs) regarding the PIP. If any investigation results of such meetings, these will be managed following the established policies and procedures for FWA investigations, unless otherwise directed by ASES, OIG-HHS or other government agency. MMM shall maintain ASES and Medicaid Program Integrity Office informed of those investigations by identifying these investigations in FWA and PIP reporting requirements. If ASES requires status of any ongoing investigation resulting of such meetings, additional reports or information will be handled through the Medicaid Compliance Officer or designee. MMM comply with the following established standards by Medicaid Fraud Control Units and /or law enforcement agencies;

- All cases of suspected Provider fraud are referred to the antifraud / integrity organization's unit;
- If the antifraud / integrity Unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for;
    - Access to, and free copies of, any records or information kept by the organization or its contractors;
    - Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit;
    - Access to any information kept by Providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of recipients;
- Communicate to ASES (and other appropriate Federal and State agencies, as required) preliminary findings within two (2) business days of completing the investigation; and
- On referral from the Unit, coordinate with ASES and the appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a Provider.
- The PIP must recommend having in the Provider's Contract a disclaimer that as a contracted Provider any data related to services or payments provided must be available for review of the Integrity staff.

MMM must 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 FWA prevention, including attendance at meetings and trainings covering FWA prevention and detection techniques and best practices. 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.

XXIII. Provider Credentialing, Screening and Required Disclosures of Information:

Provider Credentialing is considered an essential part of the Program Integrity Plan. During the initial credentialing process, once all credentials are gathered in a file, they are evaluated or

reviewed by an MMM Credentialing Committee. The committee may recommend approval without conditions, approval with conditions, denied participation, or defer the decision for further investigation. All applicants receive written notice within ten (10) calendar days after the committee has rendered a final decision.

MMM notifies ASES and Medicaid Program Integrity Office of any adverse or negative action taken on a Provider application or actions to limit the ability of the Provider to participate in the program within five (5) days of the decision. Pursuant to legal and regulatory requirements, MMM has established policies and procedures for the screening of Providers before Contracting. Screening and Enrollment procedures is performed based on PPACA requirements applicable to Program Integrity provisions including:

a. Enhanced Provider Screening and Enrollment, Section 6401;
b. Termination of Provider participation, Section 6501;
c. Provider disclosure of current or previous affiliation with excluded Provider(s), Section 6401; and
d. Provider Screening and Enrollment.

MMM has also established policies and procedures to ensure that all Providers and Fiscal Agents comply with disclosure of information requirements pursuant to the Medicaid Program Integrity Plan. For this purpose, a process is performed to update the Provider enrollment packages, including the application form and credentialing procedures. Providers are requested a Certificate of Criminal Background (Good Behavior as defined in PR) and to identify Agents or managing Employees' criminal convictions. The following disclosures are required of Providers, Agents, and Employees during the Enrollment, Contracting and/or Application process:
Information related to;

a. Ownership, Control and Conflict of Interest;
b. Business transactions;
c. Persons convicted of crimes or illegal conduct.

MMM not approve a Provider agreement or contract with a Fiscal Agent and will terminate an existing agreement or contract if the Provider or Fiscal Agent fails to disclose the required information. If any disclosure of criminal convictions is received by MMM from a Provider or Fiscal Agent during the credentialing process, this information will be submitted to ASES, Medicaid Program Integrity Office, MFCU and HHS-OIG within twenty (20) business days.

XXIV. Provider Cancellation due to Inactivity:

MMM has established policies and procedures for Provider contract cancellations which include the element of inactivity for the past twelve (12) consecutive months. Any identified Provider who has been inactive for the established timeframe will be terminated. A communication is sent to the Provider notifying the cancellation due to inactivity, where the Provider is granted the opportunity to demonstrate evidence of billing activity during that time.

XXV. Program Integrity Work Plan:

The Program Integrity Work Plan encompasses all the compliance related activities for the Department. It captures overarching compliance themes, applicable lines of business, regulatory

citations, activities completed to maintain compliance, and documentation references to support those activities, as well as business owners for each task. The work plan functions as a repository of regulatory requirements to ensure Program Integrity within MMM operation. The Program Integrity function within the Medicaid Compliance Department is also responsible for updating and maintaining this Program Integrity (FWA) Plan in addition to working closely with the state and federal regulators to review and ascertain appropriate documentation for all requirements.

XXVI. Record Retention Policy:

It is the policy of MMM to retain records, regardless of media, in accordance with applicable federal, state, and local statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), and guidelines set forth by NCQA, URAC, and other industry standards. MMM Medicaid Compliance Department maintains Program Integrity and FWA documents according to MMM policy. Requirements vary by contractual requirements, lines of business, and type of collateral.

