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Regulatory Trainings

2025

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), 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 2025
- ✓ 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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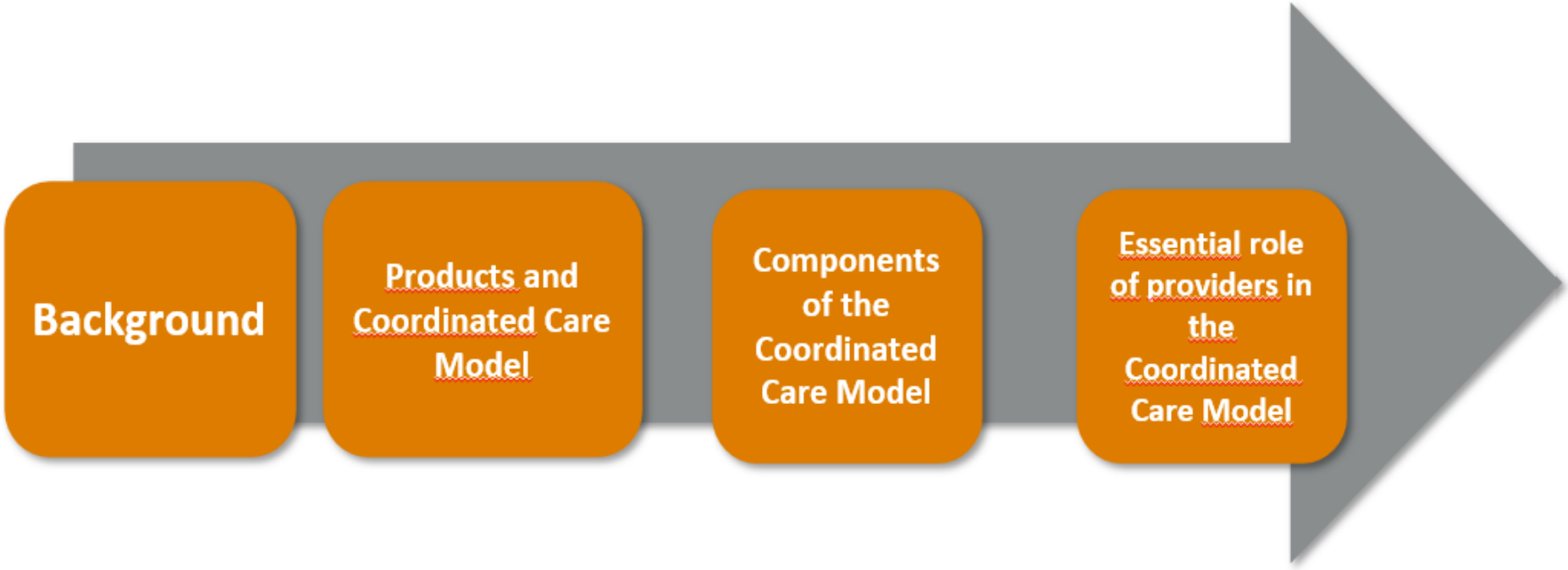
Coordinated Care Model 2025

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*.

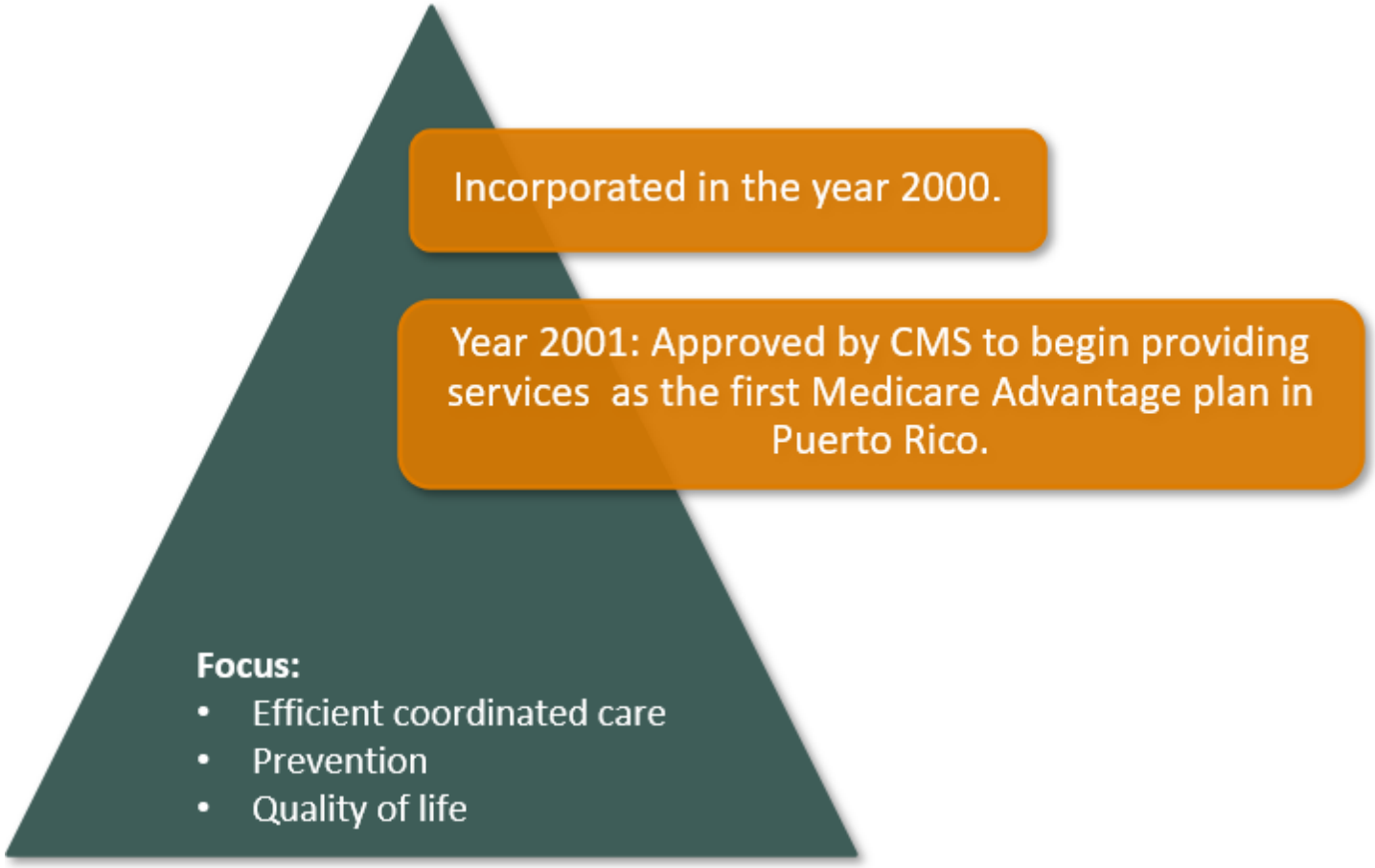
Every Medicare Advantage insurer must provide and document training on the Coordinated Care Model** to all employees, contracted personnel, and providers.

It 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


4.5 Stars
We celebrate that one of our contracts has been rated 4.5 stars under the Medicare Star Rating Program for eight consecutive years.
*Contract H4004.
Every year Medicare evaluates the plans based on a 5-Star Rating System.

What is the Coordinated Care Model?

- Structure to carry out coordinated care efficiently
- Focus on beneficiaries with special needs

- Vital tool
- Improve the quality
- Ensure that needs are met under SNP*

*SNP –Special Needs Plan


MMM
COVERAGE
2025

Special Needs Plans

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

Special Needs Plans

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

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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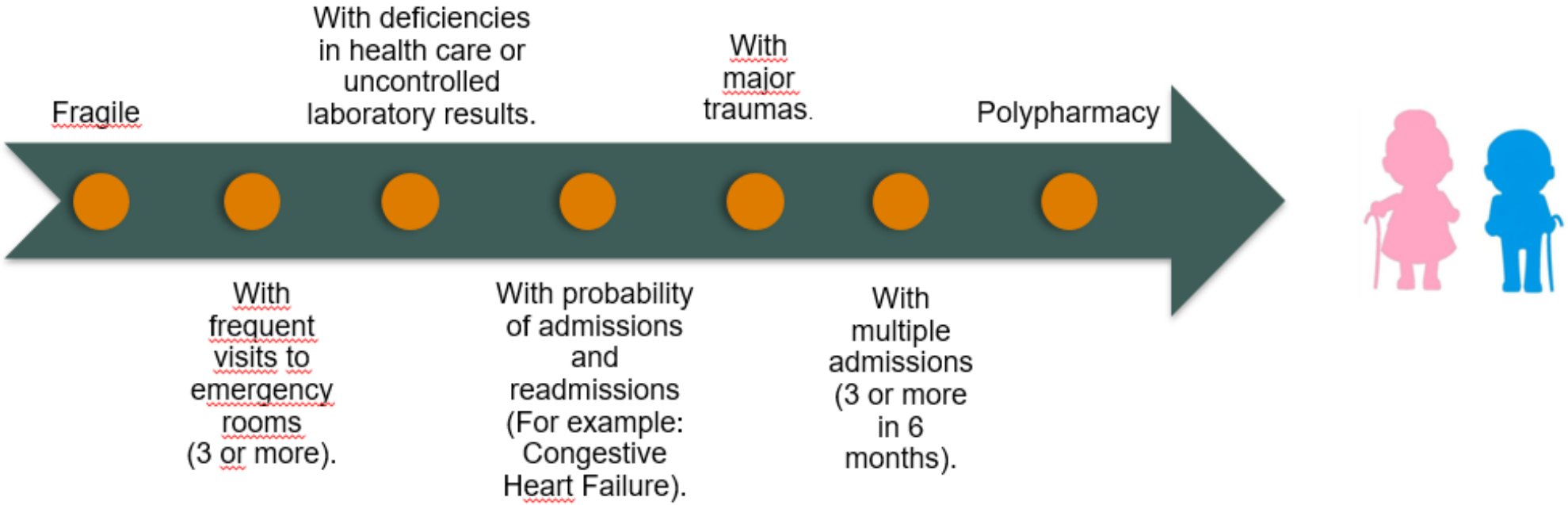
The Most Vulnerable

