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Regulatory Trainings

2026

What are Regulatory Trainings?

Regulatory Trainings are a requirement established by the Centers for Medicare & Medicaid Services (CMS) and the Health Services Administration of Puerto Rico (ASES, for its acronym in Spanish), which audits compliance with them. All providers contracted under MSO of Puerto Rico must complete these trainings annually.

These Regulatory Trainings contain the following:

- ✓ Coordinated Care Model 2026
- ✓ Compliance Program & Fraud, Loss, and Abuse
- ✓ Regulations Applicable to the Health Industry
- ✓ Vital Plan Overview

Why should I take these trainings?

Regulatory Trainings integrate fundamental aspects that range from the implementation of the Coordinated Care Model to the promotion of cultural competences, as well as respect for the rights and responsibilities of the patient, among other laws that govern the health sector in Puerto Rico.

These trainings also cover key issues such as the establishment of compliance and integrity programs that are crucial to maintain high ethical and legal standards in medical care.

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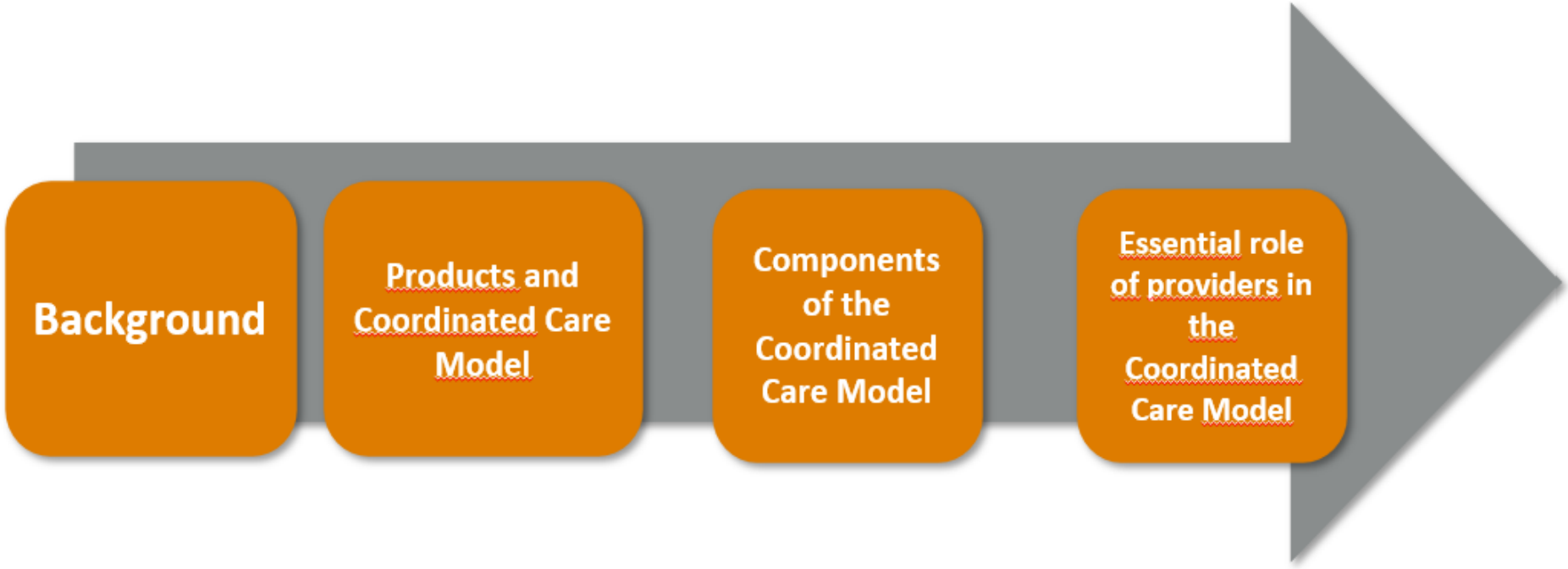
Coordinated Care Model 2026

Objectives


Background
Products and Coordinated Care Model
Components of the Coordinated Care Model
Essential role of providers in the Coordinated Care Model

Model of Care: Training

Developed to comply with the guidelines of the Centers for Medicare and Medicaid Services*.

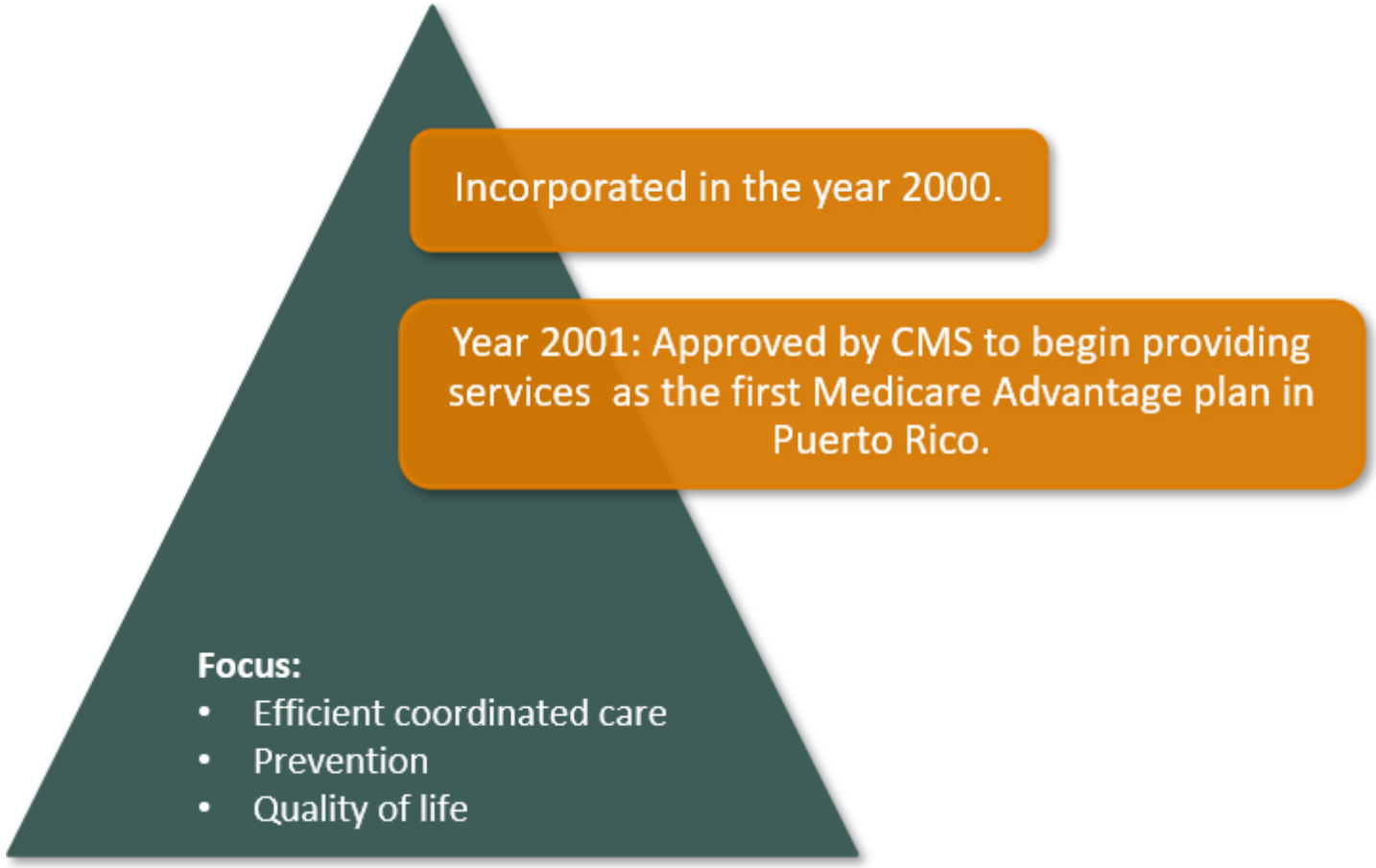
Every Medicare Advantage insurer must provide and document training on the Coordinated Care Model** to all employees, contracted personnel, and providers.

This training is an annual requirement.

- Methodology or types of intervention:
  - ❑ Face-to-face
  - ❑ Interactive (Internet, audio/video)
  - ❑ Self-study (printed material or electronic media)

* CMS **MOC

Background


Incorporated in the year 2000.
Year 2001: Approved by CMS to begin providing services as the first Medicare Advantage plan in Puerto Rico.
Focus:
• Efficient coordinated care
• Prevention
• Quality of life

Background

5 Stars: We celebrate that our two main contracts have received the highest star rating, 5 stars out of 5, under Medicare's Star Rating Program.

Contracts H4003 and H4004: Each year, Medicare evaluates plans based on star ratings, with 5 stars being the highest rating awarded.

What is the Coordinated Care Model?

- Structured to carry out coordinated care efficiently.
- Focuses on beneficiaries with special needs.

- It is a vital tool.
- Improves the Quality of care.
- Ensures that needs are met under SNP*.

*SNP –Special Needs Plan

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2026

COVERAGES

Special Needs Plans (SNP)

D-SNP (Dual Eligible Special Needs Plan)	
MMM Diamante Platino (HMO D-SNP)	Members eligible for Medicare and Medicaid.
MMM Relax Platino (HMO D-SNP)	
MMM Dorado Platino (HMO D-SNP)	
MMM Combo Platino (HMO D-SNP)	
MMM Flexi Platino (HMO D-SNP)	
PMC Premier Platino (HMO D-SNP)	

Special Needs Plans (SNP)

C-SNP (Chronic Condition Special Needs Plan)	

MMM Supremo (HMO C-SNP)	Members with chronic or disabling conditions:
	• Diabetes
	• Chronic heart failure (CHF)
	• Cardiovascular diseases:
	  ○ Cardiac arrhythmia
	  ○ Peripheral vascular disease
	  ○ Coronary artery disease
	  ○ Chronic venous thromboembolic Disorder

Elements of the MOC

Description of Special Needs Population (SNP)

Coordinated Care

- Mandatory assessment of Health Risks and Reassessment (HRA)
- Medical Visits (Face-to-Face)
- Individual Care Plan (ICP)
- Interdisciplinary Team (ICT)

Provider Network

Quality Metrics and Performance Improvement

MOC 1: Description of the Special Needs Population (SNP)

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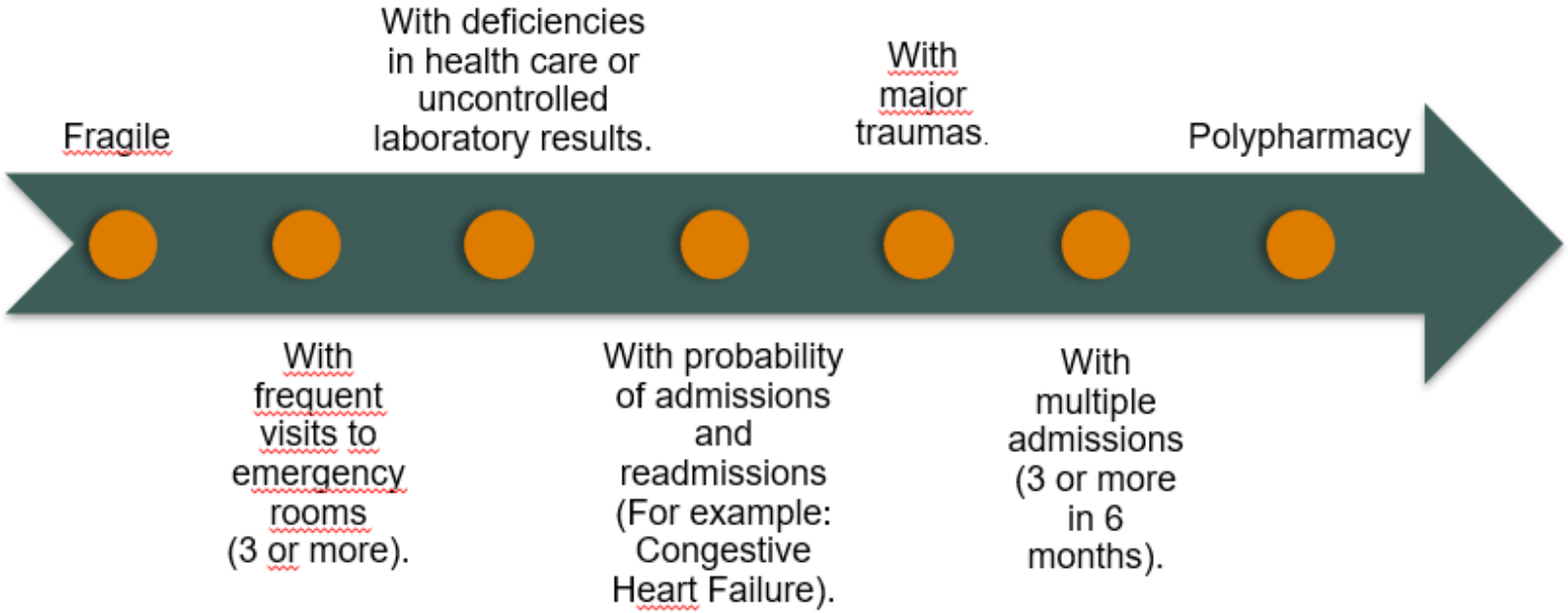
The Most Vulnerable

- **Identify those members with the greatest fragility.**



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The Most Vulnerable

- **Members with uncontrolled chronic conditions:**
  - COPD (Chronic Obstructive Pulmonary Disease)
  - Asthma
  - CHF (Congestive Heart Failure)
  - Cardiovascular disease / Arteriosclerosis
  - HTN (Hypertension)
  - Diabetes
- **Members with disabilities**
- **Members that require complex procedures and/or care transition:**
  - Organ transplant
  - Bariatric surgery

MOC 2:
Coordination of services

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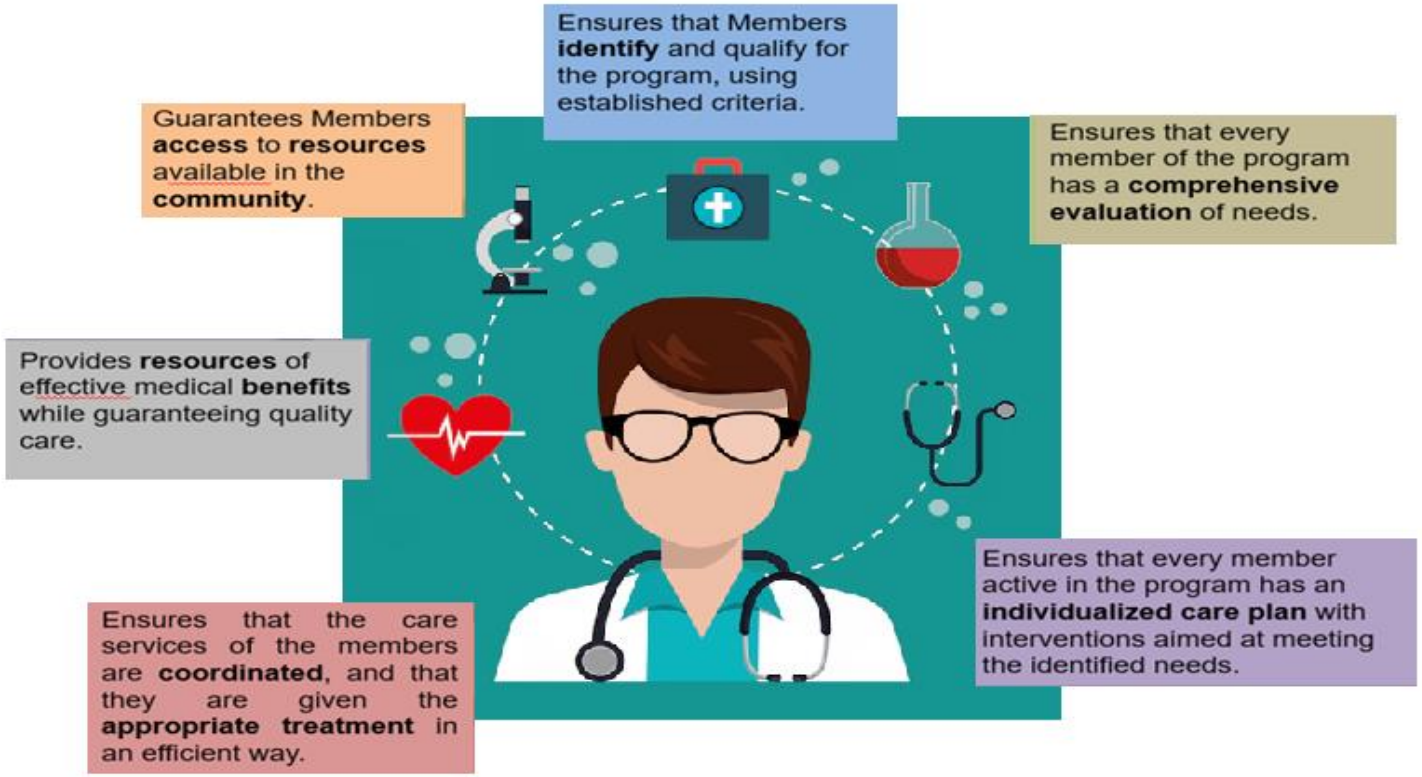
Coordinated Care

Ensures the attention of the health needs of beneficiaries of an SNP. The information is shared among interdisciplinary staff.