XXVII. Reporting Mechanisms:

MMM has established reporting mechanisms such as;

- **Ethics-Point Hotline (1-844-356-3956**);
- **Email address** (VITALSIU@mmmhc.com) for Providers, Subcontractors, Beneficiaries and public. Individuals or entities may **anonymously** report fraud, waste, abuse or misconduct. Any Employee, Director, Provider, Subcontractor, Delegated Entity, or Beneficiary, who in good faith believes they know of a potential violation of this program or its policies and procedures, must report their findings to MMM. Violations to the Program or its policies and procedures or failure to report known violations of the program or its policies and procedures are a serious violation of MMM policy's resulting in the imposition of disciplinary actions, which may include the termination of employment and/or business relation. **No body must be subjected to any form of retaliation based solely on the good faith or honest intention of reporting a suspected violation.**
- **For employees: Every employee has the responsibility to report Misconduct and Ethics :** Suspected or observed misconduct, including violations of the code, company policies and procedures, laws and regulations, or other ethical concerns, should be reported to Ethics Departments.
  There are various channels to submit reports or ask questions;

1. Speak with an immediate supervisor or manager;
2. Fill out the online form at elevancehealthethicshelpline.com
3. Call the Ethics and Compliance HelpLine (877) 725-2702
4. Send an email to ethicsandcompliance@elevancehealth.com
5. Send a letter to;

Ethics Department
VP, Chief Ethics and Privacy Office
220 Virginia Avenue, Indianapolis 46204 United State

Employee Participation and Reporting

It is the responsibility of every MMM Employee to abide by applicable laws and regulations and support MMM compliance efforts by:

a. Being aware of potential compliance issues, especially those related to the prevention and detection of FWA activities;
b. Seeking advice from the Legal Counsel, the Medicaid Compliance Officer, or their delegates regarding compliance issues, as appropriate;
c. Reporting, in good faith, any suspected, actual, or potential compliance violation of fraud, waste, abuse and misconduct;
d. Fully cooperating with the investigation and compliance investigators;
e. If applicable, being completely honest in all dealings with Federal and State agencies and representatives.

Employees may confidentially report suspected misconduct or potential FWA either verbally or in writing to their supervisor, a higher-level manager, the Medicaid Compliance Department, or the Medicaid Compliance Officer; or by calling the Ethics Point Hotline. MMM, at the request of the reporting Employee, maintain their anonymity to the extent permissible under the law, regulations applicable to MMM and consistent with its obligations to investigate all matters brought to the attention of MMM, as well as warranted corrective action. **An Employee must not be subject to retaliation of any kind, including the terms and conditions of employment, because of reporting in good faith or because of an employee's cooperation in any immediate or subsequent investigation.**

XXVIII. Suspension of payments in case of potential FWA:

MMM suspend payments to Providers as a mechanism to prevent wrong disbursement of payments when there is a credible allegation of fraud for which an investigation is pending unless the agency has a good cause to not suspend payments or to suspend payment only in part.

<u>Basis for suspension</u>
The State Medicaid Agency (ASES) must suspend all Medicaid payments to a Provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

The PR Medicaid Agency (ASES) may suspend payments without first notifying the Provider of its intention to suspend such payments. A Provider may request, and must be granted, administrative review where State law so requires. Therefore, MMM must refer to ASES and Medicaid Program Integrity Office all suspected cases of fraud as indicated below, for ASES to decide related to the suspension of payment after the proper evaluation and in consultation with the applicable law enforcement agency, such as the Medicaid Fraud Control Unit. In addition, MMM must suspend payments at the direction of ASES if ASES finds that a credible allegation of fraud exists for which an investigation is pending under the Medicaid program.

<u>Notice of suspension</u>
If directed by ASES, MMM must send notice of its suspension of program payments within:

1. Five (5) days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice.
2. Thirty (30) days if requested by law enforcement in writing to delay sending such notice, which request for delay may be renew in writing up to twice and in no event may exceed ninety (90) days.
3. The notice must include or address all the following:
    a. State that payments are being suspended in accordance with 42 CFR 455.23;
    b. Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;
    c. State that the suspension is for a temporary period, as stated on 42 CFR 455.23(c) and cite the circumstances under which suspension will be terminated;
    d. Specify, when applicable, to which type or types of Medicaid claims (capitation or claims) or business units of a Provider suspension is effective.
    e. Inform the Provider of the right to submit written evidence for consideration by the agency.
    f. Set forth the applicable administrative appeals process and corresponding citations to State law.

Duration of suspension

All suspension of payment actions under this section will be temporary and will not continue after either of the following:

1. The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider.
2. Legal proceedings related to the Provider's alleged fraud are completed.
3. It must be documented in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a Provider.