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



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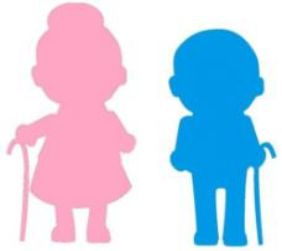
The Most Vulnerable

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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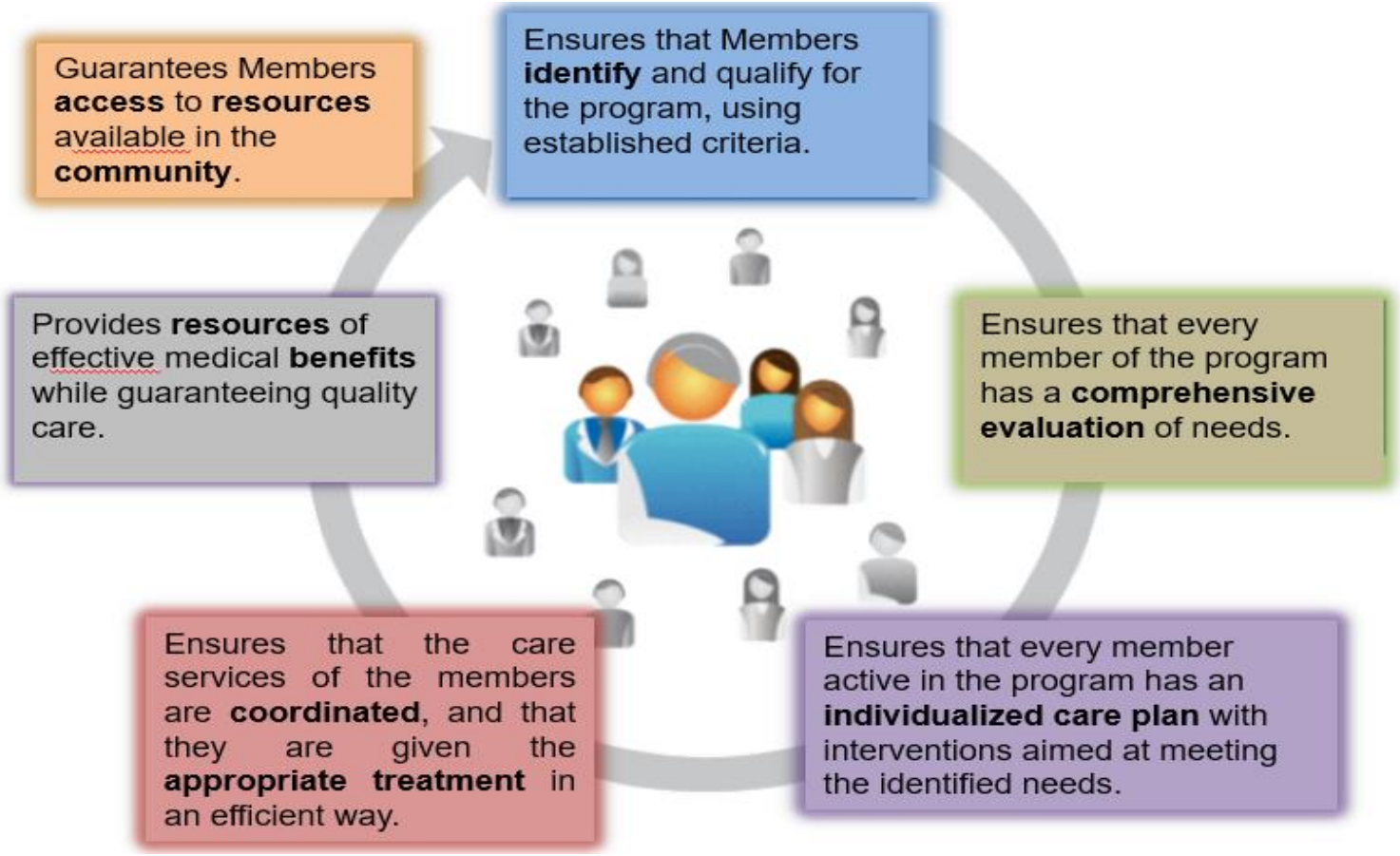
Coordinated Care

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

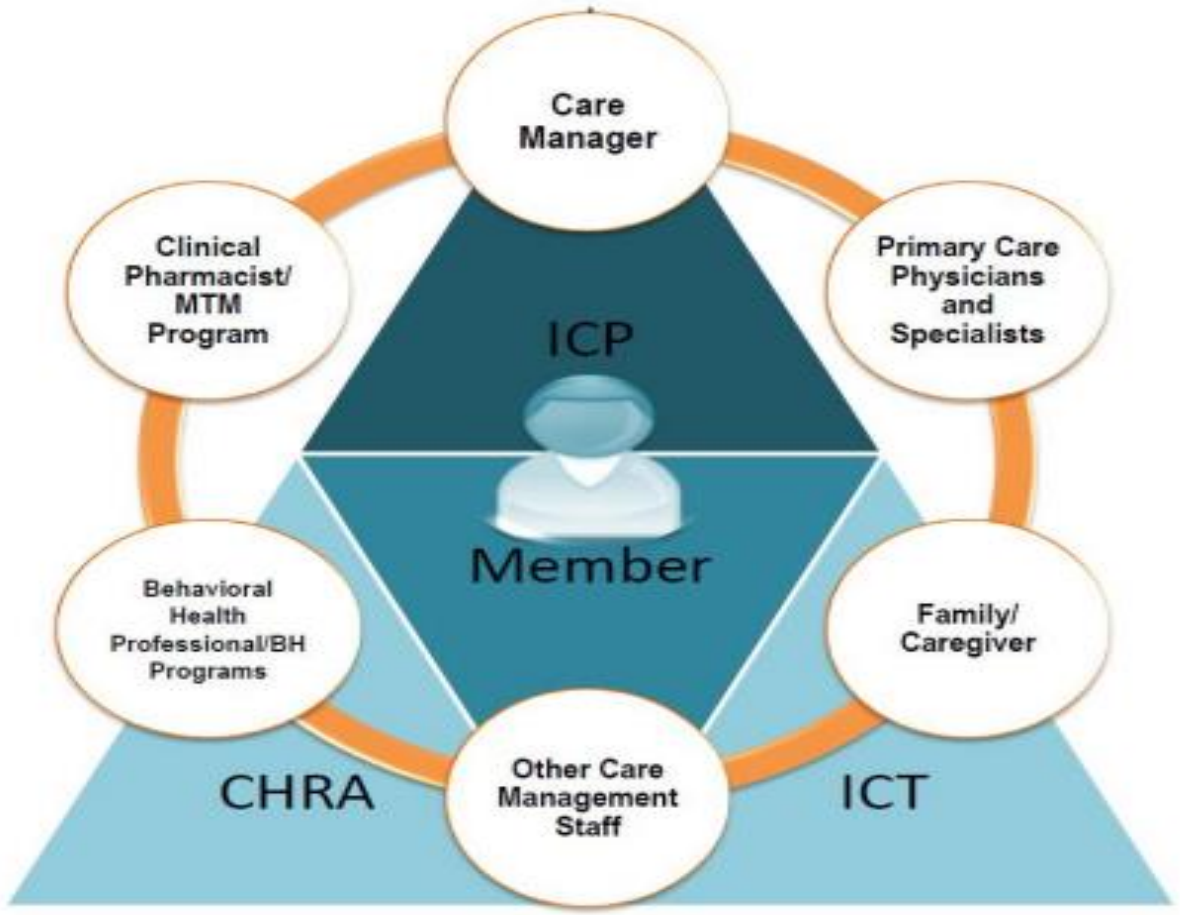
Responsabilities of providers in the ICT:

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 monitor:

- ✓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 establishes a Quality Improvement Program to monitor health outcomes and performance of the care model through:

- Data collection and monitoring of measures of the Five 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

1. *Model of Care Scoring Guidelines for Contract Year 2024*. Obtained from: https://snpmoc.ncqa.org/static/media/CY2025SNP_MOC_Scrng_Gdlns_508.4c71d8c17b37b33ff079.pdf

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.

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Effective Compliance Program Guidelines & Puerto Rico Laws Applicable to the Healthcare Industry 2025

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.

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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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Effective Compliance Program Guidelines

Lesson Compliance Training

- **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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Lesson Compliance Training

- **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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Lesson Compliance Training

- **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?**

  Now that you have read the general ethical guidelines, how do you know what is expected of you in a specific situation?

  Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their 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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Lesson Compliance Training

- **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

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Lesson Compliance Training

- **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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Lesson Compliance Training

- **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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Combating Fraud, Waste and Abuse

Introduction

- This training helps Medicare Parts C and D plan Sponsors' employees, governing body members, providers, and their first-tier, downstream, and related entities (FDRs) to satisfy their fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance 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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Lesson 2

- **Course Objectives:**

  - After completing this course, you should be able to:
    - Recognize FWA in the Medicare & Medicaid Programs
    - Identify the major FWA laws and regulations
    - Recognize potential consequences and violations penalties
    - Identify methods to prevent FWA
    - Identify how to report FWA
    - Recognize how to correct FWA

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Lesson 2 What is FWA?

- **Fraud** is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment when no entitlement would otherwise exist. Knowingly soliciting, getting, offering, or paying remuneration (for example, kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health care programs.
- Making prohibited referrals for certain designated health services is another example. Fraud requires intent to get payment and knowledge the actions are wrong. The Criminal Health Care Fraud Statute (18 United States Code (USC) 1347) makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It's also subject to criminal fines up to $250,000.
- The statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:
  - Defraud any health care benefit program
  - Get (by means of false or fraudulent pretenses, representations, or promises) money or property owned by, or controlled by, any health care benefit program

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary power wheelchair claims.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

- **Waste** describes practices that, directly or indirectly, result in unnecessary Medicare & Medicaid Programs costs, like overusing services. Waste is generally not considered to be criminally negligent actions but rather the misuse of resources.
- **Abuse** describes practices that, directly or indirectly, result in unnecessary costs Medicare Program costs. Abuse includes any practices that doesn't provide beneficiaries with medically necessary services or meet professionally recognized standards of care.

