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REGULATORY TRAININGS 2024

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 are divided into 5 parts:

- ✓ Coordinated Care Model 2024
- ✓ Regulations Applicable to the Health Industry
- ✓ Medicare Compliance & Fraud, Loss, and Abuse
- ✓ Vital Plan Overview
- ✓ Vital Compliance and Integrity Program

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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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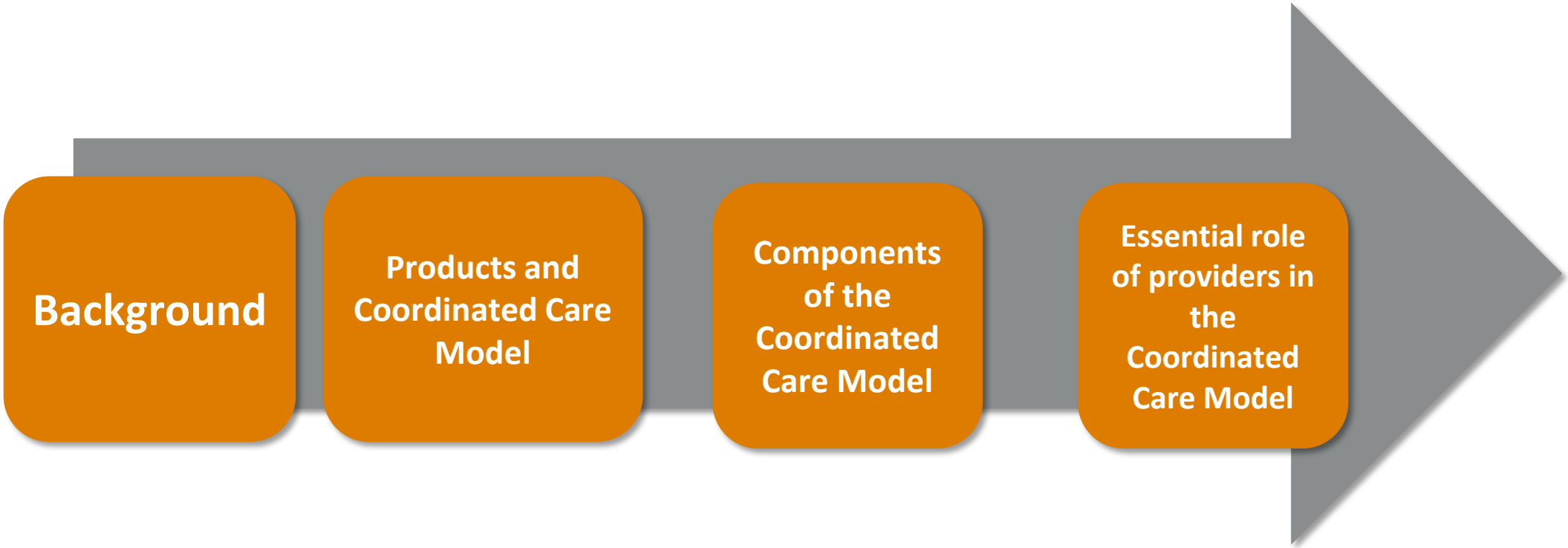
Coordinated Care Model 2024

Objectives



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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

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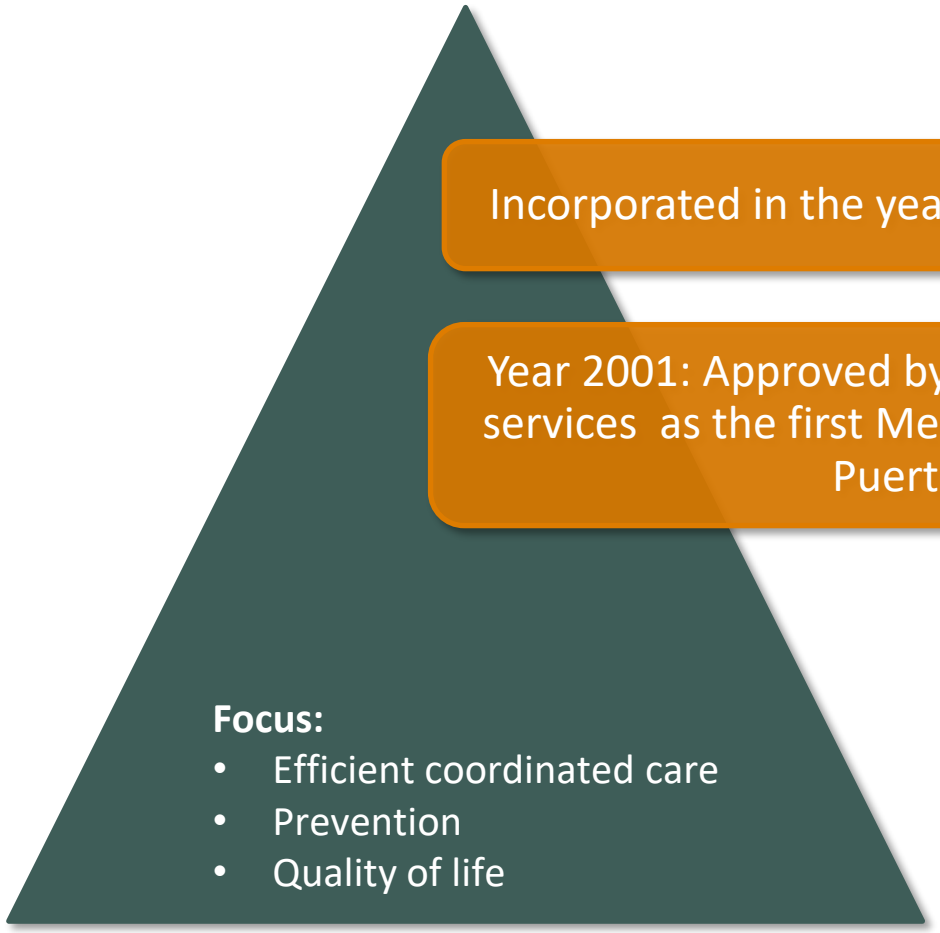
Background