Coordinates the delivery of specialized services and benefits that meet the needs of the most vulnerable population.

Carries out Health Risk Assessments and Individualized Care Plan and has an established Interdisciplinary Team.

Focus of the Program



Health Risk Assessment (HRA)

It is done to identify medical, mental, psychosocial, cognitive, and functional needs of people with special needs.

Initial HRA – 90 days after the affiliation to complete it. Annual HRA from 365 days after the initial or last HRA.

Health Risk Assessment (HRA)

It is done by phone or on paper.

Results → Individualized Care Plan:

* Problems, goals, and interventions with an interdisciplinary team.

HRA refers to → Care Management Programs

* Case management, among others.

Shared care plan with:

member + PCP and Interdisciplinary Team

Medical Visits (Face-to-Face)

Essential elements:

- Effective management of preventive care.
- Establish treatment plans to control chronic diseases and improve overall health.
- Support members in the active participation of their medical care.
- Identify members who can qualify and benefit from case management programs established by the medical plan.
- Promote effective coordinated care.

Individualized Care Plan (ICP)

- The interdisciplinary team develops an ICP for each SNP coverage member, identifying the needs of the member from the results obtained in the HRA.

- The ICP guarantees that the needs are met, the course of evaluation and coordination of services, and the benefits of the member.

Individualized Care Plan (ICP)

- ICP is communicated to the member or caregiver and is shared with the Provider through our InnovaMD portal.

- Review annually or when state of health changes.

Interdisciplinary Team (ICT)

Group focused on the member. Discusses the state of health and interventions for the patient.

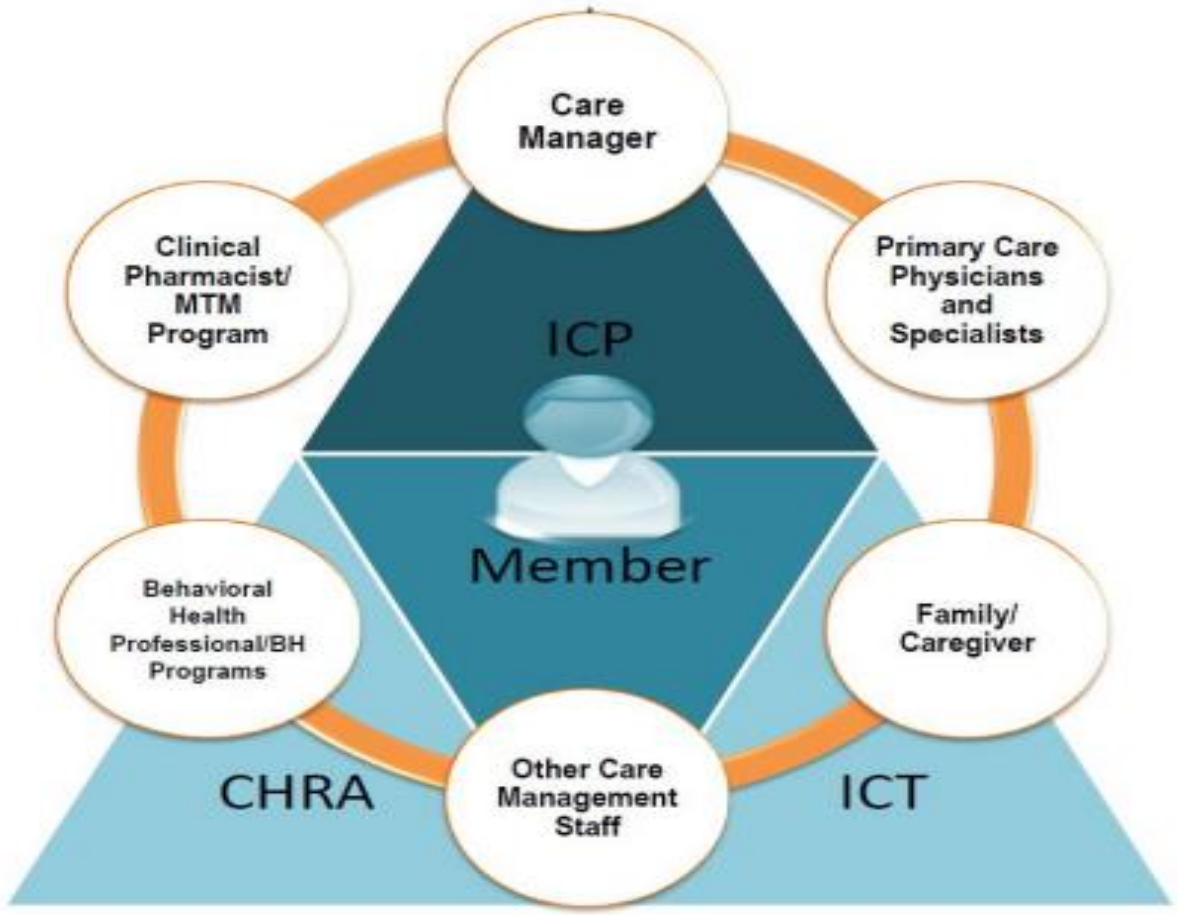
Responsabilities of providers in the ICT:

1. Participate in ICP discussion.
2. Collaborate in setting goals.
3. Involve members in the management of self-management and follow up.
4. Integrate other physicians and providers.
5. Participate in ICT meetings.
6. Communicate changes to ICT components through meetings or phone calls.
7. Refer to the management programs available through the plan.

Transition of Care

- Transition processes and protocols are established to maintain continuity of care.
- The different units work in collaboration with primary doctors and providers to guarantee and support the coordinated care that the member deserves.
- Staff available in the discharge planning unit facilitates communication between care centers, the primary physician, and the member or their caregiver.
- The member's ICP is shared with member and their primary physician, when a care transition occurs.

Protocols for Care Transition



Role of the Provider in the Model of Care

- Ensures continuous access to service and verify what needs and information are shared among staff.
- Promotes the post-discharge visit in a period within seven days after hospitalization.
- Coordinates specialized services to the most vulnerable population.
- Promotes health risk assessment for the Individualized Care Plan.
- Actively participates as part of the interdisciplinary team.
- Performs an annual health assessment.

MOC 3:
Specialized Provider Network in the Care Plan

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Focus

Maintain a network of specialized providers to meet the needs of our members, as the primary link in their care.

The Provider Network monitors:

- ✓Use of clinical practice guidelines and protocols.
- ✓Collaboration and active communication with ICT and case administrators.
- ✓Assistance in the preparation and updating of care plans.
- ✓Guarantee that all network providers are evaluated qualified through a credentialing process.

MOC 4:
Quality Measurement and Performance Improvement

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Quality Measurement and Improvement

The plans stablishes a Quality Improvement Program to monitor health outcomes and performance of the care model
According to the established SNP Quality Improvement Program plans, the plans establish a Quality Improvement program to monitor health outcomes and performance of the care model through: • Data collection and monitoring of measures of measures of the Fives Star Program, SNP specific. (HEDIS, Healthcare Effectiveness Data, and Information Set) • The carrying out of an Annual Quality Improvement Project, which focuses on improving the clinical aspect or service that is relevant for the SNP population. • Measurement of SNP member satisfaction.

Quality Evaluation and Improvement

The plans establish a quality improvement program to monitor health results and performance of the care model through:

- Chronic Care Improvement Program (CCIP) for chronic disease, which identifies eligible members, and intervention to improve disease management and evaluates the effectiveness of the program.
- The collection of data to evaluate if the objectives of the SNP program are met.
- Share annual performance results with members, employees, vendors, and the general public.

References

- *Model of Care Scoring Guidelines for Contract Year 2026*. Obtained from: Model of Care Scoring Guidelines for Contract Year (CY) 2026.

1. *Medicare Managed Care Manual*. Chapter 5 - Quality Assessment, section 20.2 Additional Quality Improvement Program Requirements for Special Needs Plans (SNPs). Obtained from:

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

Our commitment to quality

- Today we are proud to see that MMM special needs coverage will continue to improve the quality of life for thousands around the island.

For more information:

787-993-2317 (Metro Area)

1-866-676-6060 (toll free)

Monday through Friday from 7:00 a.m. to 7:00 p.m.

Effective Compliance Program Guidelines & Laws Applicable to the Healthcare Industry in Puerto Rico

2026 Training – Providers and Vendors

Introduction

- This training is designed to provide you an awareness about policies and procedures in the areas of Compliance, Fraud, Waste and Abuse, and Regulations Applicable to the Healthcare Industry in Puerto Rico.
- Compliance is everyone's responsibility. How we work together to achieve our mission and values helps to create our shared culture of integrity. This culture is foundational to everything we do and grounded in Doing the Right Thing while staying compliant with our laws, regulations, and policies.
- Our company has a tremendous opportunity to simplify and improve the healthcare experience for the communities we serve, and we're glad you're a part of it. We sincerely appreciate your contributions and hope you find this training informative.

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Introduction

When we talk about compliance in the healthcare industry, the regulation refers to seven main elements that must be implemented in any organization, no matter its size. Although the general perception is that compliance programs are required only for large organizations, the truth is that the size of the organization does not matter, whether it is a hospital, a medical office, a laboratory, any medical service center and/or contractor that administers any benefit of the plan or performs any administrative function, having a compliance program ensures that you have an infrastructure that allows the personnel who work there to know the standards and procedures that help prevent and detect any non-compliance with federal and state laws and regulations that govern the healthcare industry.

Introduction

Organizations must ensure that a culture of ethics and commitment to compliance is promoted within their facilities, no matter the size of their organization.

This material is a reference to assist you in identifying key requirements of an effective compliance program. Completing your study is not a guarantee that a sponsor, supplier or delegated entity has an effective compliance program. Sponsors, providers, and First tier, Downstream, and Related entities (FDRs) are responsible for establishing and implementing their own policies and procedures to ensure compliance with federal and state regulations and program guidelines.

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An Effective Compliance Program

- **What Is an Effective Compliance Program?**

– An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance.
- Is fully implemented and is tailored to an organization's unique operations and circumstances.
- Has adequate resources.
- Promotes the organization's standards of conduct.
- Establishes clear lines of communication for reporting non-compliance.

– An effective compliance program is essential to prevent, detect, and correct Medicare & Medicaid non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

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Seven Core Compliance Program Requirements

1. **Written Policies, Procedures, and Standards of Conduct**
   These articulate the sponsor's commitment to comply with all applicable federal and state standards and describe compliance expectations according to the Standards of Conduct.

2. **Compliance Officer, Compliance Committee, and High-Level Oversight**
   The sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. The sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the sponsor's compliance program.

3. **Effective Training and Education**
   This covers the elements of the compliance plan as well as preventing, detecting and reporting of FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

4. **Effective Lines of Communication**
   Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith compliance issues reporting at Sponsor and First-Tier, Downstream, or Related Entity (FDR) levels.

5. **Well-Publicized Disciplinary Standards**
   Sponsor must enforce standards through well-publicized disciplinary guidelines.

6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**
   Conduct routine monitoring and auditing of sponsor's and FDR's operations to evaluate compliance with regulatory requirements as well as the overall effectiveness of the compliance program. NOTE: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the sponsor's Medicare and Medicaid Programs comply with these Programs requirements.

7. **Procedures and System for Prompt Response to Compliance Issues**
   The sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

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Compliance Program

- **Ethics: Do the Right Thing!**

  As part of the Compliance Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!

  - Act fairly and honestly.
  - Adhere to high ethical standards in all you do.
  - Comply with all applicable Federal and State laws and regulations.
  - Report suspected violations.

- **How Do You Know What Is Expected of You?**

  – The Standards of Conduct (or Code of Conduct) of an Organization states its compliance expectations and operational principles and values. Organizational Standards of Conduct vary. The organization should tailor the Standards of Conduct content to their individual organization's culture and business operations. Ask management where to locate your organization's Standards of Conduct.

  – Reporting Standards of Conduct violations and suspected non-compliance is **everyone's** responsibility.

  – An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

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Compliance Program

- **What is Non-Compliance?**
  Non-compliance is conduct that does not conform to the law, federal health program requirements, state requirements, or an organization's ethical and business policies. High risk areas are:

  - Agent/broker misrepresentation
  - Appeals and grievance review (for example, coverage and organization determinations)
  - Beneficiary notices
  - Conflicts of interest
  - Claims processing
  - Credentialing and provider networks
  - Documentation and timeliness requirements
  - Ethics
  - FDR oversight and monitoring
  - Health Insurance Portability and Accountability Act (HIPAA)
  - Marketing and enrollment
  - Pharmacy, formulary, and benefit administration
  - Quality of care

  For more information, refer to the Compliance Program Guidelines in the "Medicare Prescription Drug Benefit Manual" and "Medicare Managed Care Manual."

Know the Consequences of Non-Compliance

Failure to follow Medicare & Medicaid Programs requirements and CMS guidance can lead to serious consequences including:

- Contract termination
- Criminal penalties
- Exclusion from participation in all Federal health care programs
- Civil monetary penalties

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training
- Disciplinary action
- Termination

Compliance Program

- **Non – compliance affects everybody:**

  Without programs to prevent, detect, and correct non-compliance, we all risk:

  Harm to beneficiaries, such as:
  - Delayed services
  - Denial of benefits
  - Difficulty in using providers of choice
  - Other hurdles to care

  Less money for everyone, due to:
  - High insurance copayments
  - Higher premiums
  - Lower benefits for individuals and employers
  - Lower Star ratings
  - Lower profits

- **How to Report Potential Non-Compliance:**
  - Call the Medicare Compliance Officer
  - Make a report through your organization's website
  - Talk to a manager or supervisor
  - Call your ethics/compliance help line
  - Report to the sponsor

Don't Hesitate to Report Non-Compliance

When you report suspected non-compliance in good faith, the sponsor can't retaliate against you.

Each sponsor must offer reporting methods that are:

- Anonymous
- Confidential
- Non-retaliatory

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Compliance Program

- **What Happens After Non-Compliance Is Detected?**

  Non-compliance must be investigated immediately and corrected promptly.

  Internal monitoring should ensure:

  - No recurrence of the same non-compliance
  - Ongoing compliance with requirements
  - Efficient and effective internal controls
  - Protected enrollees

- **What Are Internal Monitoring and Audits?**

  Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.