Section 20 of the "Medicare Managed Care Manual", Chapter 21 and "Prescription Drug Benefit Manual" , Chapter 9 have fraud, waste, and abuse definitions.

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Lesson 2 What is FWA?

- **Fraud, Waste and Abuse Examples**

– **Fraud** examples:
  - Knowingly billing for services of higher complexity than services actually provided or documented in patient medical records
  - Knowingly billing for services or supplies not provided, including falsifying records to show item delivery
  - Knowingly ordering medically unnecessary patient items or services
  - Paying for federal health care program patient referrals
  - Billing Medicare for appointments beneficiaries don't keep

– **Abuse** examples:
  - Billing unnecessary medical services
  - Charging excessively for services or supplies
  - Misusing codes on a claim, like upcoding (assigning an inaccurate medical procedure or treatment billing code to increase payment) or unbundling codes

– **Waste** examples:
  - Conducting excessive office visits or writing excessive prescriptions
  - Prescribing more medications than necessary for treating a specific condition
  - Ordering excessive lab tests

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Lesson 2 What is FWA?

- **Differences Among Fraud, Waste, and Abuse**
  - There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge.
  - Fraud requires intent to get payment and knowledge the actions are wrong.
  - Waste and abuse may involve getting an improper payment or creating unnecessary Program costs but don't require the same intent and knowledge.
- **Understanding FWA**
  - To detect FWA, you need to know the **law.**
  - The following pages provide high-level information about these laws:
    - Federal Civil False Claims Act (FCA)
    - Criminal Health Care Fraud Statute
    - Anti-Kickback Statute (AKS)
    - Physician Self-Referral Law (Stark Statute)
    - Civil Monetary Penalties Law (CMPL)
    - Exclusion Statute
    - Health Insurance Portability and Accountability Act (HIPAA)
    - For details about the specific laws, consult the applicable statute and regulations.

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Lesson 2 What is FWA?

- **Federal Civil False Claims Act**

– The Civil False Claims Act (FCA) (31 USC 3729–3733) makes a person liable to pay damages to the government if they knowingly:

  - Conspire to violate the FCA
  - Carry out other acts to get government property by misrepresentation
  - Conceal or improperly avoid or decrease an obligation to pay the government
  - Make or use a false record or statement supporting a false claim
  - Present a false claim for payment or approval

– Additionally, under the criminal FCA (18 USC 287), individuals or entities may face criminal penalties, including fines, imprisonment, or both for submitting false, fictitious, or fraudulent claims.

- **Whistleblowers:** A person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- **Protected**: A person who report false claims or brings legal actions to recover money paid on false claims is protected from retaliation.
- **Rewarded**: A person who brings a successful whistleblower lawsuit get at least 15%, but not more than 30% of the money the government collects.

EXAMPLES:

A Florida Medicare Part C plan:

- Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase CMS risk capitation payments
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported
- Failed to report the unsupported diagnosis codes to Medicare
- Agreed to pay $22.6 million to settle FCA allegations

The owner-operator of a California medical clinic:

- Used marketers to recruit individuals for medically unnecessary office visits
- Promised free, medically unnecessary equipment or free food to entice individuals
- Charged Medicare more than $1.7 million for the scheme
- Was sentenced to 37 months in prison

Damages and Penalties:
Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus $11,000 per false claim filed.

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Lesson 2 What is FWA?

- **Criminal Health Care Fraud Statute**
  - The Criminal Health Care Fraud Statute (18 USC 1346–1349) states, "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program or obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both."
  - Conviction under the statute doesn't require proof the violator knew the law or had specific intent to violate it.

Damages and Penalties

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

- 18 USC Section 1347 has more information

EXAMPLE

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed
- Pleaded guilty to health care fraud
- Received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan

The owners of multiple Durable Medical Equipment (DME) companies in New York:

- Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors
- Didn't provide DME to any patients as claimed
- Submitted almost $1 million in false claims to the nonprofit; $300,000 was paid
- Pleaded guilty to one count of conspiracy to commit health care fraud

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Lesson 2 What is FWA?

- **Anti-Kickback Statute**
  - The Anti-Kickback Statute (AKS) (42 USC 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or get any remuneration directly or indirectly to induce or reward patient referrals or business generation involving any item or service payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they violate the AKS.
  - The safe harbor regulations (42 CFR 1001.952) describe various payment and business practices that, although they potentially implicate the AKS, aren't treated as AKS offenses if they meet certain regulatory requirements. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses.
  - Comparison of the Anti-Kickback Statute and Stark Law handout has more information.

EXAMPLE

A physician operating a Rhode Island pain management practice:

- Conspired to solicit and get kickbacks for prescribing a highly addictive version of the opioid Fentanyl
- Reported patients had breakthrough cancer pain to secure insurance payments
- Got $188,000 in speaker fee kickbacks from the drug manufacturer
- Admitted the kickback scheme cost Medicare and other payers more than $750,000

The physician was required to pay more than $750,000 in restitution.

Damages and Penalties

Violations are punishable by:

- A fine up to $25,000
- Imprisonment up to 5 years, or both
- Section 1128B(b) of the to the Social Security Act has more information.

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Lesson 2 What is FWA?

- **Physician Self-Referral Law (Stark Law)**

– The Physician Self-Referral Law (42 USC 1395nn), often called the Stark Law, prohibits a physician from referring a patient to get designated health services from a provider with whom a physician or a physician's immediate family member has a financial relationship, unless an exception applies.
Designated health services:

- Clinical lab services
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Radiology and other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital service

Example
A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.

Damages and Penalties
We don't pay Medicare claims tainted by an arrangement that doesn't comply with the Stark Statute. A penalty of approximately $25,000 can be imposed for each service provided. There may also be a fine over $160,000 for entering into an unlawful arrangement or scheme.
Physician Self-Referral webpage and section 1877 of the Social Security Act have more information.

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Lesson 2 What is FWA?

- **Civil Monetary Penalties Law**

– The Civil Monetary Penalties Law (CMPL) (42 USC 1320a-7a) authorizes the Office of Inspector General (OIG) to seek Civil Monetary Penalties (CMPs) and sometimes exclusions for a variety of health care fraud violations. Violations that may justify CMPs include:

  - Arranging for an excluded individual's or entity's services or items
  - Failing to grant OIG timely records access
  - Filing a claim, you know or should know is for an item or service that wasn't provided as claimed or is false or fraudulent
  - Filing a claim, you know or should know is for an item or service for which we won't make payment
  - Violating the AKS
  - Violating Medicare assignment provisions
  - Violating the Medicare physician agreement
  - Providing false or misleading information expected to influence a discharge decision
  - Failing to provide an adequate medical screening exam for patients who present to a hospital emergency department with an emergency medical condition or in labor
  - Making false statements or misrepresentations on applications or contracts to participate in federal health care programs

– Section 1128A(a) of the Social Security Act has more information.

EXAMPLE

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated Medicare Part D claims for brand name prescription drugs the pharmacy couldn't have dispensed based on inventory records.

Damages and Penalties

Penalties and assessments vary based on the type of violation. Penalties can be approximately $10,000–$50,000 per violation. CMPs may also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received.

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Lesson 2 What is FWA?

- **Exclusion Statute**

– The Exclusion Statute (42 USC 1320a-7) requires the OIG exclude individuals and entities convicted of these offenses from participating in all federal health care programs:

– Arranging for an excluded individual's or entity's services or items

  - Medicare or Medicaid fraud, as well as other offenses related to delivering Medicare or Medicaid items or services
  - Patient abuse or neglect
  - Felony convictions for other health care-related fraud, theft, or other financial misconduct
  - Felony convictions for unlawful manufacture, distribution, prescribing, or dispensing controlled substances

– The OIG also maintains the List of Excluded Individuals and Entities (LEIE) website

– The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which enables various federal agencies, including the OIG, to take debarment actions.

– When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists aren't the same. 42 CFR 1001.1901 has more information.

Example

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related for not filing required reports with the FDA about oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. When the unconvicted executive was excluded, there was evidence, he was involved in misconduct leading to the company's conviction.

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Lesson 2 What is FWA?

- **Health Insurance Portability and Accountability Act (HIPAA)**
  - The HIPAA created greater access to health care insurance, strengthened health care data privacy protection, and promoted the health care industry standardization and efficiency.
  - HIPAA safeguards deter unauthorized access to protected health care information. As someone with access to protected health care information, you must comply with HIPAA.

Example

- A former hospital employee pleaded guilty to criminal HIPAA charges after getting protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

Damages and Penalties

- Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

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Lesson 2 Your Role in the Fight Against FWA

- **Where Do I Fit In?**
  - As someone who provides health or administrative services to a Medicare Part C, Part D or Medicaid enrollee, you are likely an employee or contractor of a:
    - Sponsor (Examples: Health Plan, Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
    - Provider
    - First-tier entity (Examples: Pharmacy Benefit Management [PBM]; hospital or health care facility; provider group; doctor‘s office, clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
    - Downstream entity (Examples: pharmacies, doctor‘s office, firms providing agent/broker services, marketing firms, and call centers)
    - Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®)

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Lesson 2 Your Role in the Fight Against FWA

- **What Are Your Responsibilities?**

– You play an important role in preventing, detecting, and reporting potential FWA, as well as Medicare and Medicaid non-compliance.

  - **FIRST**, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D, and the Medicaid Program requirements, including adopting and using an effective compliance program.
  - **SECOND**, you have a duty to report any compliance concerns and suspected or actual violations of which you may know.
  - **THIRD**, you have a duty to follow your organization's Code of Conduct that describes you and your organization's commitment to standards of conduct and ethical rules of behavior.