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

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Background

4.5 Stars

We celebrate that one of our contracts has been rated 4.5 stars under the Medicare Star Rating Program **for seven consecutive years.**

*Contract H4004.
Every year Medicare evaluates the plans based on a 5-Star Rating System.

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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

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MMM
COVERAGE
2024

Special Needs Plans

C-SNP (Chronic Condition Special Needs Plan)	

MMM Supremo (HMO-SNP)	Members with chronic or disabling conditions:
	• Diabetes
	• Chronic heart failure (CHF)
	• Cardiovascular diseases:
	  ○ Cardiac Arrhythmias
	  ○ Peripheral Vascular Disease
	  ○ Coronary Artery Disease
	  ○ Chronic Venous Thromboembolic Disorder

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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 Valor Platino (HMO-SNP)	
MMM Dorado Platino (HMO-SNP)	
MMM Plus Platino (HMO-SNP)	
PMC Premier Platino (HMO-SNP)	

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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

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

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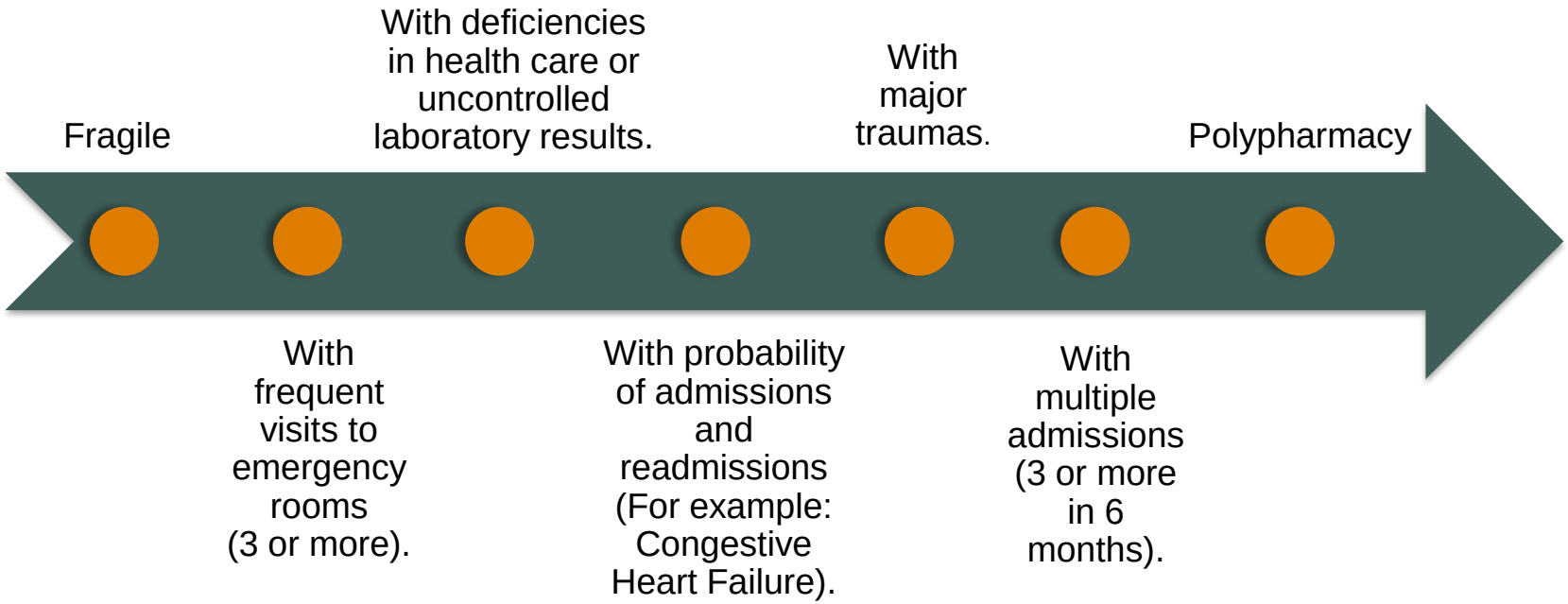
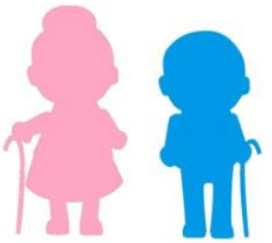
The Most Vulnerable

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

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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.