Referrals to ASES, Medicaid Program Integrity Office, Medicaid Fraud Control Unit and OIG

Whenever the MMM investigation may lead to the initiation of a payment suspension in whole or part, MMM must make a fraud referral to ASES and Medicaid Program Integrity Office who will notify the OIG and the Medicaid Fraud Control Unit and any other appropriate law enforcement agency as required by 42 CFR 455.23(d) (2) The fraud referral must meet all of the following requirements:

1. Be made in writing and provided to ASES and Medicaid Program Integrity Office not later than the next two (2) business days after MMM determines that there is a potential fraud.
2. Conform to fraud referral performance standards issued by the Secretary.
3. A recommendation of MMM related to good cause not to suspend payments or to suspend payment only in part after evaluating the elements required.
4. If the Medicaid Fraud Control Unit or other law enforcement agency accepts the fraud referral for investigation, a payment suspension may be approved until such time as the investigation and any associated enforcement proceedings are completed.
5. On a quarterly basis, MMM must request a certification from the Medicaid Fraud Control Unit or other law enforcement agency that any matter accepted based on a referral continues to be under investigation thus warranting continuation of the suspension.
6. If the Medicaid Fraud Control Unit or other law enforcement agency declines to accept the fraud referral for investigation, an approved payment suspension may be discontinued by ASES unless ASES has alternative Federal or State authority by which it

may impose a suspension or makes a fraud referral to another law enforcement agency. In that situation, the provisions of this section apply equally to that referral as well.

7. A decision to exercise the good cause exceptions in this section not to suspend payments or to suspend payments only in part does not relieve MMM of the obligation to refer any suspected case of fraud as provided in this section.
8. Good cause not to suspend payments. ASES may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:
    a. Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
    b. Other available remedies can be implemented by MMM more effectively or quickly protect Medicaid funds.
    c. ASES determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
    d. Beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:
        - An individual or entity is the sole community Physician or the sole source of essential specialized services in a community.
        - The individual or entity serves many recipients within a HRSA-designated medically underserved area.
        - Law enforcement declines to certify that a matter continues to be under investigation per the requirements of this section.
        - ASES determines that payment suspension is not in the best interests of the Medicaid program.
        - Good cause to suspend payment only in part. ASES may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of suspected fraud if any of the following are applicable:
        1. Recipient access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:
            a. An individual or entity is the sole community Physician or the sole source of essential specialized services in a community.
            b. The individual or entity serves a large number of recipients within a HRSA-designated medically underserved area.
            c. ASES determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension to MMM, that such suspension should be imposed only in part.
            d. The allegation of fraud focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a Provider; and
            e. MMM documents in writing to ASES that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

f. Law enforcement, Medicaid Fraud Control Unit or OIG declines to certify that a matter continues to be under investigation per the requirements of this section.
g. ASES determines that payment suspension only in part is in the best interests of the Medicaid program.

Termination of Payment Suspension

Reasons for termination of payment suspension:

1. Determination by the Medicaid Fraud Control Unit that there is insufficient evidence of fraud by the Provider;
    a. Law enforcement declination to investigate a fraud referral
    b. Discontinuance of a pending investigation
    c. Legal proceedings related to the Provider's alleged fraud are completed;
        i. settlement
        ii. judgment
        iii. dismissal.
2. The following steps will be taken when the Payment Suspension process is to be discontinued:
    a. ASES will notify the entity in writing with effective date to end payment suspension
    b. The entity must notify the Provider in writing of effective date to end payment suspension and will provide blind copies to previously identified parties.
    c. The entity must take the necessary action to remove the payment suspension.
    d. After payment suspension has ended, MMM is responsible for monitoring claims to ascertain whether any inappropriate payments are made or to identify aberrant billing patterns, in which case appropriate action will be initiated.
    e. MMM must submit to ASES and Medicaid Program Integrity Office on a quarterly basis a report summarizing information on the following:
        i. Regarding recommended payment suspensions:
            1. The nature of the suspected fraud;
                a. The basis for the proposed suspension; and
                b. The outcome of implemented suspensions.
        ii. About situations in which MMM recommends that good cause exists to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension:
                a. The nature of the suspected fraud; and
                b. The nature of the good cause.