- **How Do You Prevent FWA?**

– Look for suspicious activity
– Conduct yourself in an ethically
– Ensure accurate and timely data and billing
– Ensure coordination with other payers
– Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
– Verify all information you get

- **Stay Informed About Policies and Procedures**

– Know your entity's policies and procedures.
– Every Sponsor and First-Tier, Downstream, or Related Entity (FDR) must have FWA policies and procedures. These procedures should help you detect, prevent, report, and correct FWA.
– Standards of Conduct should describe the Sponsor's expectations that:
  - All employees conduct themselves ethically
  - Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA
  - Reported issues will be addressed and corrected
– Standards of Conduct communicate to employees and FDRs that compliance is everyone's responsibility, from the organization's top to bottom.

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Lesson 2 Your Role in the Fight Against FWA

- **Report FWA**
  - Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.
  - Report any potential FWA concerns you have to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.
  - Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and can't retaliate against you for reporting.
  - Review your organization's materials for the ways to report FWA.
  - When in doubt, call your Compliance Department or FWA Hotline

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Lesson 2 Your Role in the Fight Against FWA

- **Reporting FWA Outside Your Organization**
  - If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice (DOJ), or CMS.
  - Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.
- **Details to Include When Reporting FWA**
  - When reporting suspected FWA, include:
    - Contact information for the information source, suspects, and witnesses
    - Alleged FWA details
    - Alleged Medicare rules violated
    - Suspect's history of compliance, education, training, and communication with your organization or other entities

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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Lesson 2 Your Role in the Fight Against FWA

- **Correction Action**

– Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with regulatory requirements.

– Develop a plan to correct the issue. Ask your organization's compliance officer how to develop a corrective action plan. The actual plan varies depending on the circumstances. In general:

  - Design the corrective action to fix the underlying problem that results in FWA violations and prevents future non-compliance.
  - Tailor the corrective action to address the particular FWA, problem, or identified deficiency;. include timeframes for specific actions.
  - Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee and include consequences for failing to satisfactorily complete the corrective action.
  - Monitor corrective actions continuously to ensure effectiveness

Corrective Action Examples

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, like marketing, enrollment, or payment suspension
- Terminating an employee or provider

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Lesson 2 Your Role in the Fight Against FWA

- **Potential FWA Indicators**
  - Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.
  - The subsections present potential FWA issues. Each provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in delivering Medicare Parts C and D or Medicaid benefits to enrollees.

- **Key Indicators: Potential Patient Issues**
  - Does the prescription, medical record, or laboratory test look altered or possibly forged?
  - Does the patient's medical history support the requested services?
  - Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
  - Is the person getting the medical service the beneficiary (identity theft)?
  - Is the prescription appropriate based on the beneficiary's other prescriptions?

- **Key Indicators: Potential Provider Issues**
  - Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
  - Does the provider bill the Sponsor for services not provided?
  - Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
  - Does the provider perform medically unnecessary services?
  - Does the provider prescribe a higher quantity than medically necessary for the condition?
  - Does the provider's prescription have their active and valid National Provider Identifier (NPI)?
  - Is the provider's beneficiary diagnosis supported in the medical record?

- **Key Indicators: Potential Sponsor Issues**
  - Does the Sponsor encourage or support inappropriate risk adjustment submissions?
  - Does the Sponsor lead the beneficiary to believe the benefits cost a certain price, when the actual cost is higher?
  - Does the Sponsor offer beneficiaries cash inducements to join the plan?
  - Does the Sponsor use unlicensed agents?

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Lesson 2 Your Role in the Fight Against FWA

- **Potential FWA Indicators (cont.)**
  - Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.
  - The subsections present potential FWA issues. Each provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in delivering Medicare Parts C and D or Medicaid benefits to enrollees.

- **Key Indicators: Potential Pharmacy Issues**
  - Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent somewhere else)?
  - Are the dispensed drugs expired, fake, diluted, or illegal?
  - Are generic drugs provided when prescription requires dispensing brand drugs?
  - Are PBMs billed for unfilled or never picked up prescriptions?
  - Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
  - Do you see prescriptions being altered (changing quantities or Dispense As Written)?
  - Are Eligibility facilitations services (E1s) and their information being used for purposes other than for determining patient eligibility?
  - Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
  - Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics, marking up the prices, and sending to other smaller wholesalers or pharmacies?

Manufacturer Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer knowingly provide samples to entities that then billed Federal health care programs for them?
- beneficiary diagnosis supported in the medical record?

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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

Suspected or observed misconduct, including violations to laws and regulations, or other ethical concerns, should be reported!

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Corporate Training of Regulations Applicable to the Healthcare Industry

Agenda

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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What is Cultural Competency?

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.

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Cultural Competency Plan

- Employees and Associates of the Plan must provide service 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, Two-spirit better known as LGBTQIA2S+ 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.

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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 Employees and Associates are trained to assess cultural, religious and language differences.

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Cultural Competence Plan Objectives

- 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, LGBTQIA2S+ 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 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 4^{th} grade literacy.

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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.

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Cultural Competence Plan Components

- 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 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

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 160 of November 17, 2001)

Definition

- **Advance Directive:** 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.

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Advance Directives Act

- 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.

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Limitations

- In case of pregnant women, any advance directive remains without effect until end of pregnancy.
- The declarant cannot prohibit him/herself of receiving treatment for pain, hydration or feeding.
  - Except, when death is imminent, or his/her body cannot absorb food and/or liquids. In this case, only the physician will have the authority to make a decision.
  - This law does not authorize the practice of euthanasia, or mercy-killing.

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Patients Rights and Responsibilities (Act 194 of August 25, 2000, as amended)

What does the law establish?

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.

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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.

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Patient Rights

- 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.

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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.

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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".

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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

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Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors

(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 removal of a child from his or her home, placement in foster care, and initiation of appropriate court action are required.

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

- 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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Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors 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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Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors 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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Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors 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.

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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
Act No. 54 of August 15, 1989, as amended

What does the law establish?

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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What is 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 Act. Act No. 3 of January 18, 2022

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 violence. 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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What does the law establish?

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

What is financial exploitation?

- 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.

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Financial exploitation - Reasons

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

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Signs of potential 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

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How to avoid 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.

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Penalties

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.

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Applicable Laws

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 to persons of 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.

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Thanks for your attention

Government Health Plan
Puerto Rico Vital Plan

MMM multihealth

Rev. Dic.2024

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.

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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 were already offering services to Vital Plan's beneficiaries revalidated for a new 3-year term contract. These are:

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First Medical Health Plan

Plan de Salud Menonita

Triples S

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

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Foster Care Children and Survivors of Gender Violence Population

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Vital X Population: Foster Care Children and Survivors of Gender Violence

- Previously known as the Virtual Region.
- Since January 2023, MMM Multihealth has been in charge of the medical needs and management of this population.
- MMM MH has dedicated staff to attend these population.
- **Important: Employee are not authorized to provide information regarding these population.**

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

- Department of Family`s ADFAN Program
  - ✓Children and youth 0-21 years of age (once they reach 21 years of age, they leave the program) under the custody of the State of Puerto Rico.
- Women`s Advocate Office
  - ✓Survivors of gender-based violence including their childrens

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Virtual population has the following characteristics:

Information only be provided to authorized employees regarding these population

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

If YOU received any situation related to this population, please; notified your immediately 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 contact of the agency that cares for the patient (Department of Family, Gender Violence)

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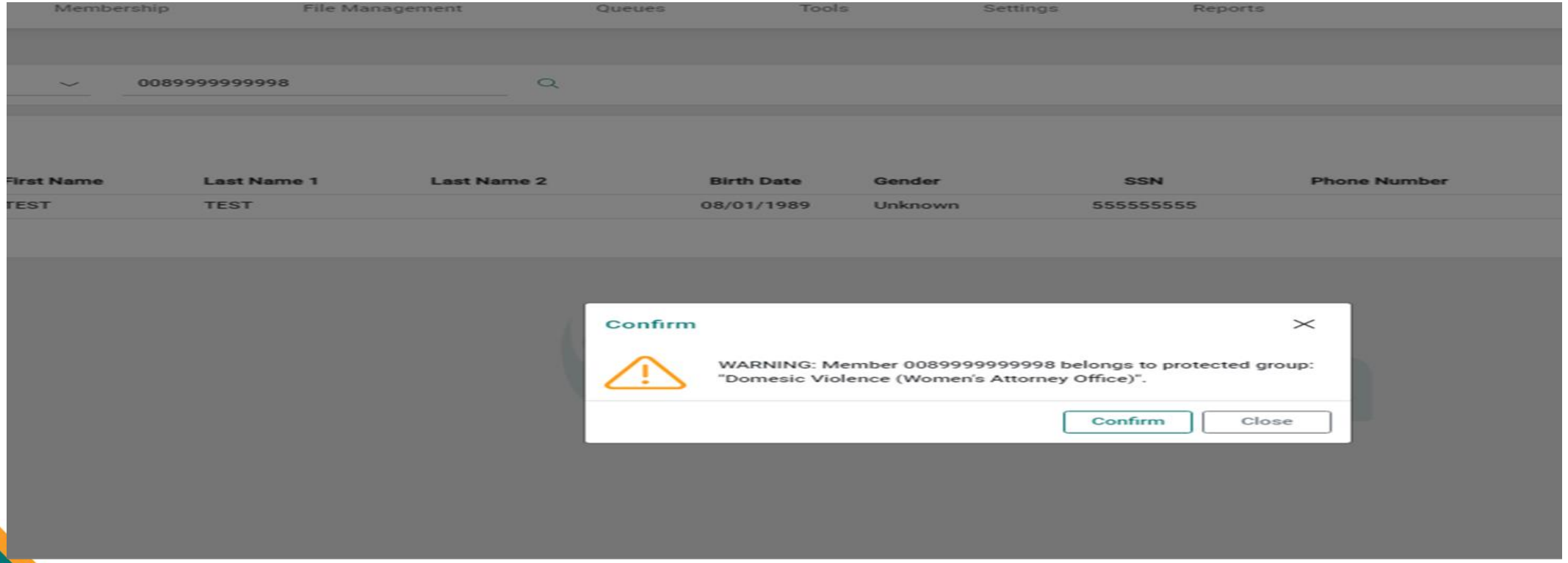
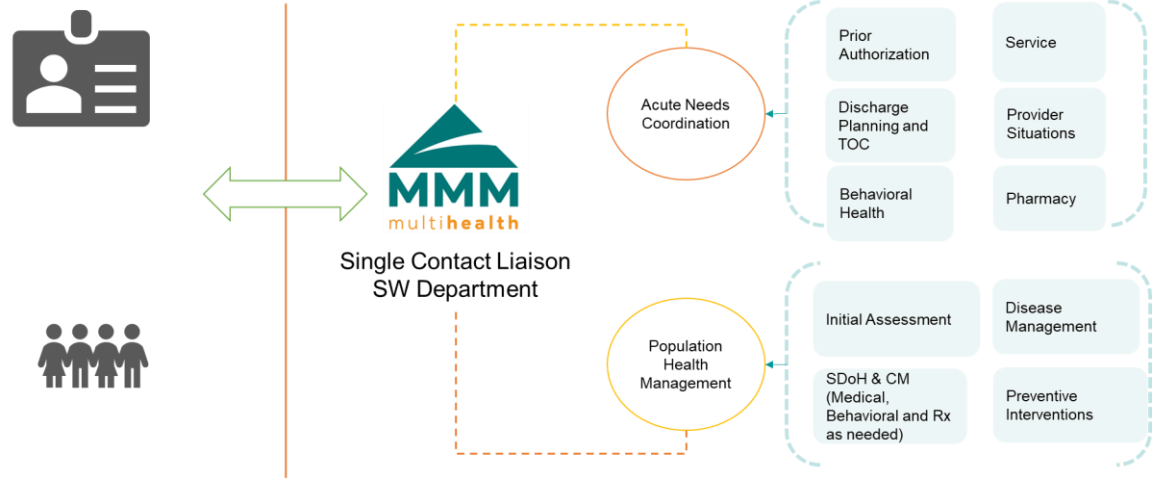
Confidentiality