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Focus of the Program

Ensures that Members **identify** and qualify for the program, using established criteria.

Ensures that every member of the program has a **comprehensive evaluation** of needs.

Ensures that every member active in the program has an **individualized care plan** with interventions aimed at meeting the identified needs.

Ensures that the care services of the members are **coordinated**, and that they are given the **appropriate treatment** in an efficient way.

Provides **resources** of effective medical **benefits** while guaranteeing quality care.

Guarantees Members **access** to **resources** available in the **community**.

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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.

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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

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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.

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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.

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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.

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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 with 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.

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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.

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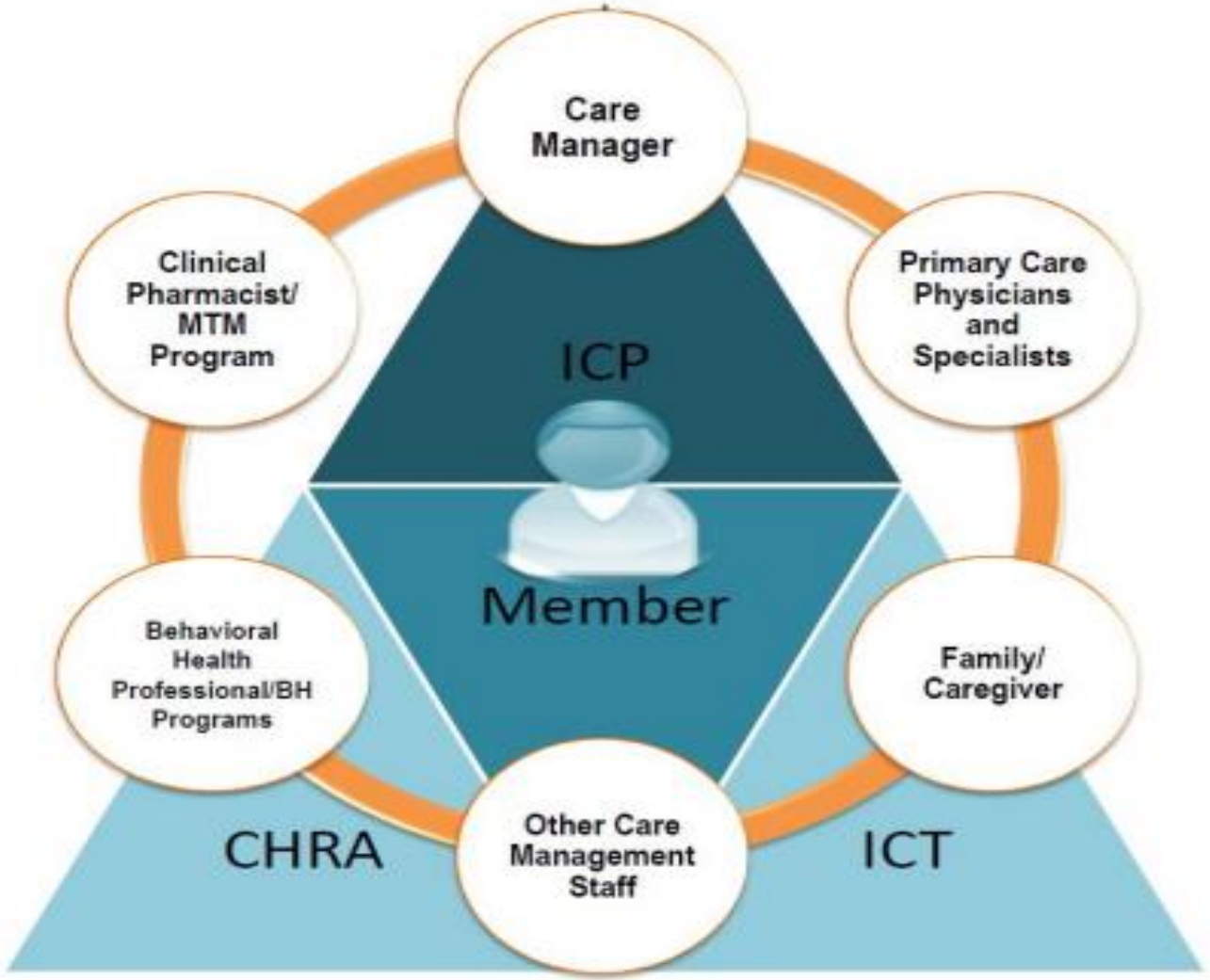
Protocols for Care Transition



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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.