Documentation and record retention

MMM must meet the following requirements:

Maintain for a minimum of ten (10) years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:

a. All notices of suspension of payment in whole or part.
b. All fraud referrals to the Medicaid Fraud Control Unit or other law enforcement agency.
c. All quarterly certifications of continuing investigation status by law enforcement.
d. All notices documenting the termination of a suspension.

e. Maintain for a minimum of ten (10) years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.
f. This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long MMM anticipates such good cause will exist.
g. Annually report to ASES summary information on each of following: Suspensions of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension. Situations in which the good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

XXIX. Subcontractors and/or Delegated Entities:

All Providers, Contractors, Subcontractors and Delegated Entities contracts should include a requirement of collaborating with MMM Medicaid Compliance Department in promptly complying the Medicaid Compliance and Program Integrity. This includes but not limited to;

A. Access to Medical records, computerized data, or any other information kept by the Provider, Contractor, or Delegated Entity in the process of performing the delegated functions or providing healthcare services.
B. HIPAA privacy and security safeguards must be taken to protect the Privacy rights of the Beneficiaries.

XXX. Disclosures:

Subcontractors/Delegated or Related Entities:
Must disclose;

a. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or the entity contracted by ASES.
b. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
c. Date of birth and Social Security Number (in the case of an individual).
d. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or the entity contracted by ASES) or in any subcontractor in which the disclosing entity (or fiscal agent or the entity contracted by ASES) has a 5 percent or more interest.
e. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or the entity contracted by ASES) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or the entity contracted by ASES) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

f. The name of any other disclosing entity (or fiscal agent or the entity contracted by ASES) in which an owner of the disclosing entity (or fiscal agent or the entity contracted by ASES) has an ownership or control interest.
g. The name, address, date of birth, and Social Security Number of any managing Employee of the disclosing entity (or fiscal agent or the entity contracted by ASES).

Disclosures from Providers or disclosing entities:
Disclosure from any Provider or disclosing entity is due at any of the following times:
a. Upon the Provider or disclosing entity submitting the Provider application.
b. Upon the Provider or disclosing entity executing the Provider agreement.
c. Upon request of ASES during the re-validation of enrollment process under § 455.414.
d. Within thirty-five (35) days after any change in ownership of the disclosing entity.
e. Disclosures from Contractors or other state-contracted entities - Disclosures are due at any of the following times:
    i. Upon submitting the proposal in accordance with the State's procurement process.
    ii. Upon executing the contract with the State.
    iii. Upon renewal or extension of the contract.
    iv. Within thirty-five (35) days after any change in ownership of the fiscal agent, manage care organizations or contracted entity. Updated information must be furnished to ASES or MMM, as applicable, at intervals between recertification or contract renewals, within thirty-five (35) days of a written request.

Consequences for failure to provide required disclosures:

Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

MMM shall not approve a Provider Contract, and must terminate an existing agreement or contract, if the Provider or fiscal agent fails to disclose ownership or control information as required by this section.

Medicaid Compliance Department Data Management:

The Medicaid Compliance Department receives at least on a monthly basis (of more frequent as needed) from the Credentialing Department the information collected regarding OD & COI. This information is part of the proactive data analysis performed into the existing Program Integrity Plan (PIP). Data is received in an Excel spreadsheet, considering all the elements determined in the COI & OD forms and described on sections 7.1 and 7.2 of this policy. The information is analyzed to identify any discrepancy and/or data that can result in a potential red flag under the requirements established with ASES and MMM PIP. The Medicaid Compliance Department uses the results of this analysis to report any finding to MMM Compliance Committee, Board of Directors, ASES or any state and federal regulatory body impacted. Results can be also used for FWA investigations. Some examples of validations are;

- Providers completes the disclosure form(s) prior to participation in MMM Multihealth Network;
- Disclosures received comply with the required timeframes defined by Medicaid;
- Percentage % of participation disclosed satisfies the requirement;

- Who is providing the disclosure(s)? E.g. Authorized Individuals or Facilities, among others.
- Once the data analysis is completed, the results are maintained in a defined log by the Medicaid Compliance Department.

XXXI. Prohibited Affiliations with Individuals Debarred by Federal Agencies:

MMM shall not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under any guidelines implementing the Executive Order.
- An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described under ASES Contract (Section 13.4.1.1.) The relationship is defined as follows:
    - A director, officer, or partner of MMM;
    - A person with beneficial ownership of five percent (5%) or more of MMM equity; or
    - Any Subcontractor or other person with an employment, consulting, or other arrangement with MMM for the provision of items or services that are significant and material the MMM obligations under the current contract.

A Network Provider or person with an employment, consulting or other arrangement with MMM for the provision of items and services that is significant and material to MMM obligations under the Contract. MMM shall not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1129 or 1128A of the Social Security Act.