  Internal auditing is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

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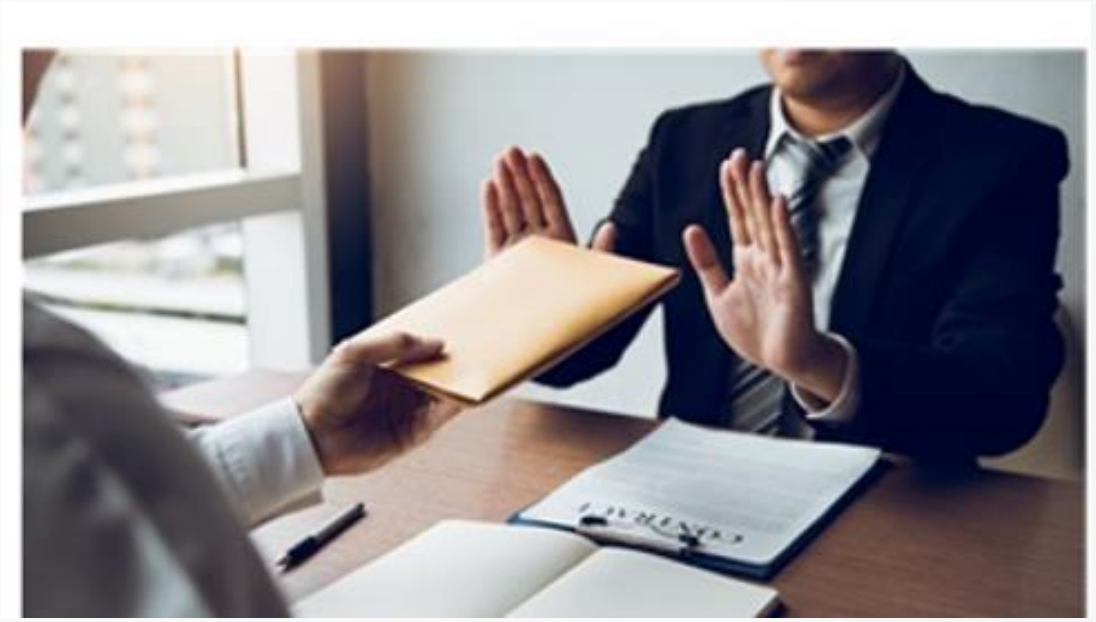
Conflict of Interest

- A **conflict of interest** arises when your personal interests or activities appear to influence or may influence your ability to act in the best interests of MMM Holdings, LLC. You are required to disclose whatever situation that may represent a conflict of interest. For example:
  - You may not own a significant financial interest in any business that does business with or competes with MMM Holdings, LLC or its subsidiaries or affiliates.
  - You are required to disclose to your Management Authority whatever there is a supervisory to subordinate personal relationship (or the appearance of one).
  - If someone close to you has a relationship with a competitor or business in the managed care industry, this requires extra sensitivity.

Bribery and Corruption

- A bribe is anything of value, a reward, advantage or benefit made, offered or accepted for the purpose of improperly obtaining or retaining business or for any other improper purpose or commercial advantage. A bribe does not have to be money. A bribe can be gifts, entertainment, and services.
- MMM Holding, LLC has a strict policy on Global Anti-Corruption and is committed to complying with the US. Foreign Corrupt Practices Act (PCPAA), the U.S. Travel Act, the U.K. Bribery Act and all other applicable anti-bribery laws.
- MMM Holdings, LLC prohibits any form of bribery or corruption, whether in commercial dealings, with private parties, or in dealings with any government.
- When working on our behalf or on our business, supplies (providers)are required to comply with all applicable U.S. and local anti-bribery laws.



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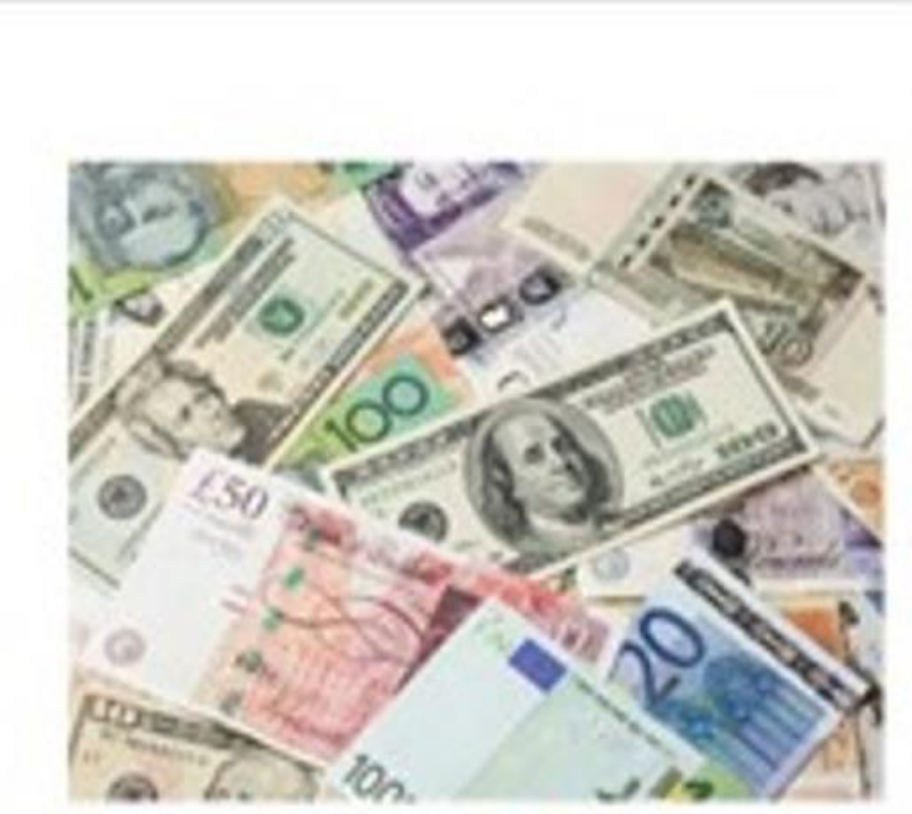
Guidelines to Accept and Offer Gifts

- Cash and/or honorariums are **NEVER** allowed.
- Gifts offered, or accepted, from external, non-government affiliated sources, cannot exceed $100 or equivalent in local currency per occasion, and no more than two times this amount from the same source within a calendar year.
- MMM Holding, prohibits any form of bribery or corruption when dealing with private or public parties or foreign government officials.
- You must ensure any gift given or received, or entertainment hosted or attended does not violate the law and customary business practices.



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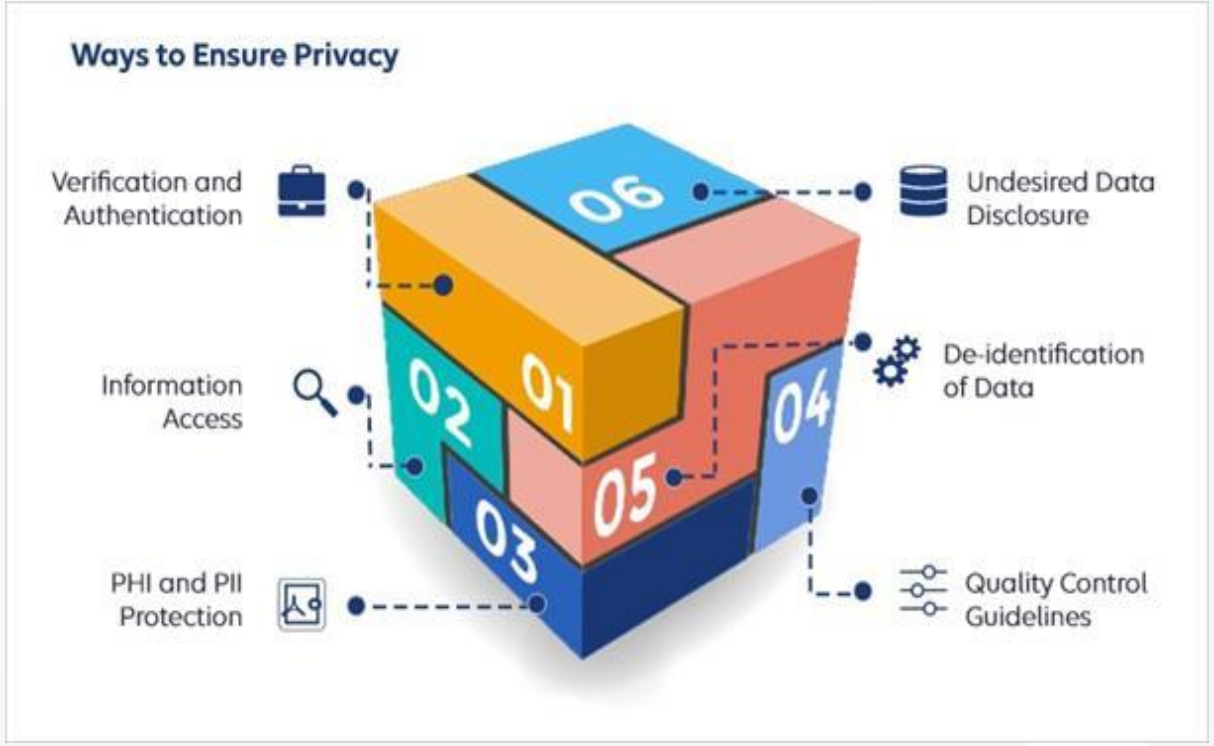
Privacy

MMM Holding, LLC operates in a highly regulated environment and is committed to protecting member information.

MMM Holding, LLC complies with the United States state and federal laws and regulations including HIPAA, the Health Insurance Portability and Accountability Act.

Any violation can result in severe legal and financial consequences for our organization.



Privacy

The three types of protected information are:

- **Personally, Identifiable Information, or PII.** PII is a general term that is used to describe any form of sensitive data that could be used to uniquely identify, contact, or locate individuals and would include personal financial information.
- **Protected Health Information, or PHI.** PHI is any medical information that can potentially identify an individual, that was created, used, or disclosed while providing healthcare services, whether it was a diagnosis or treatment. This includes past, present, and future information about treatment, payment for health care, and eligibility for Health Plan benefits. PHI can be oral, written, or electronic. In the healthcare industry, leaving PHI unattended could mean a HIPAA violation. Additionally, HIPAA and client contract provisions may limit how we can use and disclose data versus what can be done in other industries. You must follow company policies and execute professional judgement while handling PHI and PII.
- **Confidential & Proprietary information.** Any information that is generally not disclosed to individuals outside of Elevance Health or any non-public information that could be useful to our competitors is categorized as confidential and proprietary information.

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Privacy

Examples of PII:

- Full name
- Date of birth
- Phone number
- Credit Card Number
- Social Security Number and
- Address

Examples of PHI:

- Medical records
- Medical claims
- Healthcare premiums & bills
- Eligibility & Enrollment information
- Social Security Number
- Healthcare ID number
- Name
- Address
- Phone number
- Email
- Date of birth, service dates and other dates specific to an individual

Examples of Confidential and Proprietary Information:

- Financial data
- Provider contract terms
- Sales figures
- PII and PHI
- ePHI or electronic protected health information
- Business plans
- Customer lists
- Application code

In case of undesired disclosure of data, do the following:

- **Immediately contact your Management Authority.**
- **Immediately submit a Privacy & Security Disclosure Report to MMM Holdings, LLC**.

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Understand Fraud, Waste and Abuse

Fraud is intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit.

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Understand Fraud, Waste and Abuse

Waste includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.

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Understand Fraud, Waste and Abuse

Abuse is when health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

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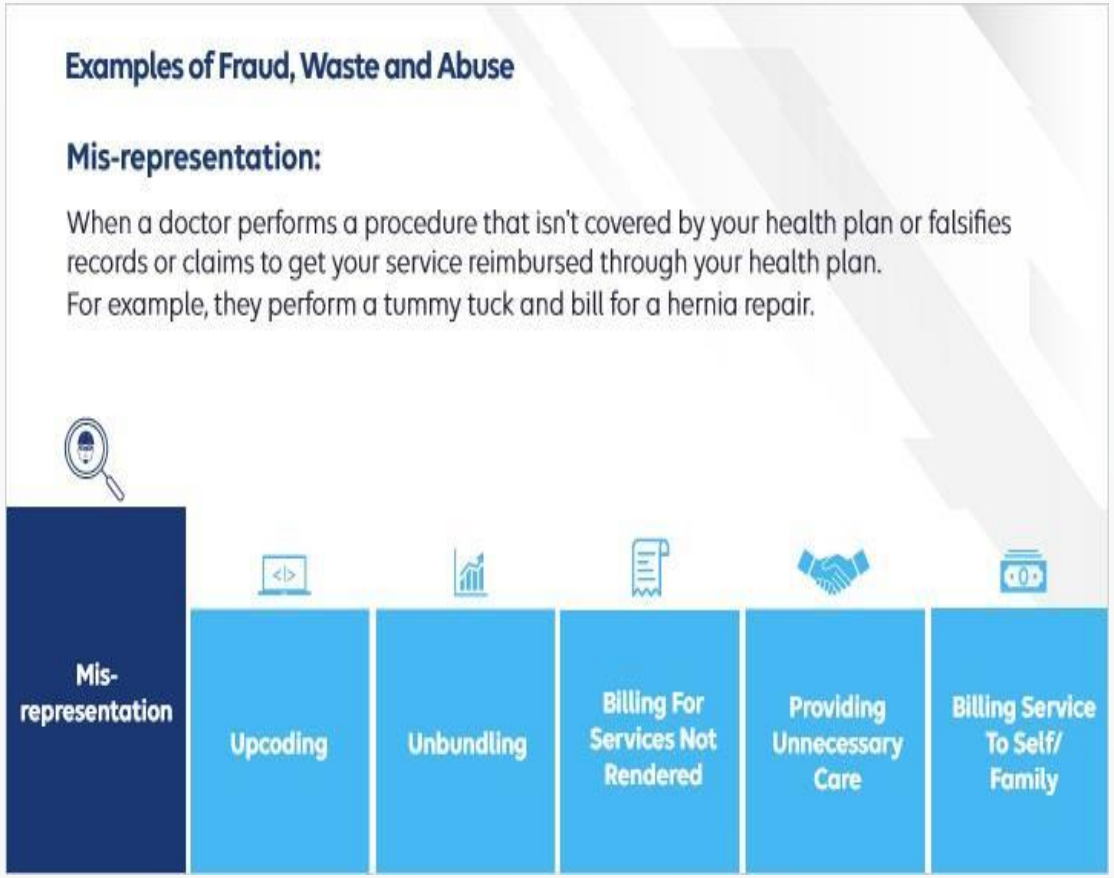
Examples of Fraud, Waste and Abuse



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Examples of Fraud, Waste and Abuse

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Examples of Fraud, Waste and Abuse

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Where to Report FWA

Medicare Providers

HHS Office of Inspector General:

- **Phone**: 1-800-HHS-TIPS (1-800-447-8477) or **TTY** 1-800-377-4950
- **Fax:** 1-800-223-8164
- **Online**: Forms.OIG.hhs.gov/report-fraud
- **Mail:** US Department of Health & Human Services Office of Inspector General ATTN: OIG Hotline Operations PO BOX 23849 Washington, DC 20026

Medicare Parts C and D:

- Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

Medicaid Program:

- PRMFCU: PRMFCU@justicia.pr.gov, 787-721-2900 ext. 1560/1561

All other Federal health care programs:

- CMS Hotline at 1-800-MEDICARE

(1-800-633-4227) or TTY 1-877-486-2048

Medicare beneficiaries:

- Online: Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

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FWA Regulatory Guidance

- You may also find additional information regarding fraud, waste, and abuse (FWA) at:
  - 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
  - 42 CFR Section 423.504(b)(4)(vi)(C)
  - Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly
  - Section 50.3.2 of the Compliance Program Guidelines (Medicare Prescription Drug Benefit Manual, Chapter 9 and Medicare Managed Care Manual, Chapter 21)

- Sponsors and their FDRs are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

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Reporting Ethical, Compliance & FWA Issues

Ethical Decision-Making Model

Are you facing an ethical dilemma? Follow the Ethical Decision-Making Model. At MMM Holding, LLC, this model is a tool used to help associates think through an ethical dilemma and arrive at an ethical decision.