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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.

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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.

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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.

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References

1. *Model of Care Scoring Guidelines for Contract Year 2024*. Obtain from: https://snpmoc.ncqa.org/static/media/MOCScrngGdlnsCY2024.98e746cc5222b535a5f4.pdf
2. *Medicare Managed Care Manual*. Chapter 5 - Quality Assessment, section 20.2 Additional Quality Improvement Program Requirements for Special Needs Plans (SNPs). Obtain from:

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

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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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Corporate Training of Regulations Applicable to the Health Industry

The following topics are included in the Corporate Training of Regulations Applicable to the Healthcare Industry:

1. Cultural Competence Plan
2. Previous Will for Medical Treatment in Case of Suffering a Terminal Health Condition or Persistent Vegetative State (Law 160 of November 17, 2001), better known as “Advance Directives”
3. Patients Rights and Responsibilities(Law 194 of August 25, 2000, as amended)
4. Prevention of Abuse, Preservation of Family Unity and for the Safety, Welfare and Protection of Minors Act" 57 Act (of 2023)
5. Gender Violence Act, 54 Act
6. Protocol for the prevention and identification of potential cases of financial exploitation of elderly or disabled adults

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Cultural Competence Plan

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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 well with different people.

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Cultural Competence 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 LGBTQIA 2 S+ population), and religion in order to recognize the values, respect, protect and preserve the dignity of each individual.

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, health Providers, about cultural and religious differences.

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Cultural Competence Plan Components

- **Analysis of Data:**
  - Periodically conduct an assessment of our population in underserved areas.
  - Carry out regular analysis of claims and meetings to identify health needs.
  - As part of the process of registration to identify specific needs in terms of race, religion, ethnic origin and language.

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Cultural Competence Plan Components

Language or Interpreter Services:

- Providers help identify beneficiaries with possible linguistic barriers.
- In coordination with the Beneficiary Services Department, they 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 material must be understanding by a person(children) with a 4thgrade of scholarship/ education.

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Cultural Competence Plan Components

Religious beliefs:

- Ensure that all Employees respect the Beneficiaries according to their religious beliefs.
- Providers must comply with 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 Law 22 2013 first legislation against discrimination based on sexual orientation.
- The Provider is responsible for training its 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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Cultural Competence Plan Components

Survey on the Cultural Competence Plan:

- To create awareness and increase the beliefs, values and attitudes that promote understanding of cultural, religious, sexual preferences, and language differences and identify areas of need for training
- This self assessment is in line with or similar to the self assessment of the National Center for Cultural Competence

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Vieques and Culebra Beneficiaries

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Vieques and Culebra Beneficiaries

- A policy is established to require the providers to give priority to the Beneficiaries resident 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
(Law 160 of Novemeber17, 2001)

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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 Law

- Recognizes the right of every elderly person, in complete use of his/her mental faculties, declare previously his/her will be related to medical treatment in case of suffering a terminal health condition and/or vegetative persistent state.
- The declarant can name a representative or leader in case any event prevents him/her from making a decision and in case he/she has not decided about a medical situation in the declaration of will he/she can decide according to his/her values and ideas.

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Advance Directives Law

- 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 relapses on the declarant.
- The advanced directive must be signed in front of a Public Notary and two witnesses that are 21 years or older.
- The Enrollee can also sign the advanced directive in presence of a physician and two witnesses who are 21 years or older.
- The Enrollee can modify the advance directives document, in part or totally in 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 her pregnancy finishes.
- 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 Responsabilities
(Law 194 of August 25, 2000, as amended)

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What does the law establish ?

Law 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 (about coordinated care, facilities, health professionals, services and service access.
- Receive healthcare services of the highest quality.
- Be treated with respect, equality and consideration before 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 Responsabilities

- Must be informed about your coverage, its' limits and exclusions.
- Inform your doctor about:
  - Changes in your health
  - Information that has not been understood
  - Reasons of why you cannot comply with the recommended treatment
- Provide your Doctor all your health information.
- Follow the treatments recommended by your doctors.
- Maintain a healthy lifestyle.

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Patient Responsibilities

- 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 will 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 (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

MSO HOLDINGS

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

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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 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.

MSO HOLDINGS

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.
- For the law, child abuse means 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.

MSO HOLDINGS

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, with considerable specificity, 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, the present law details with considerable specificity 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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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
- To 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 Contact 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

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Domestic Abuse Prevention and Intervention Act" Act No. 54 of August 15, 1989, as amended

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What does the law establish?