XXXII. Recipient ("Enrollee") Verification Survey:

The Medicaid Compliance Specialist/FWA Investigator performs reviews to verify that services billed by Providers (as well as encounters under capitated environment) were indeed rendered. To conduct this process, an assessment is made of services and Provider's types may represent a high risk:

- Inclusion of a type of service or a Provider's type or Specialty in the OIG Annual Work Plan. OIG develops their annual work plan based on potential risk and passed experience and audits;
- Inclusion in previous year's OIG Audit Reports;
- Inclusion of a specific Provider's type or service in recent Fraud Alerts;
- Provider's types or services identified as high risk in healthcare industry workgroups (meetings with another Health Plans, Task Force, ASES, MFCU);
- Identified as high risk through queries and FWA software which identifies red flags using claims and utilization data mining based on Provider's types and service codes, among others;
- History of complaints and grievances. Patterns may be traced to Provider's types and assessed as high risk. Many cases of services not rendered are identified by Beneficiary's complaints

- Assessment of previously identified trends or patterns based on Provider's types and services.

On a monthly basis, the FWA Investigator selects a random sample consisting of Enrollees who received healthcare services according to claims/encounters/based on explanation of benefits generated within forty-five (45) Calendar Days of payment of claims.

Recipient Verification Survey (RVS) – a survey is performed to all the Enrollees included in the sample. The purpose of the survey is to identify if a specific service for which the Provider submitted a claim/encounter was rendered and if the service was rendered as it was submitted to the health plan. During the first ten (10) business days following the end of the month, a written survey/call is completed to all Enrollees included in the selected sample. The survey can be completed by mail or through a call. In case that is considered by mail a pre-addressed envelope is included to return it to MMM.

During the call, the FWA Investigator ask the Enrollee the same questions included in the written RVS. Documentation of the call includes the date and time the call was completed as well as the Enrollee's answers to the survey. The quantity of the sample will be determined depending on various factors including the number of Providers identified, quantity of services billed, and quantity of lives assigned to the specific Provider/Primary Medical Group (PMG), among others. The following are techniques considered part of methodologies used with this process:

- Selection randomly sample against all Providers maintained in MMM system;
- Stratified sample, with more Providers selected from higher risk groups;
- Targeted sample – sample from a specific Provider, Group or Facility;
- Census – identification of all claims for a specific Provider, Group or Facility.

Medical Record Review – A written notification is sent to the Providers who rendered the billed services included in the sample, requesting a copy of the Enrollee's medical record. Providers is oriented to submit records/progress notes through InnovaMd in order to facilitate the process and ensure compliance with HIPAA requirements and safeguards during this process. A review of the medical record will be performed to assess if the claim information matches the medical record. The FWA Investigator must document findings of the RVS and the Medical Record Review in a written report for discussion with the Medicaid Compliance Manager and Medicaid Compliance Officer. Among other things, the following will be evaluated:

- If the recipient received the service;
- If the correct service was billed;
- If the date of service and time are correct.

If necessary, any required corrective actions such as recoveries, Provider education, among others, must be taken by the Medicaid Compliance Staff in a timely manner. Recoveries will occur for missing, inaccurate, or incomplete claims/encounters submitted.

XXXIII. Reporting to ASES and Medicaid Program Integrity Office:

MMM must ensure that all the FWA cases referred to ASES meets the following elements before submission;

- Case identification, considering control number, offender details, among others;

- Complete file with the applicable supporting documentation (considering the stage where the information is at the time of the initial or ongoing updates to ASES);
- Notification letter(s) to suspect/offender;
- Notification letter to ASES and Medicaid Program Integrity Office;
- Documentation regarding of entrance and exit interviews, and if necessary, copy of referral letters and case resolution letter to and from legal authorities, among others.

The following reporting requirements will be submitted by MMM Medicaid Compliance Department to the ASES Compliance Office on a quarterly basis:

1. A report of FWA Investigations pending, in process and completed, identifying any cases referred to the OIG, MFCU, Department of Justice, or US Attorney's Field Office.
2. Based on ASES's Reporting Guide, the following parameter and specifications are considered to Report 03.
    - Total Number of FWA Cases pending at beginning of the Reporting Period
    - Total Number of FWA Cases Open during the Reporting Period
    - Total Number of FWA Cases Closed During Reporting Period
    - Total Number of FWA Cases Pending at the End of the Reporting Period
    - Total Number of Cases Referred to ASES in the current Reporting Period
    - Total Number of Cases Referred to a Government Agency the current Reporting Period
    - Total Overpayment
    - Number of Provider Cases Pending at the Beginning of the Reporting Period (Carried over)
    - Number of Provider Cases Open During the Reporting Period
    - Number of Provider Cases Closed During the Reporting Period
    - Number of Provider Cases Pending at End of the Reporting Period
    - Total Number of Provider Cases Referred to ASES in the current Reporting Period
    - Total Number of Cases Referred to a Government Agency in the current Reporting Period
    - Overpayment Amount - Provider Cases
    - Number of Enrollee/Other Cases Pending at the Beginning of the current Reporting Period (Carried Over)
    - Number of Enrollee/Other Cases Open During the Reporting Period
    - Number of Enrollee/Other Cases Closed During the Reporting Period
    - Total Number of Enrollee/Other Cases Pending at End of Reporting Period
    - Number of Enrollee/Other Cases Referred to ASES of the current Reporting Period
    - Total Number of Cases Referred to a Government Agency of the current Reporting Period
    - Overpayment Amount- Enrollee/Other Cases
    - Total Initial Allegations for Providers and Enrollees
    - Details of any Provider Suspension or Termination due to FWA
    - Allegations must be classified in one or more of the following categories:
        i. Altering or Falsifying Documents or Medical Records
        ii. Billing for Experimental/Investigational or Noncovered Services as Covered
        iii. Billing for Services Not Rendered or Rendered by a Person Different than the Billing Provider
        iv. Billing for Unnecessary Services, Unbelievable Services or Overutilization Pattern
        v. Claims Review, Data Analysis, Audit or Re-audits Findings, Provider Profile
        vi. Coding Issues (False Coding, Upcoding, Unbundling, Wrong Modifier Use)