See 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)

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What are Social Determinants of Health?

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.

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.

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.

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- **MMM Multihealth Responsabilities**
  - 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.

- **Social Determinants of Health**

01	02	03
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.

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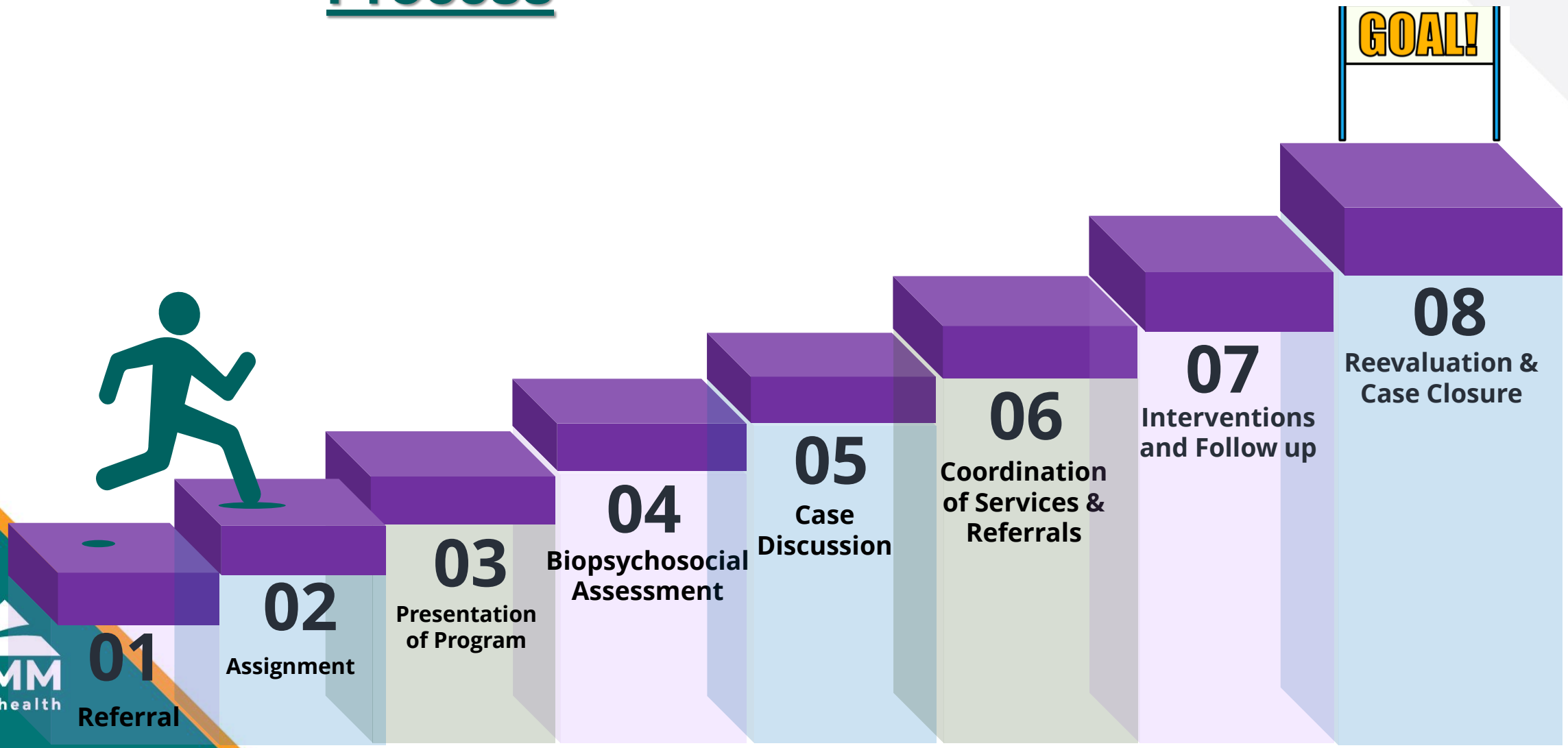
Social Work Program General Process



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/to transfer to a safe home.
- Financial issues that impact their health status

Security Threats

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

Must be referred to state protection services such as the Department of the Family, Police and/or 9-1-1.

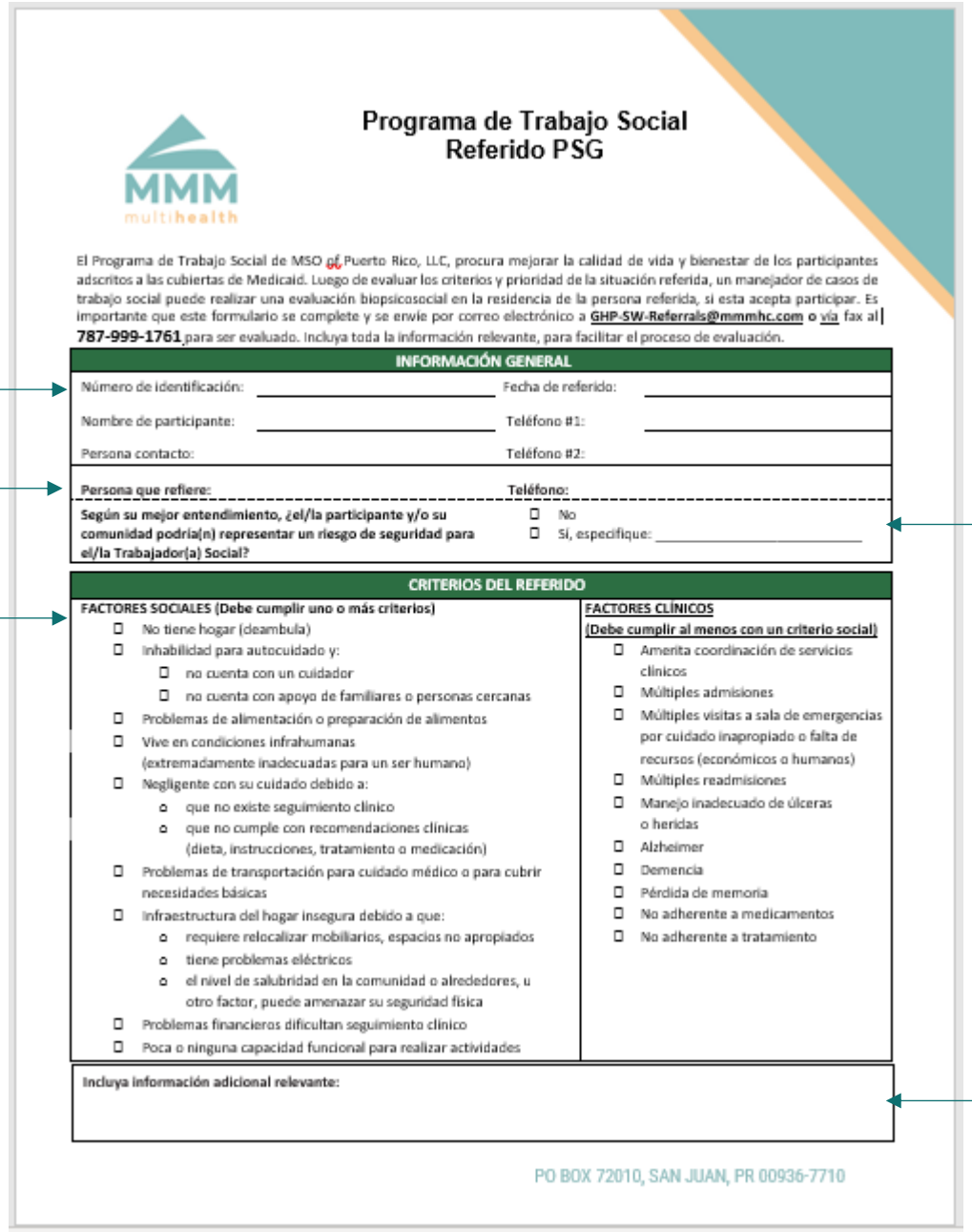
*Cases referred to state agencies can be directed to our program to offer follow-up and facilitate the processes.

How can I complete a referral?

Make sure to ALWAYS include a member ID

Identifiy yourself as the referral source and provide contact information

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



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

When in knowledge, 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

Social Work Program

How to deliver a referral?