- To 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;
- To 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 include 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
- Toll free: 1-877-722-2977
  Fax: 787-721-7711
  TTY: 787-725-5921
- **Email:**
  intercesoraslegales@mujer.pr.gov.

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Prevention and Safety Program for Victims of Gender Violence Act. Act No. 3 of January 18, 2022

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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.

MSO HOLDINGS

What does the law establish?

- To 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.
- This Act 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.

MSO HOLDINGS

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

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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.

MSO HOLDINGS

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

MSO HOLDINGS

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

MSO HOLDINGS

Factors that increase the risk of Exploitation

- Isolation
- Loneliness
- Family members with drug, alcohol, or gambling problems
- Cognitive and physical changes that make the elderly person or disabled adult dependent on others
- Lack of skills when it comes to managing financial or technological issues
- Death of spouse or adult children who managed or helped manage finances

MSO HOLDINGS

How to avoid Financial Exploitation?

Information that our Enrollees should know:

- Carefully pick and choose the person with whom you will share your financial information
- Protect your checkbook, credit cards, savings, financial statements, and any other sensitive document: keep them in a safe place
- Do not give out your Social Security number or your 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, in order to require any financial institution, cooperatives or insurance 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.

MSO HOLDINGS

Contacts

Every provider or FDRs has the responsibility to refer any potential financial exploitation situation to:

Medicaid Compliance Department
Liza Rivera-Ortiz, Compliance Officer
Medicaid
MMM Holdings, LLC
P.O. Box 71114
San Juan, PR 00936-8014
Mobile: 787-918-7332
E-mail: liza.rivera@mmmhc.com

Online, via the Ethics Point webpage:
www.psg.ethicspoint.com
Ethics Point hotline: 1-844-256-3953
Refer by e-mail: VitalSIU@mmmhc.com

Medicare Advantage Compliance Department
Myra Plumey, Chief Compliance Officer
MMM Holdings, LLC
P.O. Box P.O. Box 71114
San Juan, PR 00936-8014
Phone: 787-622-3000, Ext. 2061
Mobile: 787-379-3327
E-mail: myra.plumey@mmmhc.com

Online, via the Ethics Point webpage:
www.mmmpr.ethicspoint.com
Ethics Point hotline: 1-877-307-1211
Refer by e-mail: SIU@mmmhc.com

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Compliance & Fraud Waste and Abuse Training 2024

Introduction

This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance 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)
- Section 50.3 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)
- The "Downloads" section of the CMS Compliance Program Policy and Guidance webpage

Completing this training in and of itself does not ensure a Sponsor has an "effective Compliance Program." Sponsors and their FDRs are responsible for establishing and executing an effective compliance program according to the CMS regulations and program guidelines.

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Why Do I Need Training?

Every year, **billions** of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – **including you**.

This training helps you detect, correct, and prevent FWA. **You** are part of the solution. Compliance is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

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Training Requirements:

Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

Certain training requirements apply to people involved in Medicare Parts C and D administration. All employees of Medicare Advantage Organizations (MAOs) and Medicare Drug Plans (Part D) (collectively referred to in this course as “Sponsors”) must receive training about compliance with CMS program rules.

You may need to complete FWA training within 90 days of your initial hire. More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website. Please contact your management team for more information.

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Learn more about Medicare Part C

MA plans must cover all services Medicare covers (with the exception of hospice care). They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

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Learn more about Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to beneficiaries enrolled in Part A and/or Part B who enroll in a Part D or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to individuals living in a plan's service area.

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Compliance Program Requirement

The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans. An effective compliance program must:

- Articulate and demonstrate an organization's commitment to legal and ethical conduct
- Provide guidance on how to handle compliance questions and concerns
- Provide guidance on how to identify and report compliance violations

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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 non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

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Seven Core Compliance Program Requirements

CMS requires an effective compliance program to include seven core 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.

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Seven Core Compliance Program Requirements