vii. Duplicate Charges Pattern
viii. Forgery of Prescriptions
ix. Kickbacks, Solicitation, Bribe, Rebate
x. Miscellaneous Not Elsewhere Specified
xi. Misuse of ID Card
xii. Misuse of Service by Parent or Guardian (enrollee)
xiii. Misuse of Transportation
xiv. Overutilization of Services
xv. Poly-Pharmacy Abuse/Illicit Drug Seeking (enrollee)
xvi. Practicing Beyond Scope of License
xvii. Reimbursement/TPL or Coordination Issues
xviii. REOMBs Feedback
xix. Selling Prescribed Drugs
xx. Split Billing/Serial Billing Pattern
xxi. Use of ID Card by Non-Enrollee/ Impersonation
xxii. Using Another Provider TIN (taxpayer identification #)

- Suspension and Termination Reasons due to FWA must be related with:
    - Upcode/Overcharge Medicaid program for services rendered
    - Billing for Services not rendered or performed
    - Billing for medically unnecessary services
    - Billing for Drugs: unlicensed or unapproved Drugs
    - Billing for Drugs: Brand-name drugs when generic drugs are prescribed
    - Billing for Drugs: short-filling prescription, but charging as if the full amount of the medication was dispensed
    - Unbundling - Using multiple billing codes instead of a single billing code to increase the reimbursement amount
    - Billing for services using stolen, deceased or otherwise inappropriate provider and/or beneficiary identification number
    - Billing for unlicensed or excluded services
    - Other. Specify in Analysis and Notes

- Terminations:
    - § 455.416 Termination or denial of enrollment.

    If terminated due to reasons specified under CFR 455.416, indicate which of the following reasons apply.
        - 42 CFR 455.416(a) (a) Must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart.
        - 42 CFR 455.416(b) (b) Must deny enrollment or terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

- 42 CFR 455.416(c) (c) Must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.
- 42. CFR 455.416(d) (d) Must terminate the provider's enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.
- 42. CFR 455.416(e) (e) Must terminate or deny enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a State Medicaid agency request, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.
- 42 CFR 455.416(f) (f) Must terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing. (g) May terminate or deny the provider's enrollment if CMS or the State Medicaid agency-
- 42 CFR 455.416(g)(1) (g)(1) Determines that the provider has falsified any information provided on the application; or
- 42 CFR 455.416(g)(2) (g)(2) Cannot verify the identity of any provider applicant.
- Provider terminated/sanctioned by OIG, Medicare or another Federal Agency Other Reasons Related to FWA: Specify in Notes

3. Suspected fraud cases must be report immediately in a written format to ASES Compliance Office or Office of Program Integrity.
4. The reports must be submitted in electronic format to facilitate its inclusion in the Puerto Rico Government Medicaid Program PI Annual Report.
5. A report of Preliminary and Full investigations, audits performed, administrative actions taken against Providers, overpayments identified, including any Providers referred to the OIG, Medicaid Program Integrity Office, MFCU and/or Department of Justice.
6. MMM must submit a certification signed by the Medicaid Compliance Officer and the President or CEO indicating that all full investigations were made in accordance with regulatory requirements (42 CFR 455.15). If there is no data to report, a certification will be submitted signed by the Medicaid Compliance Officer and the President or CEO.

MMM Multihealth, LLC.