1: Identifie:

- Beneficiarie contract number (member ID)
- Beneficiaries primary social needs adversly 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

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PROGRAMA TRABAJO SOCIAL MMM

Interoperability Rule

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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.
- **What's the purpose of the rule?**
- It is intended to facilitate the patient increased access to their personal health information (PHI), choice and 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 in order to make informed clinical decisions, which can lead to a better coordinated care.
- **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.

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Second Opinion

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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, 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.

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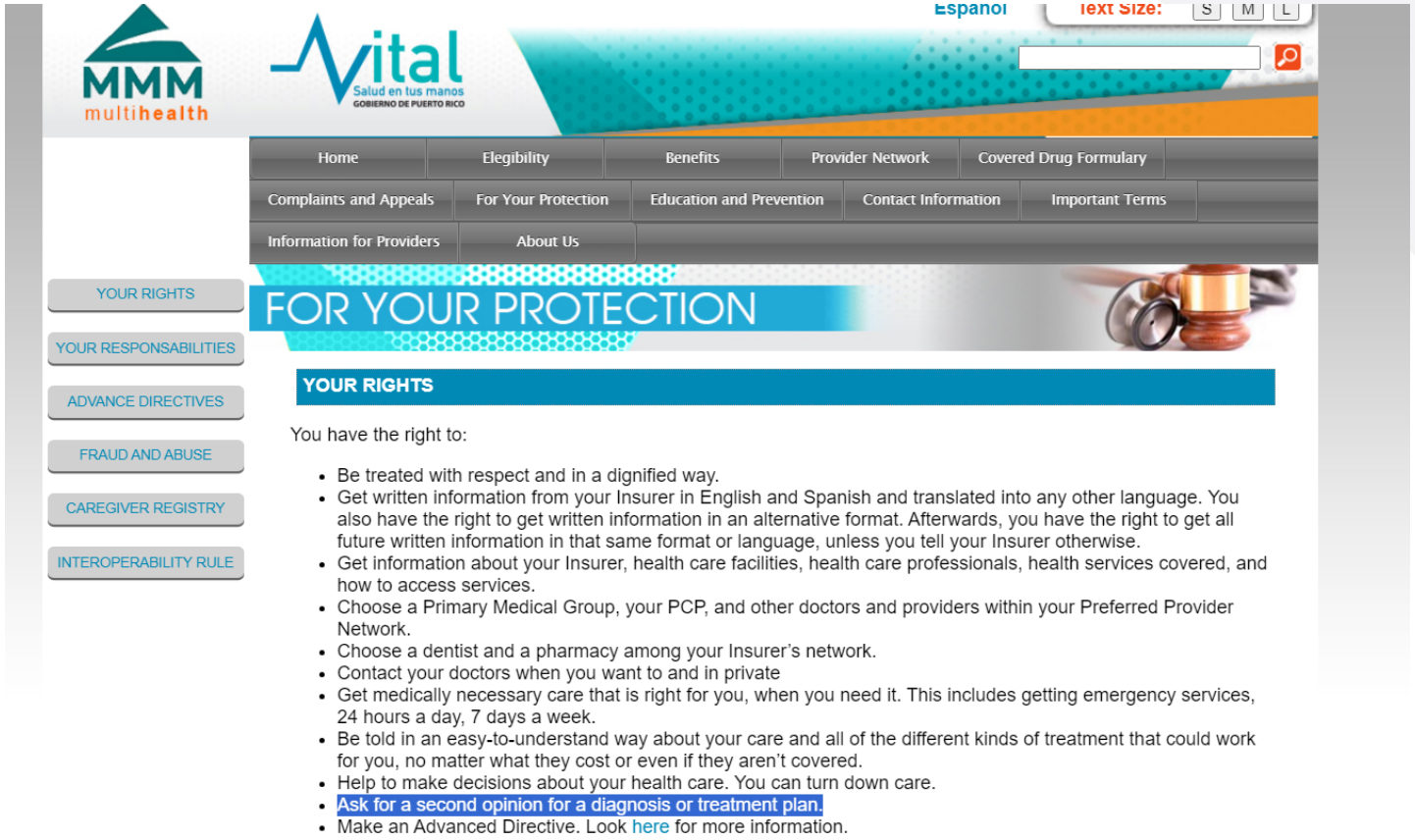
Second Opinion

- MMM MH has this information at
- Web page- https://www.multihealth-vital.com/eng/protection.html
- Beneficiary Handbook
- Provider's guideline
- Internal Policies and Procedure



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Medicaid Compliance Department

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¿What is your responsibility?

Comply with all ASES and Medicaid's requirements, statutes and regulations

Report any violations regarding unethical behavior, suspected fraud, waste, abuse, privacy or security

Comply with all operational, regulatory and compliance trainings

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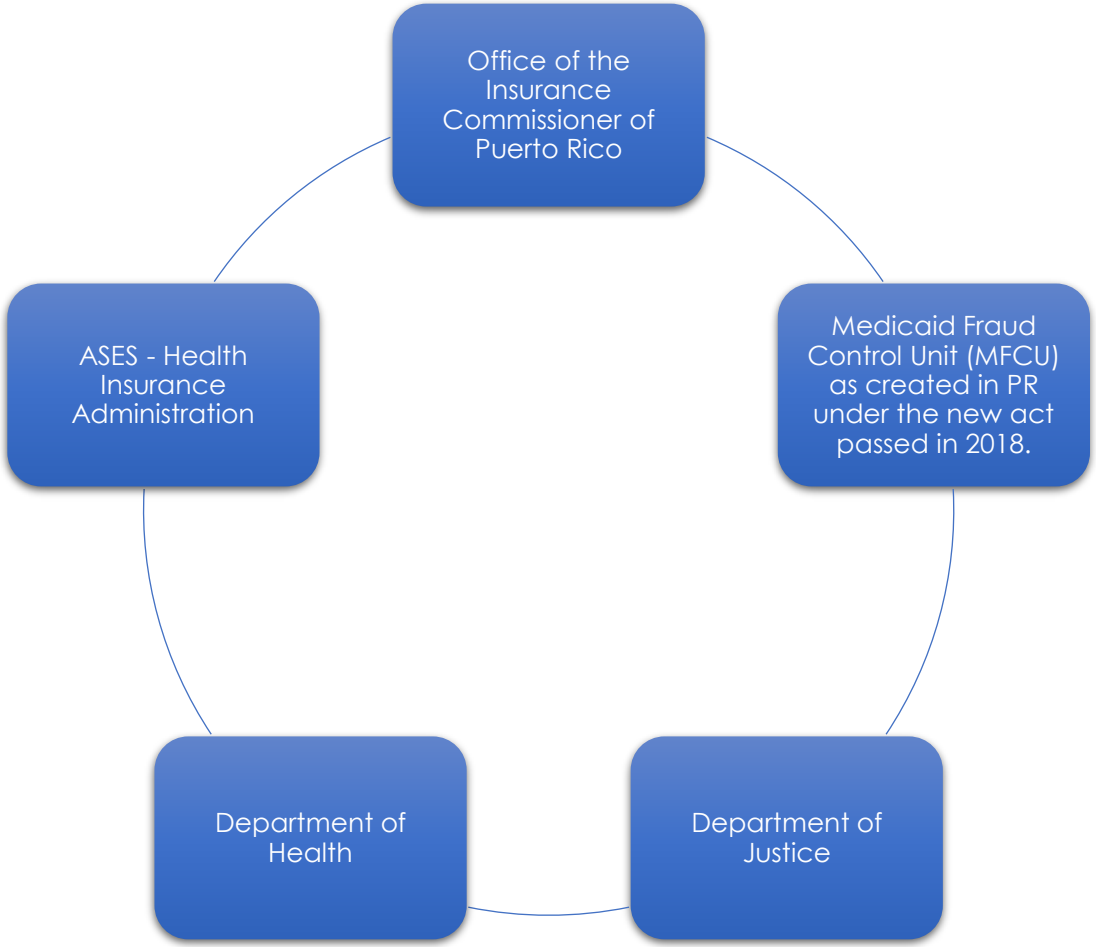
Regulatory Agencies attentive to the FWA



Contact Information in Puerto Rico:

Contact Information available to beneficiaries, providers, and delegated entities to report any situation of non-compliance:

- **Ethics Point website - Confidential:** www.psg.ethicspoint.com
- HotLine **1-844-256-3953**
- Email: **VitalSIU@mmmhc.com**

Suspected or observed misconduct, including violations to laws and regulations, or other ethical concerns, should be reported!

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Marketing Materials

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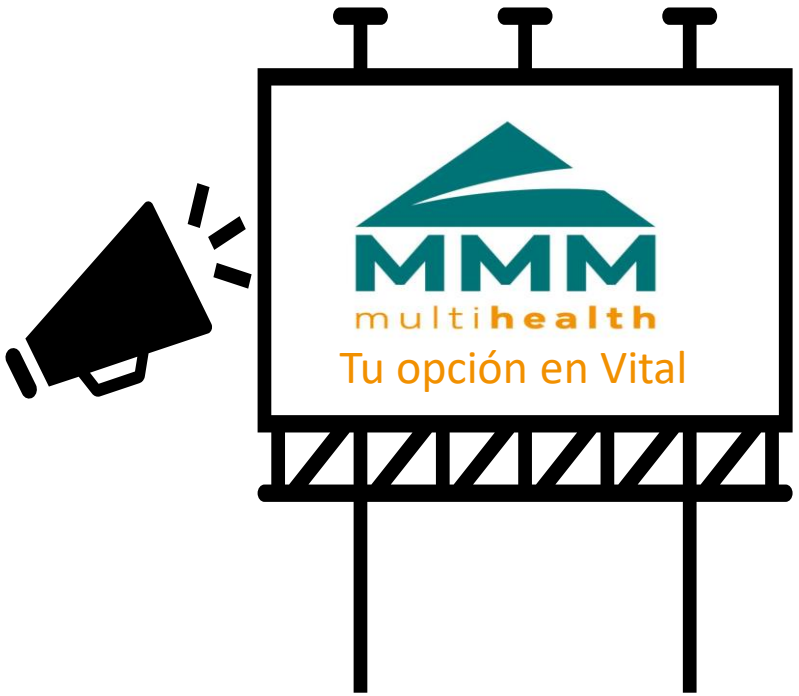
Marketing Material

- 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 produced in any medium, by or on behalf of MMM that can reasonably be interpreted as intended to market to Potential Enrollees.