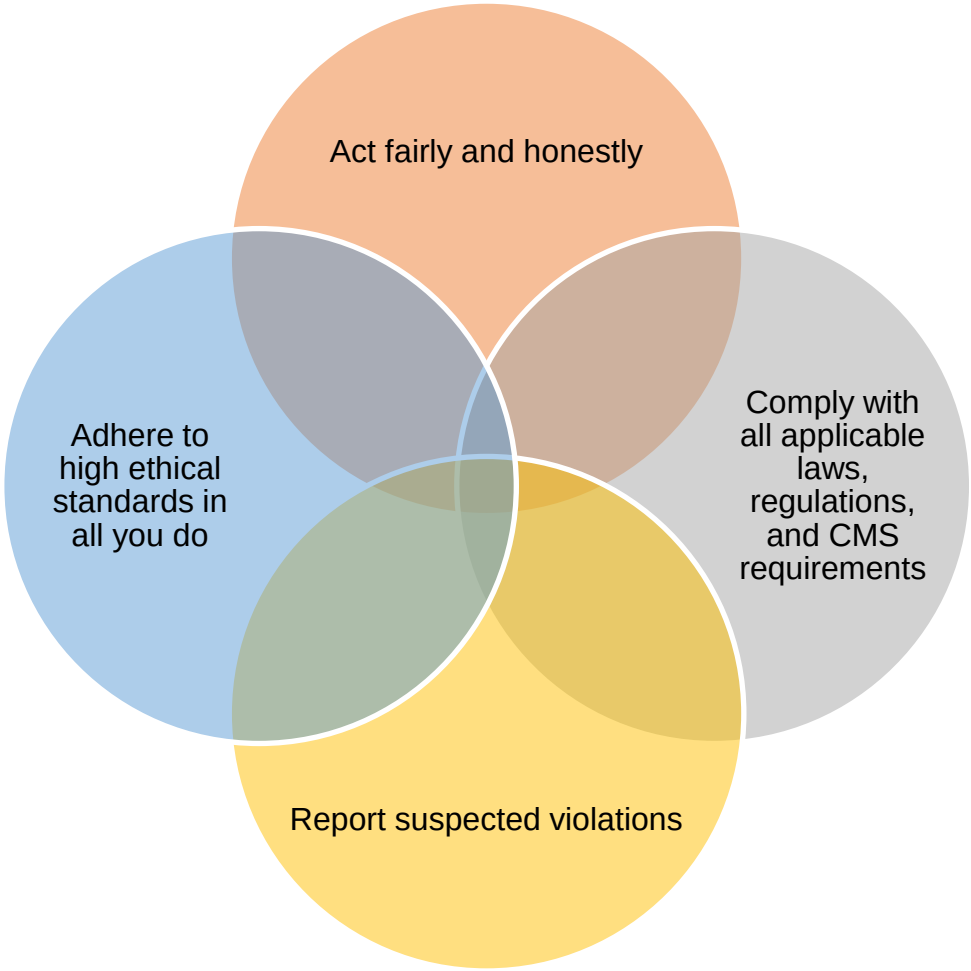
5. **Well-Publicized Disciplinary Standards:** Sponsor must enforce standards through well-publicized disciplinary guidelines.

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 CMS 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 Parts C and D program comply with Medicare Program 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.

Ethics: Do the Right Thing!

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



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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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What is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal health program requirements, or an organization's ethical and business policies. CMS identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation
- Appeals and grievances 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.”

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Know the Consequences of Non-Compliance

Failure to follow Medicare Program 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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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

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How to Report Potential Non-Compliance

Employees of a Sponsor

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How to Report Potential Non-Compliance

First-Tier, Downstream, or Related Entity (FDR) Employees

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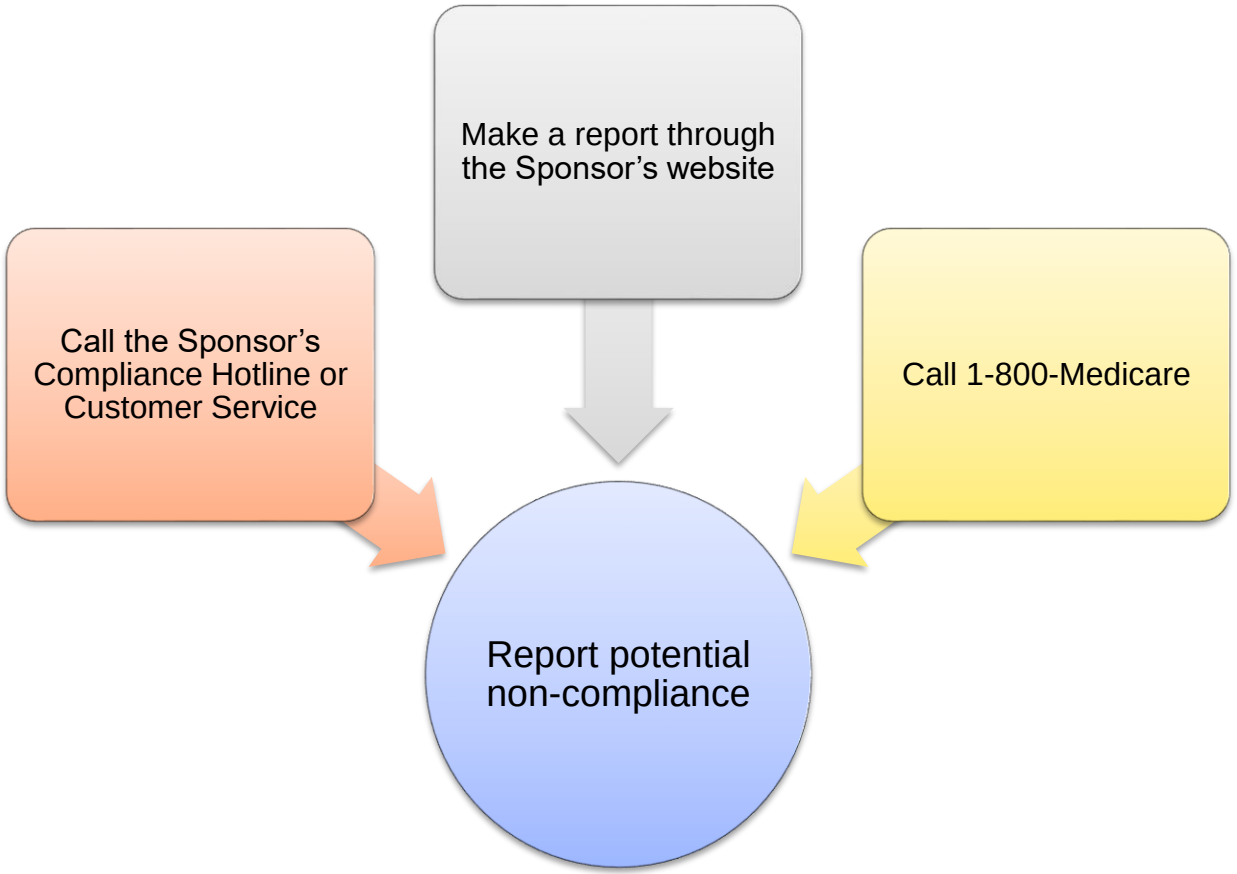
How to Report Potential Non-Compliance