Medicaid Compliance Department

Cultural Competency Plan

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Introduction

The legal entity MMM Multihealth, LLC, who contracts with the Puerto Rico Health Insurance Administration (Administración de Seguros de Salud de Puerto Rico, hereinafter referred to as ASES) is governed by a separate Code of Conduct, Compliance Program, and Fraud Waste and Abuse (FWA) Prevention Plan from the parent organization, Elevance Health. In addition, MMM Multihealth established this Cultural Competency Plan to assure the integration of all requirements established by ASES detailed in the contract between both parties in the administration and delivery of services for the Puerto Rico Government Health Plan Program (Plan Vital).

MMM Multihealth, LLC, ("MMM MH Vital") has established a comprehensive Cultural Competency Plan to provide a standardized method to assure that all the services provided are culturally competent to its Enrollees. The following information provides a clear understanding on how MMM MH Vital operates and describes how the Employees, Directors, Providers, Contractors, Subcontractors, and systems within MMM MH Vital will effectively provide services to people of all diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, gender identity, LGBTTQ+(Lesbian, Gay, Bisexual, transexual, Transgender, Queer+) communities or religion in a manner that recognizes values, affirms, and respects the worth of the individual Enrollees and protects and preserves the dignity of each individual.

Plan Purpose

To ensure that the unique and diverse needs of all Enrollees are met. Employees and Associates of MMM MH Vital value diversity within the organization, providing services to people of all cultures, races, ethnic backgrounds, "LGBTQIA2S" (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, Two-spirit.) communities and religions in a manner that recognizes, values, affirms, and respects the worth of each Enrollee and protects and preserves the dignity of everyone.

Regulatory Reference

ASES is the agency empowered in law to administer the Government Health Plan (GHP). ASES has contracted MMM Multihealth, LLC (MMM MH Vital), a Managed Care Organization (MCO) to provide and deliver services under the GHP program.

As per sections 6.11, 10.3.1.29 and 15.3.1 of the contract between both parties, ASES requires MMM MH Vital to develop, implement and maintain a Cultural Competency Plan for its Enrollees, assuring that its Provider's Network, Enrollees and Staff is trained and familiar about the basis of the plan and how this can be activated when its needed. MMM MH Vital as part of the procedures adopted requires reviewing the plan at least annually to determine effectiveness. In addition to ASES's requirements the following regulations has a direct impact with this plan.

- 42 CFR 438.206
- ASES Normative Letter – 19-0305 Amended

Plan Description

Definitions:

- **Cultural Competency** refers to a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and the sensitivity to know how these

differences influence relationships with Enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Enrollees' needs, and to work with knowledgeable people of and from the community in developing focused interactions, communications, and other supports.

- **Ethnic:** relating to large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background
- **Religion:** a cause, principle, or system of beliefs held to with ardor and faith
- **Culture:** the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic
- **Sexual orientation:** A person's emotional, sexual and/or relational attraction to others. Usually classified as heterosexual, bisexual, and homosexual (i.e., lesbian, and gay).
- **ASES**: Puerto Rico Health Insurance Administration
- **Enrollee:** means a Medicaid beneficiary who is enrolled in the Government Health Plan.
- **LGBTTQ+:** Lesbian, Gay, Bisexual, Transexual, Transgender, Queer +, and people communities.
- **Provider:** refers to any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.

Objectives:

- Identify Enrollees with potential cultural or linguistic barriers for which alternative communication methods are needed;
- Use appropriate and culturally sensitive educational materials for each type of cultural constraint, including race, religion, gender identity, gender expression, actual or perceived sexual orientation (LGBTTQ+), ethnic origin or language;
- Decrease discrepancies in medical care received;
- Ensure resources are available to meet the unique language barriers and communication barriers that exist with certain Enrollees;
- Ensure Providers recognize the culturally diverse, and needs of the population they serve, considering any protocol that needs to be adopted to ensure a proper quality of services;
- Ensure Providers recognize the diverse religious beliefs of the population they serve;
- Ensure Employees, Directors, Board of Directors, Contracted Providers, Contractors, and Subcontractors are educated to value the diverse cultural, religious, and linguistic differences in the organizations and the population they served;
- Provide mechanism to avoid cultural barriers;
- Act as a facilitator to the Providers, Enrollees, Contractors, Subcontractors, understanding and attending the LGBTTQ+ (Lesbian, Gay, Bisexual, Transexual, Transgender, Queer+) communities, ensuring accessibility of services;
- Learn about the state and federal regulations related to Cultural Competency Plan.

Goals:

- Improve communication to Enrollees for whom cultural or linguistic barriers exist.
- Decrease disparities in the healthcare received by the minorities whom MMM MH Vital serves.
- Improve understanding regarding the cultural and religious diversity within the population served.
- More awareness about values, attitudes, beliefs, diversity and inclusion;
- More inclusion with LGBTQ+ community;
- Expand communication efforts to assure Enrollees' accessibility.