Ask yourself the following questions:

- One, is my action legal?
- Two, will my action appear appropriate to others?
- Three, is my action honest?
- Four, does my action comply with the company's values ?
- Five, would I be proud to tell my family or friends about my actions?

Seek guidance from your Management Authority before you act.

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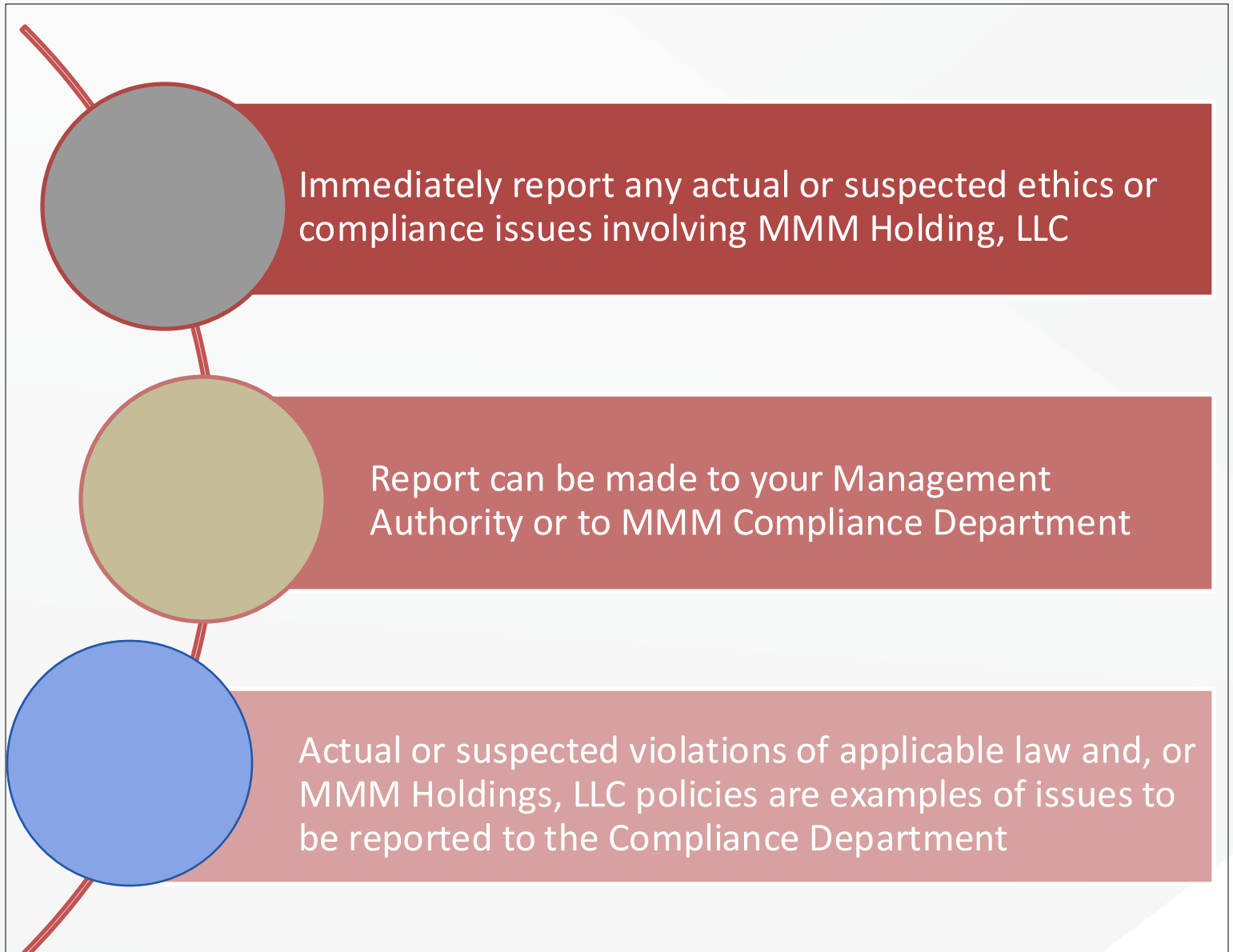
Reporting



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Report ethical, compliance, fraud, waste and abuse violations of the **Medicare Program** in a confidential manner by accessing:

www.mmmpr.ethicspoint.com

Or, calling

Report ethical, compliance, fraud, waste and abuse violations of the **Medicaid Program** in a confidential manner by :

- **Website Ethics Point :** www.psg.ethicspoint.com
- **Hot Line 1-844-256-3953**
- **Email:** VitalSIU@mmmhc.com

MMM Holdings, LLC Non-Retaliation Policy prohibits retaliation or retribution for reporting in good faith a known or suspected ethical or compliance issue.

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Regulations Applicable to the Healthcare Industry in Puerto Rico

Topics

1. Cultural Competency Plan
2. Act 160 of 2001, as amended - Living Will for Medical Treatment in Case of Suffering a Terminal Health Condition or Persistent Vegetative State, better known as “Advance Directives”
3. Act 194 of 2000, as amended - Patients Rights and Responsibilities
4. Act 57 of 2023, as amended - Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors Act
5. Act 54 of 1989, as amended - Gender Violence Act
6. Protocol for the prevention and identification of potential cases of financial exploitation of elderly or disabled adults

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Cultural Competency

- **Cultural Competency** is 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. It is the ability to understand, interact and collaborate with different people.
- Services should be provided to all beneficiaries of any culture, race, ethnicity, gender identity, gender expression, real or perceived sexual orientation (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual) better known as LGBTQIA+ population), and religion; to recognize the values, respect, protect and preserve the dignity of everyone.
- The purpose is to ensure that the diverse needs of the beneficiaries are considered.

MMM Holdings

Cultural Competence

Cultural Competence Plan Objectives:

- Identify beneficiaries who have cultural limitations or language barriers.
- Ensure that all available resources meet communication requirements regarding language barriers.
- Ensure that health providers understand and recognize needs according to cultural differences.
- Ensure that all amployees and associates are trained to assess cultural, religious and language differences.
- Increase communication with beneficiaries who have cultural competences or language barriers.
- Utilize culturally sensitive and appropriate educational materials for each type of cultural limitations including race, religion, LGBTQIA+ population communities, ethnicity or language.
- Decrease discrepancies in medical care received.
- Increase the understanding of our employees, contractors and health providers, about cultural and religious differences.

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Cultural Competence

Cultural Competence Plan Components:

- **Language or Interpreter Services:**
  - Providers must help identifying beneficiaries with possible linguistic barriers.
  - In coordination with the Beneficiary Services Department, enrollees receive free interpreter services to access the covered services.
  - Interpreter services include interpretation for beneficiaries with limitations in the Spanish language or auditory impairments.
  - Contractors who provide service to our beneficiaries must comply with the approved Cultural Competency Plan.
  - Written materials are available in both Spanish and English.
  - All materials must be drafted to be understood by a person with a 4th grade literacy.

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Cultural Competence

Cultural Competence Plan Components:

- **Religious beliefs:**
  - Ensure that all Employees respect the Beneficiaries according to their religious beliefs.
  - Providers must respect the religious beliefs of the Beneficiaries when providing medical treatment services.
- **LGBTQIA2S+ Population Anti-discrimination:**
  - A Providers Guide is available for sensitive and adequate management when providing health services to LGBTQIA2S+ population and is distributed to all providers.
  - Respect all laws applicable in Puerto Rico such as Act 22-2013, the first legislation against discrimination based on sexual orientation.
  - The Providers are responsible for training staff on sensitivity to the LGBTQIA2S + population.
  - The approval and dispatch of medications, as well as medical services, should not be restricted by the Enrollee sex.

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Cultural Competence

Cultural Competence Plan Components

- **Provider Education:**
  - Provider must be educated according to the Cultural Competency Plan.

- **Electronic Media:**
  - Beneficiaries have access to the TTY/TDD line for audio-impaired services
  - Services to the Beneficiary will provide the necessary follow-up services in addition to the call.

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Vieques and Culebra Beneficiaries

- A policy is established to require providers to give priority to the beneficiaries residents of Vieques and Culebra, so that they are taken care of within a reasonable time after arriving at the office.

- This preferential treatment is necessary due to the location of these municipal islands, considering the longer travel time necessary for their residents to obtain medical attention.

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Advance Directives Act

- **Advance Directive (Act 160 of November 17, 2001) :** A written instruction, such as a living will or durable power of attorney, granting responsibility over an individual's health care, as defined in 42 CFR 489.100, and as recognized under Puerto Rico law under Act 160 of November 17, 2001, as amended, relating to the provision of health care when the individual is incapacitated.
- Recognizes the right of every person, in complete use of his/her mental faculties, to previously declare his/her will regarding medical treatment in case of suffering a terminal health condition and/or vegetative persistent state.
- The declarant can name a representative in case any event prevents him/her from deciding and in case he/she has not decided about a medical situation in the declaration of will; and can decide according to the declarant's values and ideas.

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Advance Directives Act

- The beneficiary has the responsibility of notifying his/her doctor and/or the health institution about the existence of an advance directive and providing them a copy of such document.
- The advanced directive must be signed in front of a public notary and two witnesses 21 years or older.
- The enrollee can also sign the advanced directive in presence of a physician and two witnesses 21 years or older.
- The enrollee can modify the advance directives document, in part or totally, at any moment.
- The revocation of the document can only be requested by written.

MMM Holdings

Patients Rights and Responsibilities

Patients Rights and Responsibilities - Act 194 from August 25, 2000

- Created to establish the Patient Rights and Responsibility Act.
- Provide the patients rights and responsibilities and medical-hospitalary utilizers in Puerto Rico, including providers of these services and their health insurances.
- Define terms; establish dispute settlement procedures, impose penalties; and for other related purposes.
- Custodian, guardian, spouse, relatives, legal representative, attorney-in-fact, or any other person appointed by the courts or by the patient, may exercise these rights if the patient lacks the capacity to make decisions, is declared incapable by law or is a minor.

MMM Holdings

Patient Rights

- Obtain information of the Government Health Plan (GHP) about coordinated care, facilities, health professionals, services, and service access.
- Receive healthcare services of the highest quality.
- Be treated with respect, equality and consideration for dignity and privacy.
- Obtain information about option treatment alternatives.
- Participate in decisions about healthcare, including the right to refuse treatment.
- Receive emergency services 24 hours a day, seven days a week.
- Continuity of services.
- Request and receive copy of your health care records.
- Confidentiality of your information and healthcare records.
- Settle a complaint, grievance or appeal freely and not affecting adversely the way you are treated.
- Be able to exercise your rights without retaliation.
- Receive information about Advanced Directives and Medical Treatment.

MMM Holdings

Patient Responsibilities

- Must be informed about coverage, as well as limits and exclusions.
- Inform physician about:
  - Changes in health
  - Information that has not been understood
  - Reasons of why cannot comply with the recommended treatment.
- Provide physician all health information.
- Follow the treatments recommended by physicians.
- Maintain a healthy lifestyle.
- Communicate your health treatment Advanced Directives.
- Maintain appropriate behavior that does not impair, hinder or prevent other patients receiving the necessary medical care.
- Provide the information required by your plan.
- Notify about any possible fraudulent activity or inappropriate action related to health services, providers, or Facilities.

MMM Holdings

Penalties and Patients' Advocate Office Role

- Any insurer, health care plan, health professional or health-care provider or person or entity that fails to fulfill any of the responsibilities or obligations imposed by this Act, will incur in an administrative fault and shall be punished with penalty of a fine not less than five hundred (500) dollars nor more than five thousand (5,000) dollars for each incident or violation of law.

- The Office of the Patient Advocate (OPP for its Spanish acronym) was created in 2001 to guarantee compliance with the rights and responsibilities of the patient. It is empowered by Act No. 77-2013 and Act No. 170-1988, as amended, to investigate and address any complaint related to the violation of the legal provisions set forth in Act No. 194-2000, as amended, known as "Patient Rights and Responsibilities Charter".

MMM Holdings

OPP Contact Information:

Patient`s Advocate Office

Mailing Address: PO Box 11247 San Juan , Puerto Rico 00910-2347

Physical Address: Mercantil Plaza Building, floor 9 Hato Rey, Puerto Rico.

Telephones: 787-977-1100 (Urban) 1-800-981-0031 (Island) ;
To request a grievance: 787-977-1100
Fax: 787-977-0915
info@opp.pr.gov
www.opp.pr.gov

MMM Holdings

Act No. 57- 2023

Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors - Act No. 57- 2023

- This Act repealed Act No. 246, known as the "Act for the Safety, Welfare and Protection of Minors" of December 16, 2011. It seeks to establish the "Law for the Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors Act," for the purpose of ensuring compliance with Parts B and E of Title IV of the Social Security Act, as amended by the Family First Prevention Services Act, 42 USC §§621-629m and 42 USC §§670-679c;
- This law incorporates several new terms and concepts in our jurisdiction, necessary for the modification of the programmatic paradigm of the child protection system. One of the most important terms is "child at risk of entering foster care," which refers to a child and his or her family who may benefit from treatment and services aimed at preserving the family unit in the face of a situation of risk of abuse or neglect and to prevent the child from entering foster care.
- The term is also used to distinguish situations where preservation efforts are feasible from those where the removal of a child from his or her home, placement in foster care, and initiation of appropriate court action are required.
- Its purpose is to guarantee the welfare of children, and to ensure that proceedings in child abuse cases are dealt with diligently.
- This law defines child abuse as any kind of harm, humiliation, physical or psychological abuse, neglect, omission or negligent treatment, maltreatment, sexual exploitation, including sexual assault and obscene behavior, and any kind of violent assault directed at a child or young person by his or her parents, legal guardians or any person.

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Act No. 57- 2023

- The law incorporates the phrase "best interests of the minor" to refer universally to the set of actions and processes aimed at guaranteeing a minor's integral development and a dignified life, as well as the material and affective conditions that allow him/her to live fully and reach his/her maximum potential, including, but not limited to factors that affect safety, physical, mental, emotional and other wellbeing.

- In this way, all these factors are gathered in a single term, thus eliminating the use of several expressions that can cause confusion, since they can mean the same thing, such as "better welfare of the child", "welfare of the child", among others.

- An important term whose meaning changes in the law is "person responsible for the minor", which now includes any person who is in charge of the minor temporarily or permanently, such as the parents, a relative, among others.

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Act No. 57- 2023

- This law also clarifies the prerogatives and limits that the Department of the Family has with respect to the administrative determination of where to place a child. It also clarifies what is expected of the case managers of said agency with respect to the preparation of different plans aimed at preserving the family unit by encouraging the return of the child to his or her home, in the event of removal, his or her permanent placement with a family resource or through the mechanism of adoption.

- Regarding judicial actions, details the different steps to be followed in all stages of child protection proceedings before our courts. This includes the terms of time for holding different critical hearings, the language to be used in orders, resolutions and judgments, among others.

- The terms of time to carry out reasonable reunification efforts were also revised in view of the need and possibility of providing services of this nature to families for more than six (6) months. All of this is done with the objective of promoting the implementation of this law in a uniform manner throughout all the courts of Puerto Rico.

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Act No. 57- 2023

Health Department Responsibilities:

- Provide diagnostic and medical treatment services to abused children and their families;
- Provide training for medical and non-medical professionals on medical aspects of child maltreatment;
- Providing priority medical evaluation and care to children in the Department's custody, and providing prescribed medications;
- Ensuring health services to children in the Department's care, regardless of where they are placed;
- Coordinate the provision of addiction and mental health services with the Department's Service Plan.
- Establish service programs for maltreated children with special health care needs; and
- Provide expert advice on health issues and expertise in situations of institutional abuse and/or institutional neglect in educational institutions;
- Ensure that providers or privatizing entities of mental health services and facilities offer immediate attention to situations where maltreatment exists, as well as medications, and that they comply with the obligations herein imposed on the Department of Health.
- Develop collaborative agreements with the governmental entities obligated under this Act to provide mental health or addiction services to minors, fathers, mothers or person responsible for a minor who has engaged in abusive conduct.