Beneficiaries



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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

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 CMS requirements
- ✓ Efficient and effective internal controls
- ✓ Protected enrollees

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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.

MSO HOLDINGS

Compliance is Everyone's Responsibility!

Prevent	Operate within your organization's ethical expectations to prevent non-compliance!
Detect & Report	Report detected potential non-compliance!
Correct	Correct non-compliance to protect beneficiaries and save money!

MSO HOLDINGS

Combating Medicare Parts C & D Fraud Waste & Abuse

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Introduction

This training helps Medicare Parts C and D plan Sponsors' employees, governing body members, 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.

MSO HOLDINGS

Why Do I Need Training?

Every year, **billions** of dollars are improperly spent because of FWA. It affects everyone **including you**.

This training helps you detect, correct, and prevent FWA. **You** are part of the solution.

Combating FWA is **everyone's** responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund

MSO HOLDINGS

Training Requirements:

Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

Certain training requirements apply to people involved in Medicare Parts C and D administration. All employees of Medicare Advantage Organizations (MAOs) and Medicare Drug Plans (Part D) (collectively referred to in this course as “Sponsors”) employees must get training about to prevent, detect and correct FWA.

FWA training must occur within 90 days of initial hire and at least annually thereafter.

MSO HOLDINGS

Learn more about Medicare Part C

Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to beneficiaries who enroll in an MA plan.

MA plans must cover all services Medicare covers (with the exception of hospice care). They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

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Learn more about Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to beneficiaries enrolled in Part A and/or Part B who enroll in a Part D or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to individuals living in a plan's service area.

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Objectives

After completing this training, you should be able to:

- ✓ Recognize FWA in the Medicare Program
- ✓ 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

MSO HOLDINGS

What is FWA? - Fraud

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.

MSO HOLDINGS

What is FWA? - Waste & Abuse

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program 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 to the Medicare Program. Abuse involves paying for items or services when there is not legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

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

MSO HOLDINGS

Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

- 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.

Examples of actions that may constitute Medicare **abuse** include:

- 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

MSO HOLDINGS

Examples of FWA

Examples of actions that may constitute Medicare **waste** include:

- 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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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 the knowledge that the actions are wrong. Waste and abuse may involve getting an improper payment or creating an unnecessary cost to the Medicare Program, but do not require the same intent and knowledge.

MSO HOLDINGS

Understanding FWA

To detect FWA, you need to know the **law.**

The following pages provide high-level information about the following laws:

1. Federal Civil False Claims Act (FCA)
2. Criminal Health Care Fraud Statute
3. Anti-Kickback Statute (AKS)
4. Physician Self-Referral Law (Stark Statute)
5. Civil Monetary Penalties Law (CMPL)
6. Exclusion Statute
7. Health Insurance Portability and Accountability Act (HIPAA)

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

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Federal Civil False Claims Act (FCA)

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

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents 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.

MSO HOLDINGS

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.

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

MSO HOLDINGS

Examples

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.

MSO HOLDINGS

Criminal Health Care Fraud

- ✓ 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.

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.

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Examples

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
- Provided no DME to any beneficiaries 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

MSO HOLDINGS

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.

MSO HOLDINGS

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.

EXAMPLE

A physician operating a pain management practice:

✓ Conspired to solicit and receive 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 must pay more than $750,000 restitution and is awaiting sentencing

MSO HOLDINGS

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

MSO HOLDINGS

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.

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.

MSO HOLDINGS

Civil Monetary Penalties (CMP) 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.