This plan endorses the view of the federal and local government that achieving cultural competency improves services, care and health outcomes of our potentially culturally, religious, and linguistically diverse beneficiaries.

Plan Activities

Section 1: Data Analysis

- MMM MH Vital perform periodically an assessment of its population considering the areas served and selecting Medicaid data.
- Claims and Encounter data is also analyzed to identify population's health needs or any restriction by type of sex considering the needs of the LGBTTQ+ communities.
- As part of the Enrollment process, MMM MH Vital collect information related to race, ethnicity, religion, and the language spoken by members to attend their specific needs.

Section 2: Linguistic Services

- The Contractor shall provide oral interpreter services to any Enrollee or Potential Enrollee who speaks any other language than English or Spanish as his or her primary language, regardless of whether the Enrollee or Potential Enrollee speaks a language that meets the threshold of a Prevalent Non-English Language
- Providers help to identify Enrollees with potential linguistic barriers where alternative communication methods are required.
- If is required, Enrollees have the option to request Interpreter Services at no cost to receive more information about covered services, benefits, Provider accessibility etc.
- Also includes the use of auxiliary aids and services such as TTY/TDD and the use of American Sign Language. The Contractor is required to notify its Enrollees of the availability of oral interpretation services and to inform them of how to access oral interpretation services
- Interpreter Services available shall include verbal interpretation to those Enrollees with limited Spanish proficiency and sign language for the hearing impaired.
- Contracted Subcontractors where Customer Services line(s) will be delegated will have a Cultural Competence Plan previously approved by MMM MH Vital.
- Written materials are available for Enrollees in Spanish and English.

Section 3: Religious Beliefs

- Make sure our Employees are sensitive to Enrollees and treated with respect regarding their religious beliefs.
- Enforce Providers to become knowledgeable regarding religious beliefs of patients and the practice of medicine.

Section 4: LGBTQ+ Population Anti-Discrimination

- Provide guidance and a general understanding of the terms used by us for orientation/identification.
- Review and analyze signage or intake form verbiage that is safe and non-discriminatory.
- Use "partner" instead of "spouse" or "boy/girlfriend".
- Replace marital status with relationship status on forms or collecting information.
- Protect patient rights with confidentiality and privacy.
- ASES issued a Provider's Guide for sensitive and adequate management when providing health services to LGBTTQ+ Enrollees that is distributed to all Providers.
- The Provider is responsible for training its staff on sensitivity to the LGBTTQ+ population.
- The approval and dispatch of medications, as well as medical services, should not be restricted by the Enrollee's sex.

Section 5: Provider Education

- The Provider is educated regarding the Cultural Competency Program through the Provider's Manual on annually basis. The Provider can request via web, telephone call or in person the hard copy of this Plan with not charge. Information is also published in the MMM MH Vitals' Providers Website at https://www.innovamd.com/, a resource for Physicians and other contracted Providers. MMM MH Vitals' staff recruiting, and Provider Network development processes are driven by membership and Enrollee's language and cultural needs. Additionally, Cultural Competency training allows the Provider to perform the training at their convenience. The training addresses the same elements described in this plan for the Employee training. Finally, recognizing that Providers may require assistance communicating with Beneficiaries who speak languages other than Spanish and English, MMM MH Vital train the Providers to use MMM MH Vitals' translation services through initial orientation, the Provider Guideline and ongoing Provider relations visits.

Section 6: Electronic Media

- Enrollees have access to the TTY/TDD line for hearing impaired services. Enrollees Services Representatives will follow-up on any necessary additional calls to Enrollees.

Section 7: Cultural Competency Questionnaire

- To increase awareness of practices, beliefs, attitudes, and values that promote cultural, religious, understanding of LGBTTQ+ communities and linguistic competence, as well as to identify training needs, Employees providing direct services to Enrollees will participate in a yearly self-assessment like the one promoted by the National Center for Cultural Competence, Georgetown University or a similar entity to measure the Cultural Competency Plan effectiveness.

Work Plan

Activity	Frequency
MMM MH Vital New hire Employees Training	Within ninety (90) days upon hire
Annual Training (Employees, Contracted Providers, Subcontractors)	Q3 or Q4 of each year
Cultural Competency Plan submission and approval to ASES	Annually
Provider's & Enrollee Websites' Review	Annually
Provider's Educational Bulletin	Quartely
Cultural Competency State and Federal regulations review	Q4 of the year
Annual Employee Questionnaire Completion to measure Cultural Competency Plan effectiveness	Annually

VII: References:

- 42 CFR 438.206
- ASES Contract 6.11-Appendix L

Plan's Approval

Approver Name: Liza Rivera Ortiz	**Position:** Medicaid Compliance Officer
Approver Signature: Signature on File	**Approved Date:** 12/18/2023