MMM Holdings

Department of Family's ADFAN Program Contacts Information

Physical Address

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

Postal Address

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

Telephone:

- 787-625-4900

ADFAN Lines

- Abuse Hotlines
  787-749-1333/ 1-800-981-8333

Guidance Hotlines

- 787-977-8022 1-888-359-7777

Domestic Abuse Prevention and Intervention Act

Law 54 - Law for the Prevention and Intervention with Domestic Violence:

- Establish a set of measures aimed at preventing and combating domestic violence in Puerto Rico; to define the crimes of Abuse, Aggravated Abuse, Abuse by Threat, Abuse by Restraint of Liberty, and Spousal Sexual Assault, and to establish penalties;

- Empower the courts to issue Orders of Protection for victims of domestic violence and to establish an easy and expeditious procedure for the processing and adjudication of such Orders; to establish measures aimed at the prevention of domestic violence and to order the “Oficina de la Procuradora de las Mujeres” to disseminate and orient the community on the scope of this Act and to allocate funds.

- In 2022 was included the threat of mistreatment or abuse of domestic animals within the criminal conduct that is part of the definition of domestic violence.

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Domestic Abuse Prevention and Intervention Act

Domestic Violence is a type of gender violence that happens to people who are or were partners and between whom there was a consensual relationship. It is not necessary that they live together or that they have had children together.

Domestic violence includes:

- physical violence,
- psychological,
- intimidation or threats,
- sexual assault and
- deprivation of liberty.
- Sometimes, the aggressor does not cause harm directly to the survivor but damages the survivor's things or other people in the interest of causing emotional harm to the survivor.

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Women`s Advocate Office Contact Information

Physical Address:

- 161 Avenida Juan Ponce de León
  San Juan, 00917

Postal Address:

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

Telephones:

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

Prevention and Safety Program for Victims of Gender Violence

- Gender violence occurs when a person demonstrates behaviors that cause physical, sexual or psychological harm to another person physical, sexual or psychological harm to another person motivated by gender stereotypes created by society.

- Statistically, in most of these cases the victims are women in situations of violence committed by Men. . This includes women of various ages and social, educational and economic backgrounds social, educational and economic backgrounds. However, anyone could be affected by gender-based violence.

- The concept of violence includes threats, aggression, persecution and isolation, among other similar actions. These actions can occur in public and private public and private places, and manifest themselves in work, community, family, friendships, relationships, teachers, and even by strangers.

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Prevention and Safety Program for Victims of Gender Violence

The law:

- Adopt and create the "Prevention and Safety Program for Victims of Gender Violence Act" to protect victims of gender violence who have been issued a protection order, through the integration of services and alliances between the Puerto Rico Police, the Municipal Police, and the Judicial Branch; and for other purposes.

- Does not exclude any other initiative of the Executive Branch that may join efforts to provide security to victims of gender violence under the declaration of emergency issued in the Executive Order of Administrative Bulletin No. 2021-013.

- Any protocol or process approved under said Administrative Order shall be included as part of the surveillance and security program ordered in this Act, without detriment to the constitutional powers of the Legislative Assembly of Puerto Rico.

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Financial Exploitation

Protocol for the Prevention and Identification of Potential Cases of Financial Exploitation of Elderly or Disabled Adults:

- Financial exploitation is a type of abuse against the elderly or disabled adults carried out by family members, friends, neighbors, and caretakers, among others.

- Act Number 121-1986 defines financial exploitation as the improper use of the funds of a competent elderly or disabled adult, of his / her property or resources by another individual, including, but not limited to, fraud, misrepresentation, embezzlement, conspiracy, forgery of documents, falsification of records, coercion, transfer of property through fraud, or denial of access to assets.

MMM Holdings

Financial Exploitation

Key factors that make exploitation more likely to happen:

- The adult children's financial situation.
- Use and abuse of controlled substances by close family members.
- Trusting in and providing information related to finances to strangers/others.
- Cognitive decline (caused by age or illness).
- Changes in the usual management of bank accounts.
- Disputes among adult children for the parents' financial resources.

MMM Holdings

Financial Exploitation

Among the signs of Financial Exploitation of the Elderly are:

- Sudden and significant reduction of the balances in checking and savings accounts.
- Canceling certificates of deposit before their date of maturity.
- Payments made to third party bills via direct debit.
- The person looks neglected or unkempt despite adequate income.
- Signature forgery.
- Unpaid bills.
- Termination of vital utilities such as electricity, water, and telephone.
- Appearance of property liens or foreclosure notices.
- Withdrawal of large sums of cash from bank accounts or changes in spending habits.
- Loan applications or signatures on loan applications.
- Purchase of vehicles or real estate property without the victim’s consent.
- Sale of vehicles or of real estate property.
- Purchase or cancellation of insurance policies.

MMM Holdings

Financial Exploitation

Information that our Enrollees should know:

- Carefully pick and choose the person with whom financial information is shared.
- Protect checkbook, credit cards, savings, financial statements, and any other sensitive document: keep them in a safe place.
- Do not give out Social Security number or debit card's secret or personal identification number (PIN) to anyone, especially over the phone.

MMM Holdings

Financial Exploitation

Law Number 146-2012, sets the following penalties:

- When the sum of the funds, assets, personal or real estate property involved in a case of financial exploitation of an elderly or disabled person adds up to $2,500.00, the offender will incur in a misdemeanor. In those cases where the sums are larger than the abovementioned, he/she will incur in a felony.

- In all cases, the court will impose a restitution penalty in addition to the set penalty.

MMM Holdings

Financial Exploitation

The following laws protect the elderly against Financial Exploitation:

- Act Number 121-1986, as amended, known as the *Bill of Rights of the Elderly*.

- Act Number 206-2008, which orders the Commissioner of Financial Institutions, the Corporation for the Supervision and Insurance of Cooperatives of Puerto Rico and the Office of the Commissioner of Insurance to Implement Those Regulations Necessary, to require any financial, cooperatives or insurance institutions in Puerto Rico to establish a protocol for the prevention and detection of possible cases of financial exploitation of the elderly or adults with disabilities. These institutions are required to notify any situations in which financial exploitation is suspected.

- Act Number 146-2012, as amended, know as the *Puerto Rico Criminal Code*, in its Articles 127-C y D Financial Exploitation of Elderly Persons, sets forth, among other things, the modes and penalties for people who commit this crime.

MMM Holdings

Thanks for your attention

Government Health Plan Program in Puerto Rico Vital Plan

Objective

To provide general information regarding the Government Health Plan in Puerto Rico, better known as Vital Plan, and relevant regulatory requirements applicable to the services that MMM Multihealth (MMM) is currently providing to the Medicaid Program eligible members.

Medicaid Program

Medicaid is a Federal Government program that provides benefits to states and U.S. territories, including Puerto Rico, to pay for the medical expenses of certain groups of low-income individuals.

- Effective October 1, 2010, the Government Health Program created new public policy objectives to transform Puerto Rico's health care system.
- To promote an integrated approach to physical and mental health and improve access to quality primary and specialty care services.
- Under this policy, the government's health program, previously known as "Reforma", was transformed into "Mi Salud", subsequently changed to Government Health Plan (PSG).
- As of November 1, 2018, the name of the program changed to Vital Plan. In this model, beneficiaries can choose their primary care physician and medical group anywhere in Puerto Rico.

Vital Plan

Vital Plan model established an island-wide service region as of 2018.

In September 2022, the Government of Puerto Rico announced that the same insurers that until then remained offering services to Vital Plan's beneficiaries revalidated for a new contract for a 3-year term. These are:

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

ASES
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Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

Vital X Population: Children Under Foster Care & Survivors of Gender Violence.

Vital X Population: Children Under Foster Care & Survivors of Gender Violence

- Previously known as the Virtual Region.
- Since January 2023, MMM Multihealth has overseen the management and needs of this population.
- MMM MH has dedicated staff to attend this population.
- Important: Any employee is not authorized to provide information regarding this population.

As part of this region, all beneficiaries included are in the custody of:

- Department of Family`s ADFAN Program
  - Children and youth 0-20 years of age (once they reach 21 years of age, they leave the program).
- Women`s Advocate Office
  - Survivors of gender-based violence including their minor children.

Virtual population has the following characteristics:

Information only be provided to authorized employees regarding these population.

Restrictions are created in our systems for this purpose (C3PO/EMMA).

If YOU received any situation related to this population, please immediately notify your supervisor.

PCP - None assigned.

PMG - None assigned.

They have preferential shifts in the offices and medical facilities.

They have access to the entire MMM Multi Health provider network.

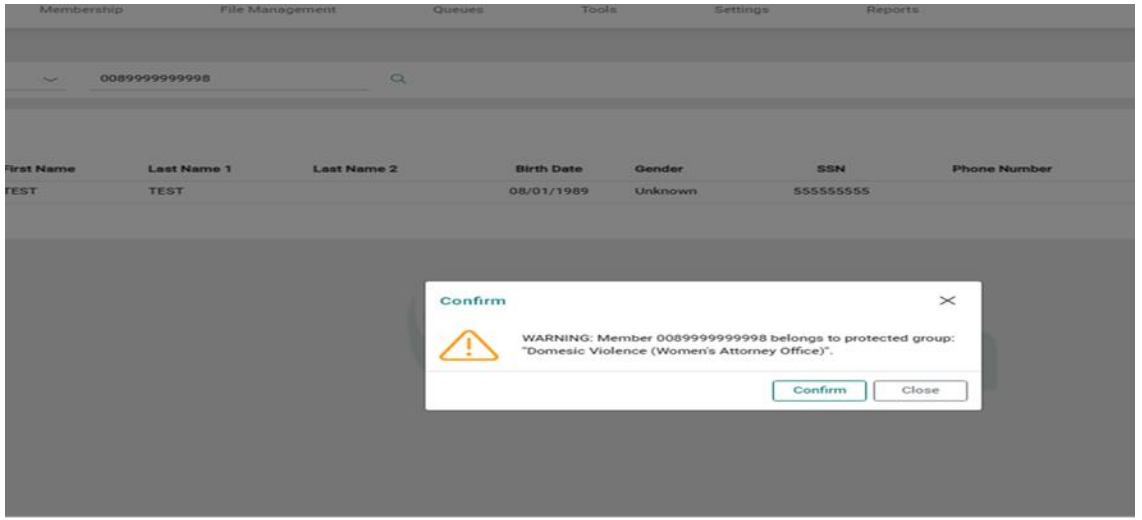
They do not need Referrals.

Welcome cards and letters are NOT mailed.

We will deliver them once a week to the single point of contact of the agency that cares for the patient (ADFAN or OPM)

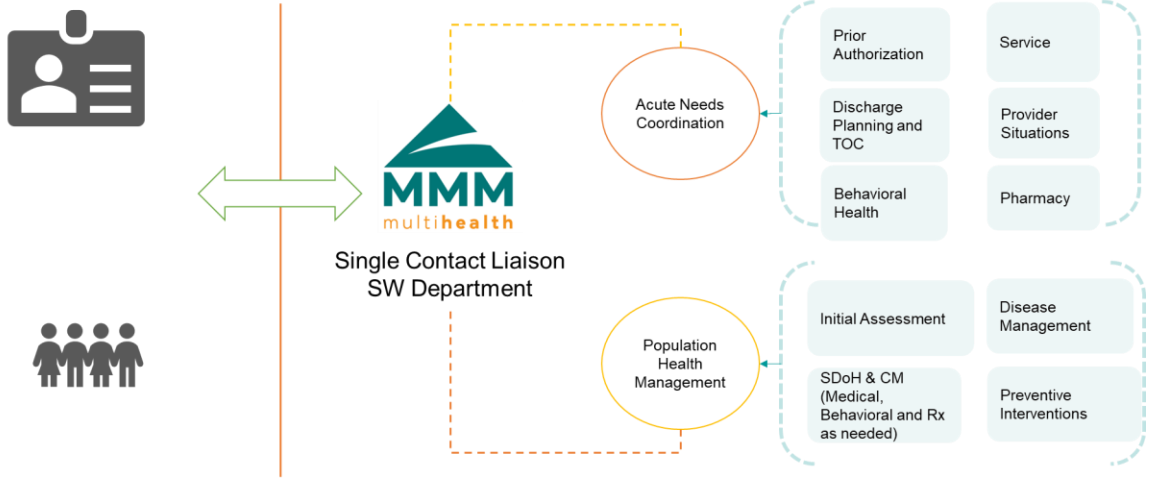
Confidentiality

Example of the message that will appear in the system.



Social Work Program

Dedicated Unit for Vital X Population



Centralized single point of contact for the authorized representatives from OPM and ADFAN.

Concierge Service

Includes **Social Workers professionals** with knowledge in case management, customer service and other operational processes.

Sense of Urgency

The DU is backed up with a **resolution team** that includes the designation of SME representatives from other operational areas the area to expedite solutions.

Operations Resolution Team

Social Determinants of Health (SDH)

What are Social Determinants of Health?

1. According to the World Health Organization, the social determinants of health are "the circumstances in which people are born, grow, work, live and age, including the broader set of forces and systems that influence the conditions of a daily life.

2. The forces and conditions includes the political system, economic, environmental, cultural, social factors and, viewed at the individual level, refers to factors related to education, employment, support networks, housing, and access to medical and social services.

3. All the conditions described above vary from person to person, as well as within population subgroups. These differences give rise to inequalities that, in some instances, may be unavoidable, but can also be addressed and eventually prevented.

Social Determinants of Health
MMM Multihealth Responsibilities

- Assess the needs of beneficiaries related to the social health determinants using a standardized screening tool provided by ASES.

- Refer beneficiaries to community services and support, as needed, based on the results of the assessment for social health determinants.

- Provide follow-up on referrals to social services and include social workers or community health professionals in care management teams and other initiatives that promote holistic and focused care for the beneficiary in medical and non-medical settings.