Allowed Marketing 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 Marketing Activities

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.

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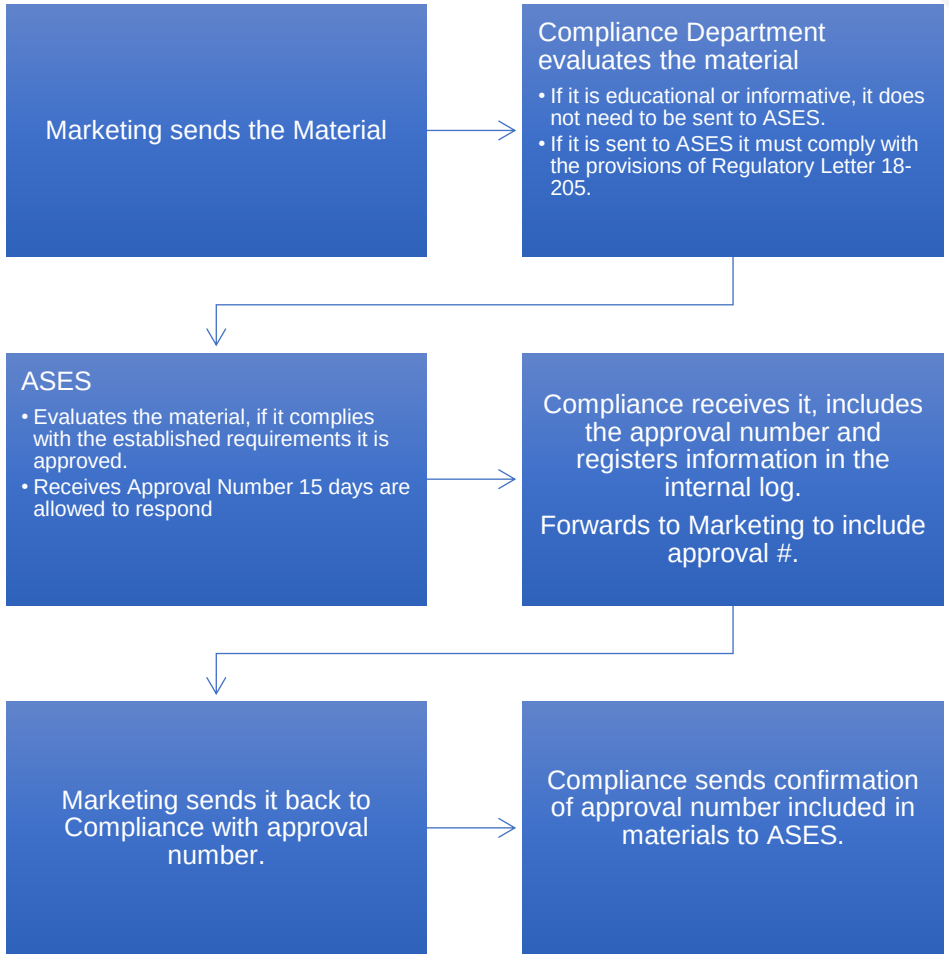
Marketing Material Approved Process

- This description is only a summary and is not intended to be an exhaustive and detailed explanation of the process.*



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Operations Vital Plan
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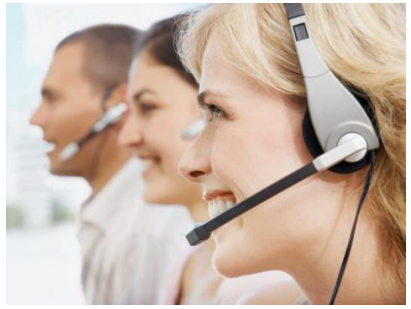
Vital Plan Service Lines

Service Lines
1-844-336-3331 (toll free)
787-523-2656 (Metro area)

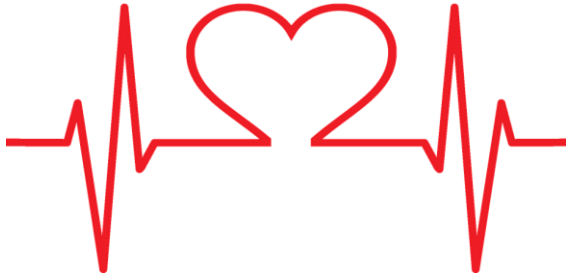
787-999-4411 TTY



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

Medical consultation line

Making Contact
1-844-337-3332 (toll free)
787-523-2653 (Metro area) 787-522-3633 TTY



24 hours/ 7 days a week

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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

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Main Office of MMM Multi Health

- We also have areas that manage Vital Plan's operations in the Kennedy

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.

Service Offices (Atlantic)

Carolina	Humacao	Vieques	Fajardo	Manatí	Canóvanas
Carolina Shopping Court •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.

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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.

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Services available at regional and satellite offices

- **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;
- Pure ALS;
- Pharmacy Benefits;
- Complaints, Grievances and Appeals;
- Coordination of Benefits;
- "PHI" information about protected patient information;
- Among others.

Materials Available to Beneficiaries:

- ID Cards;
- Beneficiary Handbook;
- Provider's Directory.

Transactions:

- Delivery of Identification Cards;
- 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.

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Eligibility

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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

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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

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Open Enrollment Period (OEP)

- The Open Enrollment Period (OEP) will be from January 1st through February 15, 2025.
- 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

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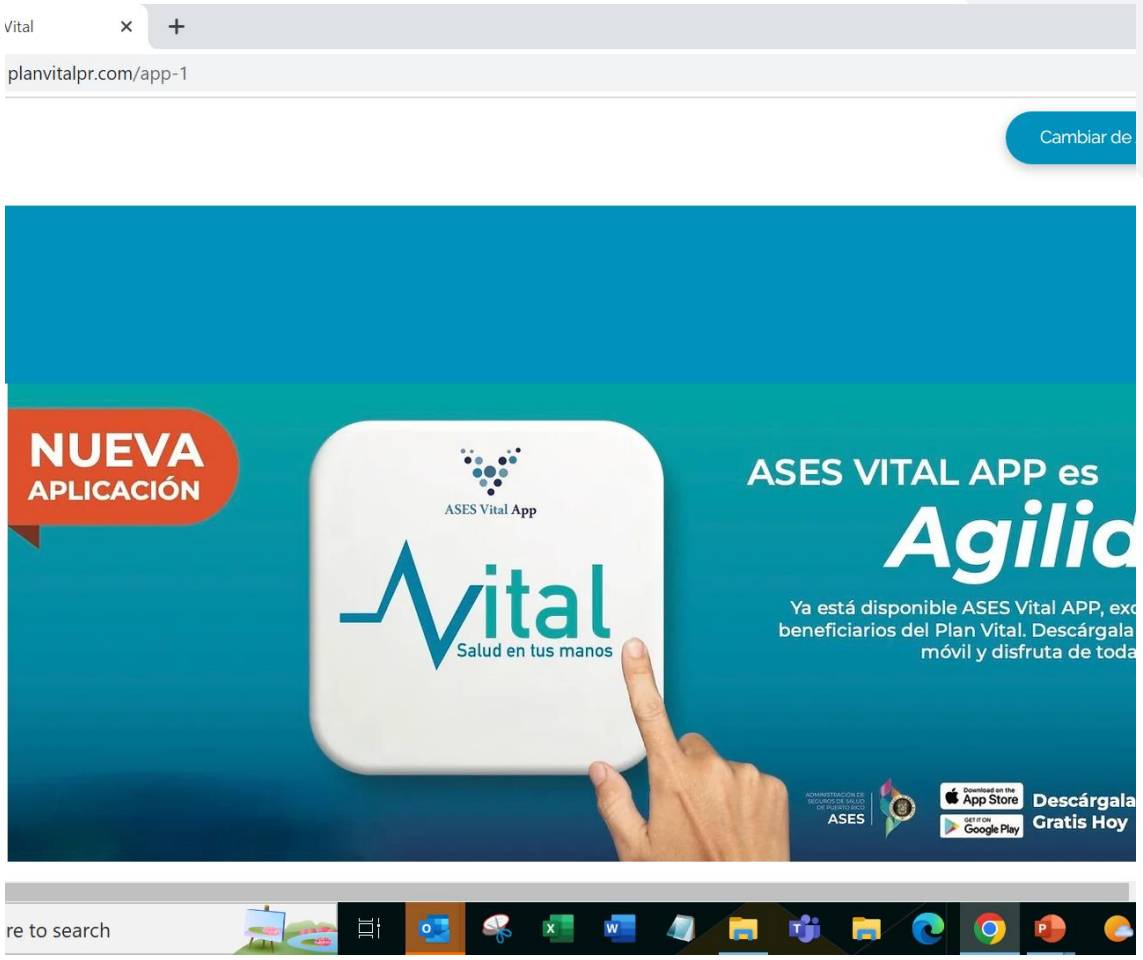
ASES's APP

- 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 Card

- The plan card will be mailed to the beneficiary within 5 days after the certified eligibility is uploaded into the system.
- If the beneficiary cannot wait, 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 emergency services in absence of the plan card.