- If a Beneficiary during an initial assessment reflects needs in specific services related to the social health determinants, MMM MH must guarantee that the activities detailed in the agreement are rendered by a social worker or community health professional

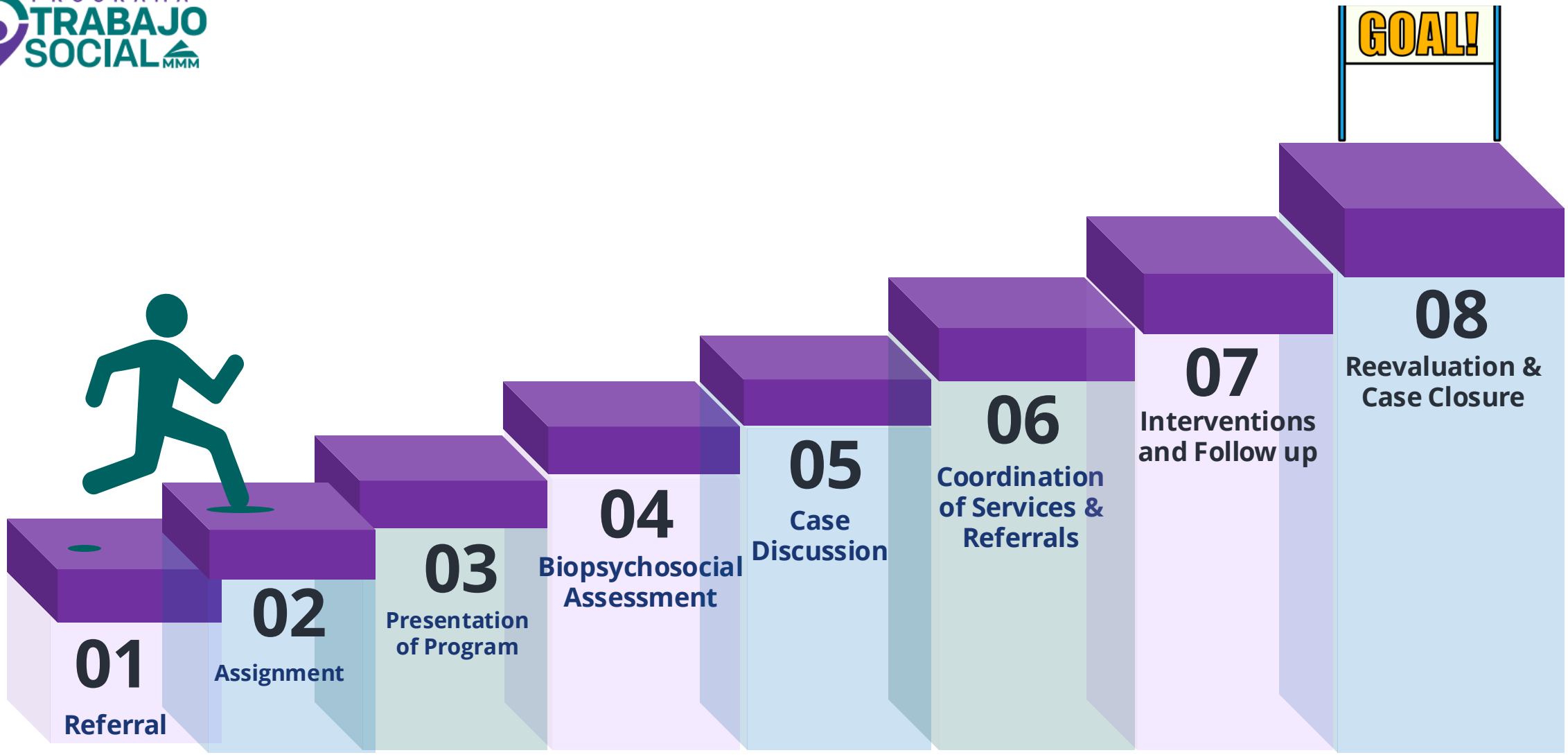
Participation in the program is voluntary; the beneficiary may opt out at any time.

Partnerships must be established throughout the continuum of care, including with other health care departments and community organizations.

Participants' care plans are established individually and with their participation to reflect their priorities, interests and needs. Participation in a benefit should be determined on an individual basis.

Social Work Program General Process

PROGRAMA TRABAJO SOCIAL MMM



Social Work Program

Who can be referred and why?

MMM Multihealth Beneficiaries

Social Needs & Determinants of Health:

- Requires, but does not have social support.
- Requires transportation coordination for continuity of care.
- Social factors preventing them from eating the recommended portions of food.
- Need a relocation/ transfer to a safe home.
- Financial issues that impact their health status

Security Threats

- Abuse
- Financial Exploitation
- Agressions and Gender Violance
- Among Others

Those type of situations must be referred to state protection services such as the Department of the Family, Police and/or 9-1-1

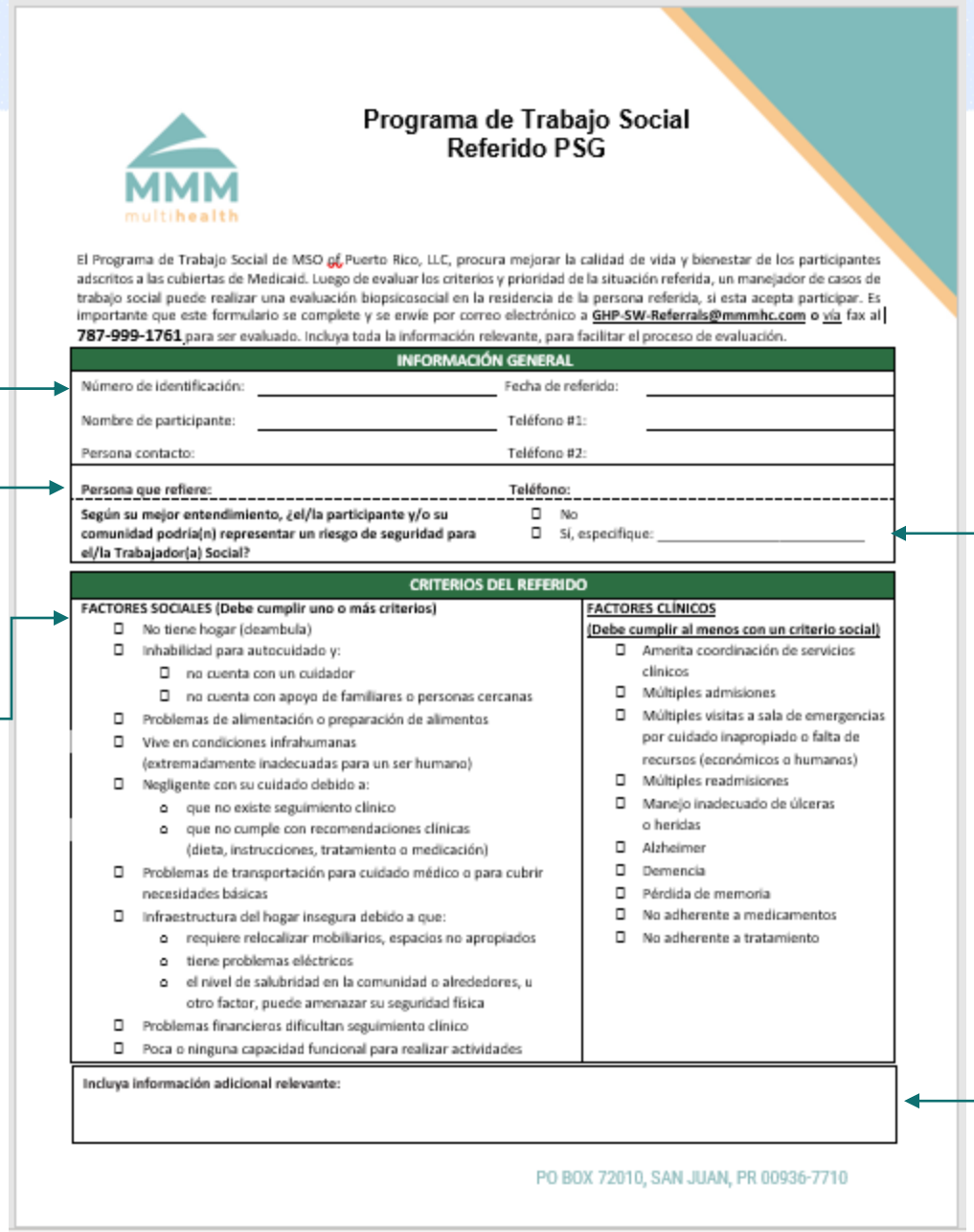
*Cases referred to state agencies can be directed to our program to offer follow-up and facilitate the processes.

How can I complete a referral?

Make sure to ALWAYS include a member ID.

Identify yourself as the referral source and provide contact information.

Make sure to identify at least one social factor to refer a beneficiary.



MMM multihealth

Programa de Trabajo Social
Referido PSG

El Programa de Trabajo Social de MSO of Puerto Rico, LLC, procura mejorar la calidad de vida y bienestar de los participantes adscritos a las cubiertas de Medicaid. Luego de evaluar los criterios y prioridad de la situación referida, un manejador de casos de trabajo social puede realizar una evaluación biopsicosocial en la residencia de la persona referida, si esta acepta participar. Es importante que este formulario se complete y se envíe por correo electrónico a GHP-SW-Referrals@mmmhc.com o vía fax al 787-999-1761 para ser evaluado. Incluya toda la información relevante, para facilitar el proceso de evaluación.

INFORMACIÓN GENERAL

Número de identificación: _____ Fecha de referido: _____

Nombre de participante: _____ Teléfono #1: _____

Persona contacto: Teléfono #2:

Persona que refiere: Teléfono:

Según su mejor entendimiento, ¿el/la participante y/o su comunidad podría(n) representar un riesgo de seguridad para el/la Trabajador(a) Social? ☐ No ☐ Sí, especifique: _____

CRITERIOS DEL REFERIDO

FACTORES SOCIALES (Debe cumplir uno o más criterios)

- ☐ No tiene hogar (deambula)
- ☐ Inhabilidad para autocuidado y:
  - ☐ no cuenta con un cuidador
  - ☐ no cuenta con apoyo de familiares o personas cercanas
- ☐ Problemas de alimentación o preparación de alimentos
- ☐ Vive en condiciones infrahumanas (extremadamente inadecuadas para un ser humano)
- ☐ Negligente con su cuidado debido a:
  - que no existe seguimiento clínico
  - que no cumple con recomendaciones clínicas (dieta, instrucciones, tratamiento o medicación)
- ☐ Problemas de transportación para cuidado médico o para cubrir necesidades básicas
- ☐ Infraestructura del hogar insegura debido a que:
  - requiere relocalizar mobiliarios, espacios no apropiados
  - tiene problemas eléctricos
  - el nivel de salubridad en la comunidad o alrededores, u otro factor, puede amenazar su seguridad física
- ☐ Problemas financieros dificultan seguimiento clínico
- ☐ Poca o ninguna capacidad funcional para realizar actividades

FACTORES CLÍNICOS
(Debe cumplir al menos con un criterio social)

- ☐ Amerita coordinación de servicios clínicos
- ☐ Múltiples admisiones
- ☐ Múltiples visitas a sala de emergencias por cuidado inapropiado o falta de recursos (económicos o humanos)
- ☐ Múltiples readmisiones
- ☐ Manejo inadecuado de úlceras o heridas
- ☐ Alzheimer
- ☐ Demencia
- ☐ Pérdida de memoria
- ☐ No adherente a medicamentos
- ☐ No adherente a tratamiento

Incluya información adicional relevante:

PO BOX 72010, SAN JUAN, PR 00936-7710

If known, provide information about any security warning social workers should have when visiting a member and/or their community.

Please add as much information as you have for the social worker to understand major concerns to provide special attention.

How to deliver a referral?

1: Identify:

- Beneficiary's contract number (member ID)
- Beneficiary's primary social needs adversely impacting their health.

2: Sent it via:
Fax: 787-999-2191

Email: GHP-SW-Referrals@mmmhc.com

3: Additional Information:

- 787-622-3000 X. 51524
- **Myriam Rivera Molina**
  (787) 398-4602
- **Liza González Cruz**
  (787) 379-3487

PROGRAMA TRABAJO SOCIAL MMM

Interoperability Rule

Interoperability Rule

1	What is the Interoperability rule set by the Centers for Medicare and Medicaid Services? (CMS)	It is a CMS mandate that provides for expanding patients' electronic access to their protected health information. All Medicaid and Medicare Advantage plans shall comply with this mandate.
2	What's the purpose of the rule?	It is intended to facilitate the patient increased access to their personal health information (PHI), to help them be the center of their own health care decisions, thus minimizing the risk of duplicating tests and other inefficiencies. This access to health information exchange (interoperability) helps to guarantee that providers are allowed to see an individual's medical history to make informed clinical decisions, which can lead to a better coordinated care.
3	What does this rule imply?	Beneficiary may download and register in an external application of their choice and may direct such app to download and access the health information available.

Second Opinion

Second Opinion

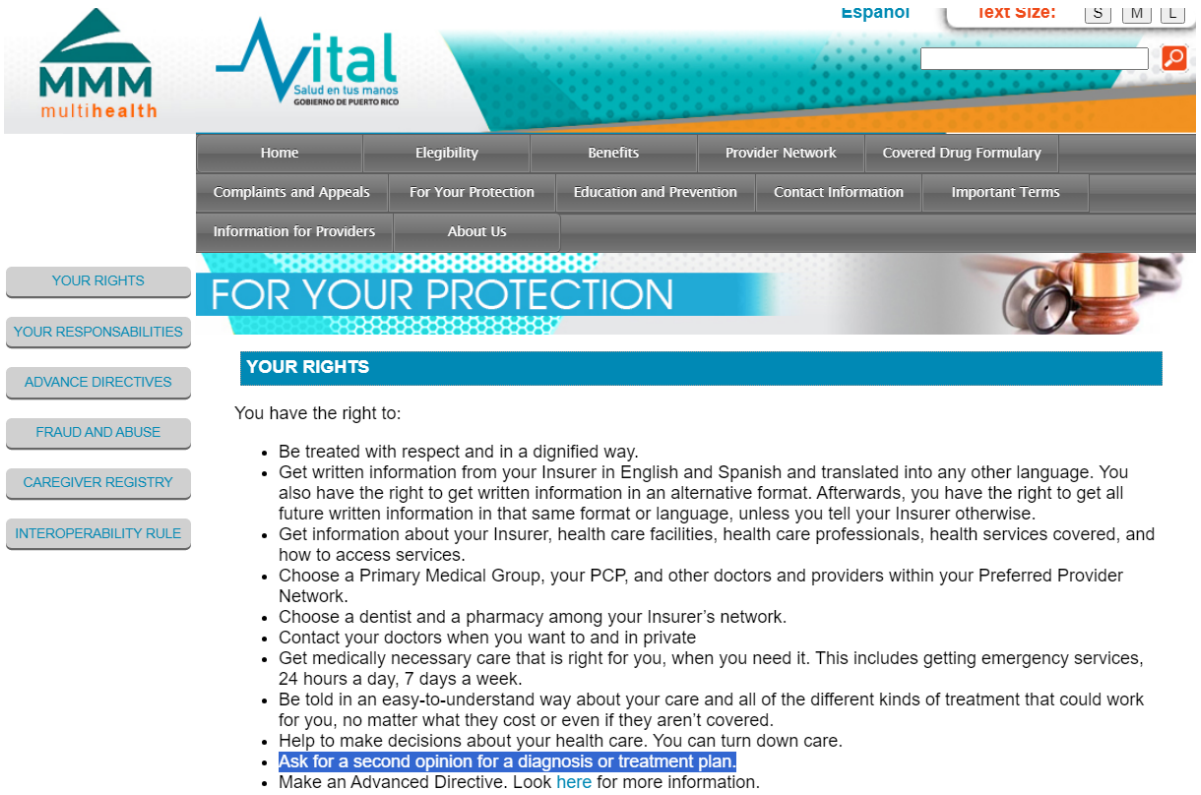
All beneficiaries under Vital Plan coverage have the right to request a medical second opinion;

- MMM MH shall provide a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery, or alternative treatments of a health condition when requested by any Enrollee, or by a parent, guardian, or other person exercising a custodial responsibility over the Enrollee.
- The second opinion shall be provided by a qualified Network Provider, or, if a Network Provider is unavailable, the Contractor (MMM MH) shall arrange for the Enrollee to obtain a second opinion from an Out-of-Network Provider.
- The second opinion shall be provided at no cost to the Enrollee.

Second Opinion

MMM MH has this information available at:

- Webpage- https://www.multihealth-vital.com/eng/protection.html
- Beneficiary Handbook
- Provider's guideline
- Internal Policies and Procedure



Marketing Materials

Marketing Material

- Marketing is any communication from MMM to any Eligible Person or Potential Enrollee that can reasonably be interpreted as intended to influence the individual to enroll in MMM's Plan, or not to enroll in another plan, or to disenroll from another plan.

- Marketing Materials: materials that is produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.

Allowed Material | Activities

- Distribute general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
- Make telephone calls, mailings and home visits only to Enrollees currently enrolled in the Vitals' plan, for the sole purpose of educating them about services offered by or available through Vital Plan;
- Distribute brochures and display posters at Provider offices that inform patients that the Provider is part of the GHP Provider Network; and
- Attend activities that benefit the entire community, such as health fairs or other health education and promotional activities.
- If Vital Plan performs an allowable activity, it is conducted island-wide.

Prohibited Material | Activity

- Directly or indirectly engaging in door-to-door, telephone, e-mail, texting or other Cold-Call Marketing activities;
- Offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce Enrollment in the Contractor's Plan;
- Distributing plans and materials that contain statements that ASES determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the Contractor's Plan is endorsed by the Federal Government or Government, or similar entity;
- Distributing materials that, according to ASES, mislead or falsely describe the Contractor's Provider Network, the participation or availability of Network Providers, the qualifications and skills of Network Providers (including their bilingual skills); or the hours and location of network services;
- Seeking to influence Enrollment in conjunction with the sale or offering of any private insurance; and
- Asserting or stating in writing or verbally that the Enrollee or Potential Enrollee must enroll in the Contractor's Plan to obtain or retain Benefits.

Marketing Material Approval Process

Marketing sends the material.

Compliance Department evaluates the material.

- If it is educational or informative, it does not need to be sent to ASES.
- If it is sent to ASES it must comply with the provisions of Regulatory Letter 18-205

ASES

- Evaluates the material. If it complies with the established requirements it is approved.
- Receives approval number 15 days are allowed to respond

Compliance receives it, includes the approval number and registers information in the internal log.

Forwards to Marketing to include approval #.

Marketing sends it back to Compliance with approval number.

Compliance sends confirmation of approval number included in materials to ASES.

Operations Vital Plan
MMM Multi Health

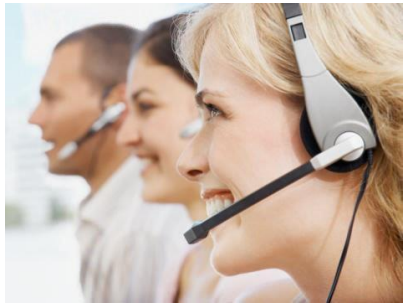
Vital Plan Service Lines

Service Lines

1-844-336-3331 (toll free)

787-523-2656 (Metro Area)

787-999-4411 (TTY)



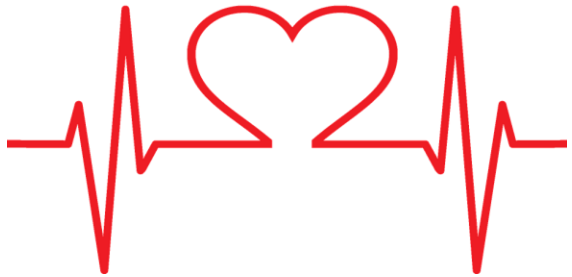
Monday to Friday
7:00 a.m. to 7:00 p.m.

Medical consultation line
Haciendo Contaco

1-844-337-3332 (toll free)

787-523-2653 (Metro area)

787-522-3633 (TTY)



24 hours/ 7 days a week

Customer Service Research Unit

First link between the beneficiary and all MMM MH units.

Coordination of appointments with specialists.

Coordination of Medicaid Program recertification appointments.

Satisfaction Surveys

Support in membership retention strategies.

Resolution of cases from the MMM MH's website, social networks and press.

Exclusive service for cases received from ASES and Fortaleza.

Management of the request for member's materials (Provider Directory, Member Manual, Letters, EOB, ID Cards).

Customer Service

Contact us: PSG-Research-Team@mmmhc.com

MMM Multi Health Main Office

Hato Rey

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

- Monday to Friday from 8:00 a.m. to 5:00 p.m.

We also have other Vital Plan's operations areas at Kennedy building.

Service Offices (Atlantic)

Carolina	Humacao	Vieques	Fajardo	Manatí	Canóvanas
Century Business Park (previously Direct TV) Bo. San Anton # 887 Int. 848, Carolina PR •Monday from 8:00 a.m. to 7:00 p.m. •Tuesday to Friday from 8:00 a.m. to 5:00 p.m. •Last Saturday of the month from 8:00 a.m. to 5:00 p.m.	**Boulevard Plaza Office Center** • Boulevard Del Río, Ramal 3 • Monday to Friday form 8:00 a.m. to 5:00 p.m.	**Centro de Servicios Integrados** • State Street Num. 200 km 0.4, Urb. Industrial Belén Castaño Vda. Díaz • Monday through Friday from 7:30 a.m. to 12:00 p.m. and from 1:00 p.m. to 4:30 p.m.	• Street #3 km. 44.1 Local #2 Bo. Quebrada • Monday to Friday from 8:00 a.m. to 5:00 p.m.	**El Trigal Plaza** • Street #2, KM 4.8 • (Corner) Street 149 • Barrio Cotto Norte • Monday to Friday from 8:00 a.m. to 5:00 p.m.	**Centro comercial Plaza Rial** • Suite 4A y 4 • Monday to Friday from 8:00 a.m. to 5:00 p.m.

Service Offices (Caribbean)

Guayama	Ponce	Orocovis	Coamo	Mayagüez	Aguadilla
FISA I Building Street. 54, km 2.2, Solar #6 •Monday from 8:00 a.m. to 7:00 p.m. •Tuesday to Friday from 8:00 a.m. to 5:00 p.m. •Last Saturday of the month from 8:00 a.m. to 5:00 p.m.	Street #2 Ponce by Pass San Jorge Mall Building • Monday to Friday from 8:00 a.m. to 5:00 p.m.	Borinquen Building Street 155 km 15.3 Bo. Gato • Monday to Firiday from 8:00 a.m. to 5:00 p.m.	Ruiz Belvis street #24 • Monday to Friday from 8:00 a.m. to 5:00 p.m.	Complejo Office Park III Street # 2, KM 157 • Monday to Friday from 8:00 a.m. to 5:00 p.m.	Plaza Victoria Shopping Center Street #2, KM 129.5 • Monday to Friday from 8:00 a.m. to 5:00 p.m.

Services available at regional and satellite offices

Materials Available for Beneficiaries

- ID Cards
- Beneficiary Handbook
- Provider's Directory

Transactions

- Delivery of Identification Card
- Cover Certification Letter
- PCP and GMP changes
- New registrations
- Enrollments - newborn
- Pure ELA Registration
- Filing of complaints, complaints and appeals
- Coordination of Benefits
- Processing and sending of Pre-Authorization documents
- Processing and sending of Case Management documents

Information/Clarification related to

- Benefits and Procedures
- Eligibility
- Cover
- Supplier Network (PCP's / GMP's)
- Medicaid Program
- Mental health
- Pre-authorizations
- Special Cover
- Case Management
- *ELA puro* registration
- Pharmacy Benefits
- Complaints
- Grievances and Appeals
- Coordination of Benefits
- "PHI" information about protected patient information
- Among others

Eligibility

Eligibility

Persons eligible under Law 72 of September 7, 1993:

- U.S. Citizens
- People with low or no income
- Federal Medicaid Population
- State Medicaid Population
- Children under the Children's Health Insurance Program (CHIP)
- Public employees, retirees and their dependents
- Puerto Rico police, their widows, widowers and surviving children
- Veterans
- Children in State Custody – Virtual Region
- Survivors of Domestic Violence - Virtual Region

Registration Process

The Puerto Rico Medicaid Program will determine if the beneficiary is eligible for Vital Plan.

- If eligible, Medicaid provides the Notice of Decision Form to the beneficiary (formerly known as MA-10).
- The document contains:
- Name
- MPI
- Type of Eligibility
- Effective Date of Eligibility with Vital Plan
- Eligibility Expiration Date
- Cover Code
- Copay cap
- The document contains the insurer selected at the time of carrying out its certification process
- The beneficiary may access covered services using the Decision Notice while receiving their card.
- The MCO will send a Welcome Letter to Vital Plan

Open Enrollment Period (OEP)

- The Open Enrollment Period (OEP) will be from January 1st through February 17, 2026.

- A beneficiary may request a change of insurer for just cause at any time by contacting the Enrollment Counselor or ASES during the Open Enrollment Period.

ASES's Call Center Numbers
Phones : 787-474-3300 / 1-800-981-2737

Enrollment Counsellor 1-833-253-7721

ASES's APP

- ASES will have a mobile application available for the beneficiaries to choose the medical plan with which they want to enroll.

- Beneficiaries who do not freely choose their Vital insurance company during the Open Enrollment period will be assigned by ASES directly.

Vital’s Cards

- The plan card will be mailed to the beneficiary on or before 5 days after the eligibility is uploaded into the system.
- If you cannot wait, you must stop by a Regional Service Office or contact Customer Service.
- A certification of coverage can be faxed or e-mailed to the beneficiary or the physician's office.
- No hospital can deny you emergency services because you do not have the card.

MMM - Vital APP

- Designed to serve as a facilitating link.
- Contains beneficiary information as it appears in our systems.
- Allows beneficiaries and caregivers to have greater involvement in their health care.
- Free, secure, easy to use.
- Downloadable from the App Store and Google Play platforms.

Available on the App Store

ANDROID APP ON Google play

MMM APP

The PROFILE function allows the beneficiary to view their personal information, clinic, plan card, primary care physician, caregivers and application settings.

HEALTH data helps to organize prevention initiatives and follow-up care. The beneficiary will be able to display their medication list for up to 6 months when visiting specialists.

The MESSAGES function allows beneficiaries and/or their caregivers to remember important data, receive invitations and note their upcoming appointments

In the CALENDAR function the beneficiary can view all scheduled events in his calendar and available MMM Events.

In SERVICES the application allows to receive notifications to know the status of pre-authorizations, expenses and information to contact the plan.

With the DIRECTORY function, the beneficiary can perform more specific searches for Primary Care, Specialists and Health Professionals, among others.

Enrollment Department Contact Information

How can I contact my health plan?
The beneficiary can go to one of our Service Offices:
www.Multi Health-vital.com/contact.html.

Call the Beneficiary Service Line:
1-844-336-3331 (Toll-Free) or TTY
(Toll-Free): 787-999-4411

Email:
PSG_Enrollment@mmmhc.com
Facsimile: 1-844-330-9330

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

Transitional Period

Transition Period

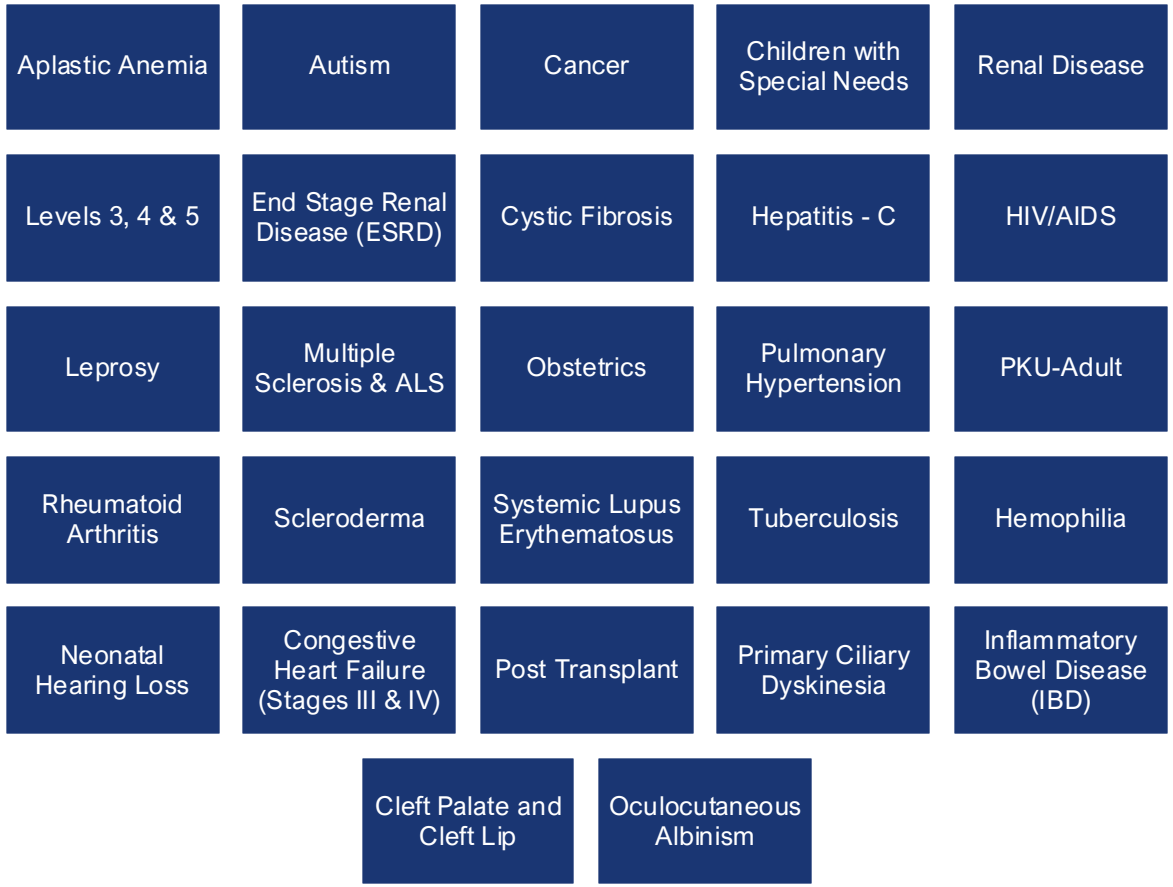
MMM Multihealth will ensure continued access to services during the transition of a beneficiary from an ASES contracted health insurer by complying with the following:

- Ensuring that the beneficiary has access to services consistent with the access he/she previously had, and is permitted to retain his/her current Provider for ninety (90) Calendar Days if that Provider is not a Network Provider; Referring the beneficiary to appropriate Network Providers;
- Fully and timely comply with requests for historical utilization data from the new Contractor or other entity in compliance with federal and state laws;
- Ensure that the beneficiary's new provider, can obtain copies of the Enrollee's medical records, as appropriate;
- Comply with any other necessary procedures specified by CMS or ASES to ensure continued access to services to prevent serious detriment to the beneficiary's health or reduce the risk of hospitalization or institutionalization.

Clinical Programs

Special Coverage

- It is a component of the Covered Services described in the ASES contract, in section 7.7 and Attachment 7.
- Special Coverage is available for beneficiaries with specific conditions that require intensive medical care caused by a complex health condition.
- Beneficiaries enrolled in the Special Coverage Registry have direct access to specialists who manage their health situations related to the condition for which they are enrolled.



Complex Case Management and Care Management Program

Specifically focused on:	Candidates are identified through:
• Special Coverage Conditions • Complex physical and mental health conditions • Prenatal and Postpartum Care • High Utilizers of Emergency Rooms • Chronic Conditions - Self Care	• Primary Care Physician or Specialist Referrals • Specialty Coverage Record • Service Utilization Analysis • Referrals through other Clinical Programs

- Provides health support and education for identified beneficiaries with both chronic and complex health conditions.
- Takes a holistic approach including healthy habit and lifestyle changes.
- Provides care coordination support as needed.
- Integrates screening tools for both physical and mental health as essential criteria for care plan development.
- Develops an individualized plan of care.
- Focuses on prevention

Prenatal Program

Program to support women during their prenatal and postpartum period.

The Program is focused on:

- Promoting a healthy pregnancy
- Prevention of complications
- Mental health
- Health education
- Newborn care

Women participating in the program receive face-to-face educational interventions including childbirth and breastfeeding classes.

Medicaid contractual goal: Ensure that 85% of pregnant women receive services under the Prenatal and Maternity Program.

What is EPSDT?

EPSDT stands for Early, Periodic, Screening, Diagnostic, and Treatment.

EPSDT is mandated health services for Medicaid eligible children and youth under the age of 21;

EPSDT has been included in Medicaid since 1967, with a primarily preventive focus, to identify any problems in early stages to provide the necessary services to ameliorate, treat or cure any condition or disease in childhood.

Pharmacy Coverage

Pharmacy Coverage

Vital beneficiaries have access to drug coverage aligned with ASES Formularies, specifically the Preferred Drug Lists (PDL):

▪This is composed of preferred and non-preferred drugs that are evaluated for exclusion or inclusion in the PDL by the ASES Pharmacy and Therapeutics Committee.