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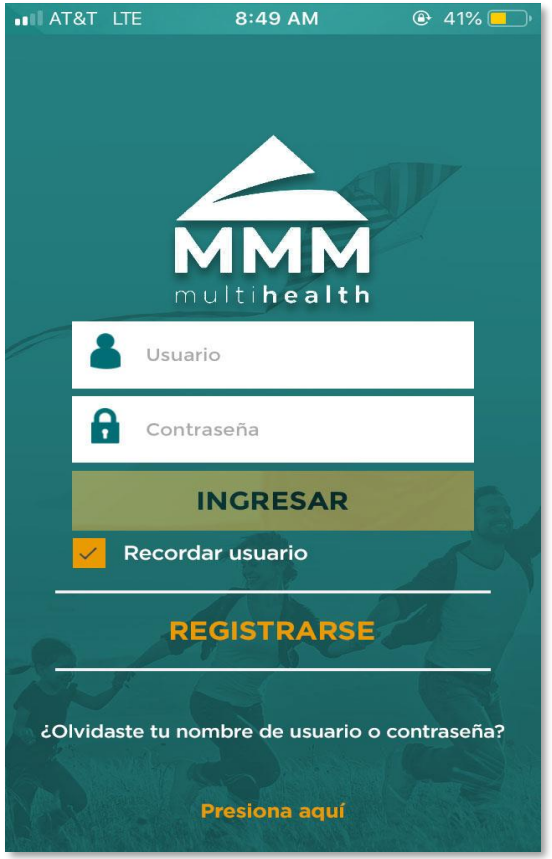
MMM- Vital APP

- 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.

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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

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Transitional Period

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Transitional 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, is able to obtain copies of the 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.

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Clinical Programs

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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.

- Aplastic Anemia
- Autism
- Cancer
- Children with Special Needs
- Renal Disease
  - Levels 3, 4 & 5
- End Stage Renal Disease (ESRD)
- Cystic Fibrosis
- Hepatitis - C
- HIV/AIDS
- Leprosy
- Multiple Sclerosis & ALS
- Obstetrics
- Pulmonary Hypertension
- PKU-Adult
- Rheumatoid Arthritis
- Scleroderma
- Systemic Lupus Erythematosus
- Tuberculosis
- Hemophilia
- Neonatal Hearing Loss
- Congestive Heart Failure (Stages III & IV)
- Post Transplant
- Primary Ciliary Dyskinesia
- Inflammatory Bowel Disease (IBD)
- Cleft Palate and Cleft Lip
- Oculocutaneous Albinism
- Evaluation for Cancer Diagnosis

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Complex Case Management and Care Management Program

Specifically focused on:

- Special Coverage Conditions;
- Complex physical and mental health conditions,
- Prenatal and Postpartum Care,
- High Utilizers of Emergency Rooms,
- Chronic Conditions - Self Care

Candidates are identified through:

- 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.

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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.

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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.

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Pharmacy Coverage

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Pharmacy Coverage

Vital beneficiaries have access to drug coverage within the GHP Preferred Drug List (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=Farmacia#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.

- RX coverage is mandatorily generic, except if the generic bio-equivalent is not available. The insurer cannot refuse to cover a drug because the generic is not available.
- 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.

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Pharmacy pre- 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 Multi Health receives the minimum information required to evaluate the case.
- If the request does not include the minimum information required for review, MMM Multi Health must return the request within the first 24 hours of receipt. However, in the event of an emergency, MMM Multi Health must evaluate the request and for an emergency supply in the event of an emergency and may authorize a 72-hour supply.
- If the request requires additional information to complete its clinical criteria, it may go through the NMI (need more information) process which provides 72 hours in addition to the initial 24 hours for evaluation.

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Pharmacy Exception Process

- When a prescribed drug is not on the PDL, it is authorized for dispensing 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, the prescribing physician must evidence the following:
  - ✓ Patient has experienced serious adverse reactions to alternatives available at PDL; for drugs outside the NPDL the prescribing physician must evidence patient has experienced serious adverse reactions to alternatives available in PDL and NPDL;
  - ✓ Therapeutic failures to all alternatives in the PDL and/or NPDL, either because those alternatives were ineffective or could adversely affect the patient's Health or condition;
  - ✓ Other circumstances such as EPSDT and its policy.

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Pharmacy prior process for J codes

For a prior authorization for an Oncology and/or biological medications requested through the J codes benefit:

- Time parameters for providing a pre-authorization determination: All pre-authorization determinations will be processed within 24 hours if requested expedite or 72 hours if requested standard after MMM Multi Health receives the minimum information required to evaluate the case.
- If additional information is needed for J codes cases, will be requested by fax or telephone during the case processing time (expedite - 24hrs or standard - 72hrs).

The minimum information required for a J codes evaluation is:	
Prescription date	Patient's full name and address
	Treatment Date
	Hospital's name / infusion center:
	Diagnosis
	Stage
	Medical justification if the treatment does not comply with established regimen for a specific condition
	Laboratory or pathology results when necessary
	Previous treatments or medical history
	Current Treatment Plan (medications used in current prescription and other medications used but not included in the specific prescription)
	Patient Weight
	Patient Height
	Body Surface Area (BSA)
	Progress notes

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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

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Mental Health

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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.

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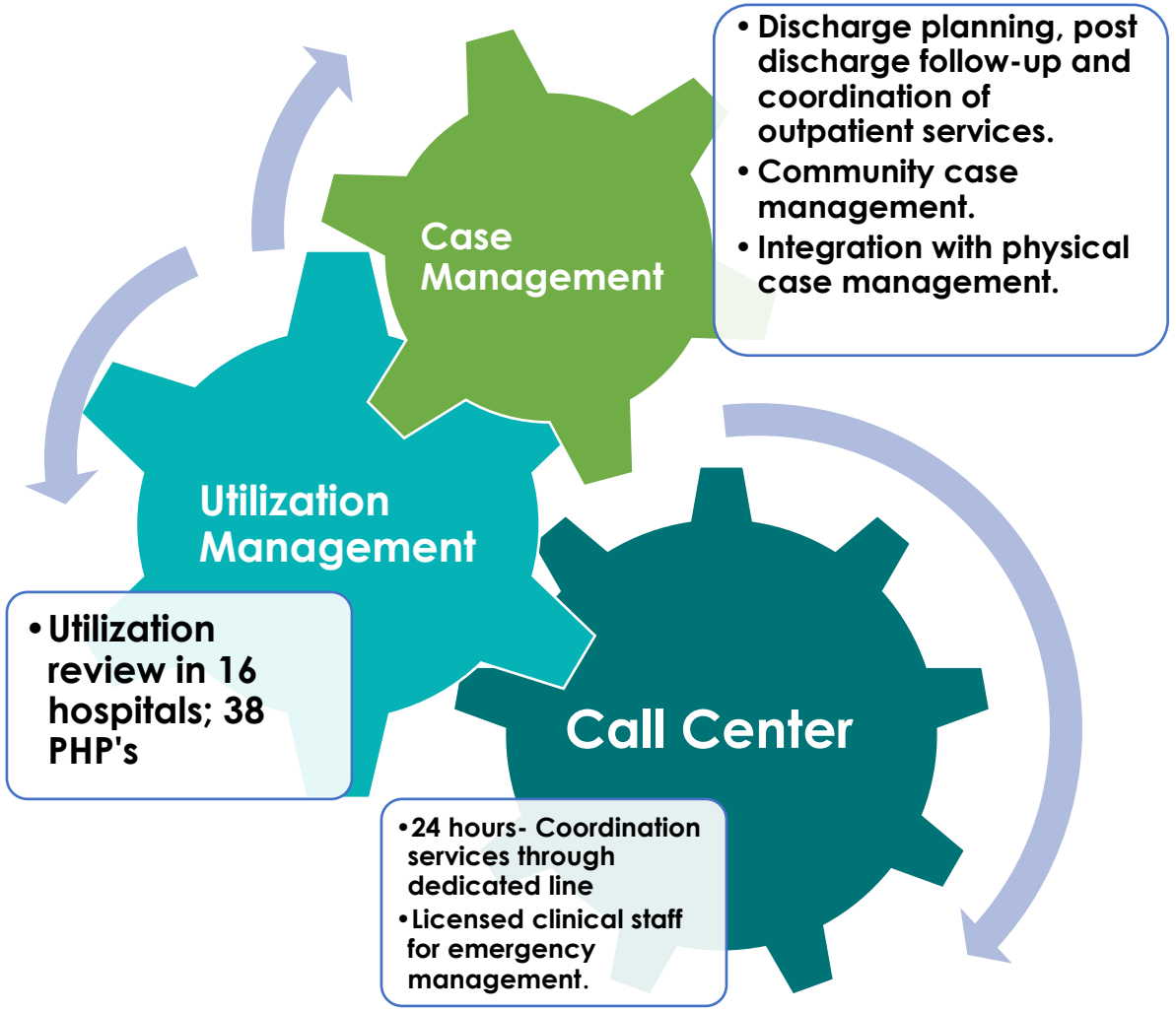
Integrated Mental Health Department: Operational Units



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Call Center- Mental Health

Hours: Monday through Friday,
7:00 a.m. - 7:00 p.m.
Phone: 1-844-337-3332

- 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.

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Call Center - Case Management Integrated Mental Health

24 hours
7 days per week.
1-844-337-3332

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

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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.

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Integrated Model of Care

Reverse Co-location

- 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.

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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.

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Coordination of Benefits

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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 shall pay according to coverage and established rules.
- If the primary plan is a from a Third Party, the secondary plan will pay for covered services not included in the primary's coverage. In case of a Medicare Dual Eligible, payment shall be treated as established in the regulation and according to established fees.
- By federal regulation, Vital Plan is the **payer of last resort** to any other plan or person in charge of paying for medical services.

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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.

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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 with final determinations guided by clinical guidelines and medical evidence.

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.

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Pre-Authorization Request

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

- Medical Order or 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)

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Information and delivery methods

- Supporting information

In order 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

Portal de Innova MD- Electrónicas

Faxes :

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

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Complaints, Grievances & Appeals

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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.

Timeframe:

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: 60 calendar days to file your appeal from the date you received the determination.

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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 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 30 calendar days if standard. If extension is required, an additional 14 days; it is sent to ASES for consideration.

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Grievances and Appeals - Contact Information

How to report a Complaint, Grievance or Appeal?

The beneficiary can go to one of our Service Offices.

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

MMM Appeals & Grievances Department

PO Box 72010

San Juan PR 00936-7710

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Quality Program

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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).

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General Provisions

To provide quality care to the 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 be in charge of monitoring the compliance of the health care offered.

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Provider's Network

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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.

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Who are considered Primary Care Physicians?

- General practitioners
- Family Physicians
- Pediatricians
- Gynecologists/ Obstetricians
- Internists

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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

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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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Thanks!

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