▪To access the GHP Preferred Drug List (PDL), use any of the following links:

https://abarcahealth.com/clients/ases-spanish/

https://www.ases.pr.gov/proveedores?tab=Farmacias&categoria=Formularios+de+Medicamentos#Farmacia

https://www.multihealth-vital.com/eng/formulary.html

The co-payments corresponding to the beneficiaries vary according to the income levels of the beneficiary or family group.

▪In addition to the PDL, there is a List of Non-Prefer Drugs (NPDL), which is composed of drugs that have been evaluated and endorsed by the Pharmacy and Therapeutics Committee (P&T) to be covered by the exception process. Drugs outside the PDL and NPDL may be covered under the pharmacy benefit through exception process as long as the drug is not excluded

Pharmacy Coverage

▪The pharmacy benefit coverage under Vital PLan establishes the mandatory use of bioequivalent generics or biosimilar as the first option and requires the use of generics classified as 'AB' by the Food and Drug Administration (FDA).

▪Brand names for medications that have an available bioequivalent generic are listed in the PDL for reference purposes only.

▪MMM Multihealth must not impose restrictions on prescribed medications beyond those established in the PDL, NPDL, or any other drug formulary approved by ASES.

▪Acute Conditions: The dispensing maximum will be to cover fifteen (15) days therapy. When medically necessary, additional prescriptions will be covered.

▪Chronic Conditions: The dispensing maximum will be thirty (30) days therapy, original prescription and five (5) refills.

Pharmacy Prior- authorization process

Some medications are subject to prior authorization as established by the ASES Pharmacy and Therapeutics Committee. Time parameters for providing a pre-authorization determination: All pre-authorization determinations will be processed within 24 hours after MMM Multihealth receives the minimum information required to evaluate the case. If the request does not include the minimum information required for review, MMM Multihealth must return the request within the first 24 hours of receipt. However, in the event of an emergency, MMM Multihealth must evaluate the request and for an emergency supply in the event of an emergency and may authorize a 72-hour supply.

Standard information: the medical prescription (in accordance with the requirements of the Puerto Rico Pharmacy Law), a supporting statement that provides the clinical justification and medical necessity of the prescribed medication meeting all requirements, and the expected duration of treatment, as required by the medical policy and/or clinical guidelines for the medication, to rule out any safety risks and ensure its effectiveness. Information, as applicable, such as lab results, medical studies, pathology, condition stage, medication and condition history, weight, height, progress notes, among others. If processed under the medical benefit, it is required to confirm who supplies and who administers the medication

Pharmacy Prior authorization process II

Clinical protocols endorsed by ASES, MMM Multihealth's medical policies, and/or clinical guidelines approved by the regulator, such as those from NCCN, are used as references.

https://drive.google.com/drive/folders/1aMde_HO_pjOwd2VtBq4k1LPn-I_leawx

https://www.mmm-pr.com/planes-medicos/politicas-medicas

https://www.nccn.org/login

If the request requires additional information to complete its clinical criteria, it may go through the RFI (Request For Information) process which provides 72 hours in addition to the initial 24 hours for evaluation.

Pharmacy Exception Process

▪When a medication that is not listed in the PDL is prescribed, it must be evaluated by the health plan through the exception process (the drug must be FDA approved for the treatment of the condition).

▪For this, the prescribing physician must provide the Pharmacy Department with written and signed clinical justification indicating the clinical reason(s) why the requested medication is clinically necessary to treat the beneficiary's disease or medical condition and the duration of the requested therapy.

Additionally, to request a medication that is not listed in the PDL, the prescribing physician must provide evidence of the following:

✓All PDL alternatives for this medication are contraindicated with the medications the patient is currently using;

✓The patient has experienced serious adverse reactions to the available alternatives in the PDL;

✓Therapeutic failures with all PDL alternatives, either because those alternatives were ineffective or could adversely affect the patient’s health or condition.

Pharmacy Exception Process

Additionally, to request a medication that is not listed in either the PDL or the Non-PDL, the prescribing physician must provide evidence of the following:

All alternatives in the PDL and Non-PDL for this medication are contraindicated with the medications the patient is currently using;

The patient has experienced serious adverse reactions to the available alternatives in both the PDL and Non-PDL;

Therapeutic failures with all alternatives in the PDL and Non-PDL, either because those alternatives were ineffective or could adversely affect the patient's health or condition.

Medications under the medical benefit (J CODES)

For the evaluation of an oncology and/or biological medication requested through the medical benefit:

MMM Multihealth's medical policies, CMS Local Coverage Determinations (LCD), National Coverage Determinations (NCD), and/or clinical guidelines endorsed by the regulator—such as those from NCCN—are used as references.

https://www.mmm-pr.com/planes-medicos/politicas-medicas

https://www.cms.gov/medicare-coverage-database/search.aspx

https://www.nccn.org/login

Regulatory time parameters for making a determination:

All authorization determinations will be processed within 24 hours if requested as expedited, or within 72 hours if requested as standard, after MMM Multihealth receives the minimum required information to evaluate the case.

If additional information is needed for J Code cases, it will be requested via fax or phone during the case processing timeframe.

Pharmacy - Contact Information

How to contact the Pharmacy Provider Call Center:

- Local: 787-523-2829
- Toll Free: 1-844-880-8820

Where can a Pharmacy request can be sent?

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

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

- For Foster Care Children and Domestic Violence Population:
  Email: VirtualXPharmacyLabel@mmmhc.com

Mental Health

What does the Mental Health Department offer?

The Mental Health Department aims to effectively and efficiently assess and manage the clinical mental health needs of the beneficiaries it serves through:

- Orientation to Mental Health services
- Information on availability of contracted Providers
- Authorization of services
- Service to the home
- Emergency Hotline
- Case Management
- Outpatient service coordination
- Guidance on documents and processes for authorization of Mental Health medications

Integrated Mental Health Department: Operational Units

1	Case Management	Discharge planning, post discharge follow-up and coordination of outpatient services.	Community case management and integration with physical case management.
2	Utilization Management	Utilization review in 16 hospitals.	38 Partial Hospital programs (PHP's).
3	Call Center	24-hour coordination services through dedicated line.	Licensed clinical staff for emergency management.

Call Center - Mental Health

- Guidance and coordination of outpatient services
- Guidance on documents and processes for medication authorization
- Request for home service coordination
- Contracted Provider Orientation
- Access to Outpatient services provided by Psychiatrists, Psychologists and Social Workers
- Inpatient and outpatient services for substance abuse and alcoholism
- Mental Health Condition Registry

Hours: Monday through Friday, 7:00 a.m. to 7:00 p.m.

Phone: 1-844-337-3331

Call Center - Case Management Integrated Mental Health

Services that require pre-authorization:

- Ambulance services
- Neuropsychological tests
- Partial Hospitalization Programs
- Electroconvulsive therapy
- Intensive Outpatient Programs

*All services with out of network providers may require preauthorization.

Hours: 24 hours a day, 7 days per week.
Phone: 1-844-337-3332

Integrated Model of Care

Colocation Model

- An integrated care model in which behavioral health services are provided in the same primary care/physical health services setting.
- The PMG must make space available to the behavioral health provider for each facility when needed.
- The mental health provider must be available to provide mental health assessments, consultations, and services to beneficiaries.
- A beneficiary identified with an acute or chronic mental health condition must be referred to a contracted mental health clinic or to the next level of care, as needed.
- Effective January 1, 2023, all primary care hospitals must have a behavioral health provider, as defined by the placement model. In this scenario a primary care physician or specialist may require the intervention of a mental health provider. The mental health professional will provide clinical interventions in person or in consultation with the interdisciplinary team (as needed) related to the mental health of emergency room or inpatient beneficiaries.

Integrated Model of Care

Reverse Colocation

- Integrated care model in which medical services are available to beneficiaries treated in mental health facilities.
- Includes beneficiaries with comorbid conditions which may be chronic or acute, with mental health diagnoses.
- A PCP is located full- or part-time at a mental health clinic/facility to monitor the physical health of beneficiaries.
- They utilize the patient's mental health record and coordinate follow-up with the GMP as needed.
- The collocated PCP may perform the same medical interventions and referrals as would a PCP in a PMG.

Mental Health Parity Act

MMM MH meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP nor prior authorization is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a contracted mental health network provider.

Coordination of Benefits

Coordination of Benefit

- Coordination of benefits is a method used by health insurers to determine payments for medical claims received by a beneficiary when there is more than one health insurer.
- The primary plan is the payer of covered services and will pay first according to established rules.
- The secondary plan will pay for covered services after the primary plan pays.
- The Vital Plan coverage will be secondary payer to any other plan or person in charge of paying for medical services.

Dual Eligibility (Medicare)

- Medicare Part A beneficiaries will be covered under the Vital Plan once the Medicare benefit limit is reached.
- Medicare Part A deductibles are NOT covered.
- Vital Plan beneficiaries who also have Medicare Part A and B will be covered for pharmacy and dental.
- Medicare Part B co-payments and deductibles are covered by Vital Plan.
  - The health care provider must accept Medicare and Vital Plan to perform coordination of benefits.

In Lieu of Services or Setting (ILOS)

In Lieu of Services or Setting (ILOS)

- In Lieu of Services (ILOS) refers to services or settings offered as substitutes for those covered under a state Medicaid plan, with the aim of addressing health-related social needs and improving care delivery, in accordance with 42 CFR§ 438.3(e)(2).
- An ILOS can be used as an immediate or long-term substitute for a State Plan service or setting, or when the use of an ILOS is expected to reduce or prevent the future need for a State Plan service or setting.
- If approved by ASES, the contractor (MMM) may offer the in lieu of service or setting to beneficiaries, as appropriate and at the option of MMM, but shall not require a beneficiary to use an in lieu of service or setting.
- Approved *"in lieu of"* services or settings are described in Appendix 25, and the requirements for delivering *"in lieu of"* services are specified in Section 7.14 of the contract with ASES

Pre-Authorizations

Pre-Authorizations

- Some medical services are subject to prior authorization as established by the contract between MMM Multihealth and ASES.

- The Pre-Authorization Process reviews requests for services by medical providers prior to the provision of services, except in cases of emergency. These are on a select list of services to determine if the service is medically necessary. Each case is handled individually based on medical necessity and final determinations based on clinical judgment.

Categories

Expedited Category

- When processing a preauthorization request, it is important that the category selection be responsive to the beneficiary's needs. CMS establishes the expedited category when the beneficiary or the beneficiary's physician believes that waiting could place the beneficiary's life, health or safety in serious jeopardy.
- These requests are determined on or before 24 hours of receipt by the plan.
- Expedited status must be established solely by the beneficiary's physician on the physician's order.

Standard Category

- Category used when the beneficiary's health is not in serious jeopardy. These requests are determined on or before 72 hours of receipt by the health plan.

Pre-Authorization Request

The following documentation and information is required to process a service request:

- Pre-Authorization request form completed in all parts.
- PCP Referral
- PCP's name and NPI number
- Specialist's name and NPI number (if applicable)
- Facility or hospital NPI name and number (if applicable)
- ICD-10 code (Diagnosis) with description
- CPT Code (Procedure) with description
- Physician's signature and license number
- Date of services (if applicable)

Information and delivery methods

Supporting information

To obtain all the information for the evaluation and determination of the requested service, the physician must include, apart from the physician-referred order, the following:

- Medical history related to the service Previous studies
- Any other information relevant to the requested service

Methods

Innova MD Portal - Electronic

Fax:

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

Complaints, Grievances & Appeals

What is a complaint, grievance, and appeal?

Complaint: Any expression of dissatisfaction, verbal or written, made by an insured to MMM MH or its providers related to the treatment received.

Grievance: An oral or written statement of dissatisfaction made by an insured to the MMM MH or its providers that relates to services received under the Vital Plan coverage or aspects of interpersonal relationships.

Appeal: An oral or written statement of dissatisfaction with an adverse determination of the organization's operations such as a denial of tests, labs and x-rays, denial of a procedure, medications or the resolution of a grievance.

Time frame

The beneficiary may file a claim at any time if he/she complies with the established terms:

- Complaint: 15 calendar days from the date of the event.
- Complaint: At any time from the date of the event.
- Appeal: sixty (60) calendar days to file your appeal from the date you received the determination.

Terms established to respond to the beneficiary

Complaint

- It must be resolved within 72 hours from the date and time of receipt. If it cannot be resolved it will become a complaint

Grievance

- Must be resolved on or before ninety (90) days and if an extension is required, an additional 14 days; sent to ASES for consideration.

Appeals

- Must be resolved on or before 72 hours from date and time of receipt if expedited and thirty (30) calendar days if standard. If extension is required, an additional fourteen (14) days; it is sent to ASES for consideration.

Grievances and Appeals - Contact Information

How to report a grievance or appeals complaint?

The beneficiary can visit one of our Service Centers, or contact us at:

- Beneficiary Service Line: 1-844-336-3331 (Toll Free) or TTY (Toll Free): 787-999-4411
- E-mail: agplanvital@mmmhc.com
- Fax: 1-844-990-1990 | 1-844-990-2990
- Mail:

MMM Appeals & Grievances Department

PO Box 72010

San Juan PR 00936-7710

Quality Program

Quality and Performance Indicators

Vital Plan of Puerto Rico has developed a series of indicators as part of the quality improvement process.

- Prenatal care services provided by your physician.
- Health education and promotion of wellness activities.
- Coordination of services in the management of acute conditions.
- Member education in the management of chronic medical conditions such as diabetes, hypertension, and asthma, among others.
- Provider education.
- Helping physicians provide better quality of care.
- Level of preventive services covered.
- Monitoring performance measures on Social Determinants of Health (SDOH).

General Provisions

- To provide quality care to its beneficiaries for the purpose of improving their health status or maintaining a good health condition.

- Work together with beneficiaries, providers and related agencies to continuously improve the health care of beneficiaries.

- ASES, along with other federal programs and according to PR regulations, will oversee monitoring the compliance of the health care offered.

Provider’s Network

What is a Primary Care Physician and what are his/her responsibilities?

What is A Primary Care Physician?

- Health Professional duly licensed to practice medicine in Puerto Rico.
- Hired by the physical health insurer as a participating physician within a Medical Group.

Their responsibilities are:

- To perform the pertinent medical evaluations of the health status of the beneficiaries.
- Provide, coordinate and order all health services and treatments needed by Vital Plan's beneficiaries.
- Provide preventive medical services to keep the beneficiaries healthy.
- To inform the beneficiary when he/she understands that it is necessary to visit a specialist or subspecialist.
- Provide referrals to beneficiaries when necessary.
- Coordinate visits to specialists or subspecialists outside the Primary Medical Group's Preferred Network.

Who is considered a Primary Care Physician?

- General Practitioner
- Family Physician
- Pediatrician
- Gynecologist/Obstetrician
- Internist

Group's Preferred Network/Primary Physician

- Specialist and subspecialist physicians
- Ancillary medical services
- Clinical Laboratories
- Specialized Diagnostic Tests
- Imaging Centers
- Cardiovascular Surgery and Catheterization Centers
- Hospitals
- Urgent Care
- Emergency Room

General Provider Network

- Specialist physicians, subspecialists, and health services facilities.
- Contracted by your physical health insurer to provide support to the Primary Medical Group.
- Provides services that the beneficiary cannot obtain through the Preferred Network of your Primary Medical Group.
- In order to visit this network, the beneficiary must obtain a referral from his/her Primary Care Physician and the corresponding copayments will apply.
- ASES establishes a minimum fee required for provider payment based on a percentage of the Medicare Fee Schedule according to the Provider`s specialty.
- ASES established rates of 100% for health care providers, such as specialists, and 75% for ambulances and DME.
- ASES establishes a minimum payment per member per month (PMPM)for the primary physician which is currently $18.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