MSO HOLDINGS

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.

Examples

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

MSO HOLDINGS

Exclusion

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.

MSO HOLDINGS

EXAMPLE

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the unconvicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction

MSO HOLDINGS

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.

Damages and Penalties

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

EXAMPLE

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

MSO HOLDINGS

Lesson Summary

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is **intent** and **knowledge**. Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment for which no entitlement would otherwise exist. Waste and abuse may involve getting an improper payment but not the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties
- Civil prosecution
- Criminal conviction, fines, or both
- Exclusion from all Federal health care program participation
- Imprisonment
- Loss of professional license

MSO HOLDINGS

Where Do I Fit In?

As someone who provides health or administrative services to a Medicare Part C or Part D enrollee, you are likely an employee of a:

- **Sponsor** (Examples: Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- **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®)

MSO HOLDINGS

I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.

- The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. Medicare Part C Plan Sponsor first-tier and related entities may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

- Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

MSO HOLDINGS

I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.

- The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flowchart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

- Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

MSO HOLDINGS

What Are Your Responsibilities?

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

FIRST	You must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
SECOND	You have a duty to the Medicare Program 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 articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

MSO HOLDINGS

How Do You Prevent FWA?

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

MSO HOLDINGS

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 policies and procedures that address FWA. 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 in an ethical manner
- 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 the bottom.

MSO HOLDINGS

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 cannot 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.

MSO HOLDINGS

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.

MSO HOLDINGS

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
- The suspect's history of compliance, education, training, and communication with your organization or other entities

MSO HOLDINGS

Where to report FWA

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)

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: Help Fight Medicare Fraud

MSO HOLDINGS

Corrective actions

- Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS 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 specific circumstances. In general:
    - Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance.
    - Tailor the corrective action to address the particular FWA problem or deficiency identified. 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 failure to satisfactorily complete the corrective action.
    - Monitor corrective actions continuously to ensure effectiveness.

MSO HOLDINGS

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, such as suspension of marketing, enrollment, or payment
- Terminating an employee or provider

MSO HOLDINGS

Indicators of Potential FWA

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 page 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 benefits to enrollees.

MSO HOLDINGS

Key Indicators: Potential Beneficiary Issues

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

MSO HOLDINGS

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 for the member?
- 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 on it?
- Is the provider's diagnosis for the member supported in the medical record?

MSO HOLDINGS

Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the 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 the information they provide being used for purposes other than for determining patient eligibility?

MSO HOLDINGS

Key Indicators:

Potential Wholesaler Issues

- 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?

Potential Manufacturer Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer knowingly provide samples to entities that bill Federal health care programs for them?

Potential Sponsor Issues

- Does the Sponsor encourage or support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe that the cost of benefits is one price, when the actual cost is higher?
- Does the Sponsor offer beneficiaries cash inducements to join the plan?
- Does the Sponsor use unlicensed agents?

MSO HOLDINGS

Lesson Summary

As a person providing health or administrative services to a Medicare Parts C or D enrollee, you play an important part in preventing fraud, waste, and abuse (FWA). Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.

Report a potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.

Promptly correct identified FWA with an effective corrective action plan.

MSO HOLDINGS

Report a potential FWA

Report ethical, compliance, fraud, waste, and abuse violations in a confidential manner by accessing: www.mmmpr.ethicspoint.com Or, calling

MSO HOLDINGS

Vital Plan Overview

Rev. December 2023

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.

ASES

Act No. 113 of June 2, 1976, as amended, known as the "Health Services Organizations Act", incorporated into the Insurance Code of Puerto Rico (Art. 19.020 et seq.) establishes that the Health Insurance Administration of Puerto Rico (ASES) is responsible for implementing, administering and negotiating through contracts with Insurers or Health Service Organizations, a health insurance system that will ultimately provide all residents of the Island with access to quality hospital medical care, regardless of the economic condition and the ability to pay of those who require it.

Call Center
Tel.: 787-474-3300 / 1-800-981-2737

For additional information: https://www.asespr.org/

Vital Plan

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

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

MMM Multi-Health

First Medical Health Plan

Plan de Salud Menonita

Triples S

Foster Care Children and Domestic Violence Population

Foster Care Children and Domestic Violence Population

- Commonly known as the Virtual Region.
- Since January 2023, MMM Multihealth has been in charge of the management and needs of this population.

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

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

Foster Care Children and Domestic Violence Population

- MMM MH will have dedicated staff to attend these population.

- The person in charge of coordinating appointments, communication and other matters with government agencies is Ms. Myriam Rivera Molina, Director of Social Work; she can be contacted through her e-mail: Myriam.Rivera-Molina@mso-pr.com

- Member Services Department will have dedicated two resources to serve as a liaison with the Social Worker Department.

Important: Any employee are not authorized to provide information regarding these population.

Virtual population has the following characteristics:

- 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 (Family, Domestic Violence

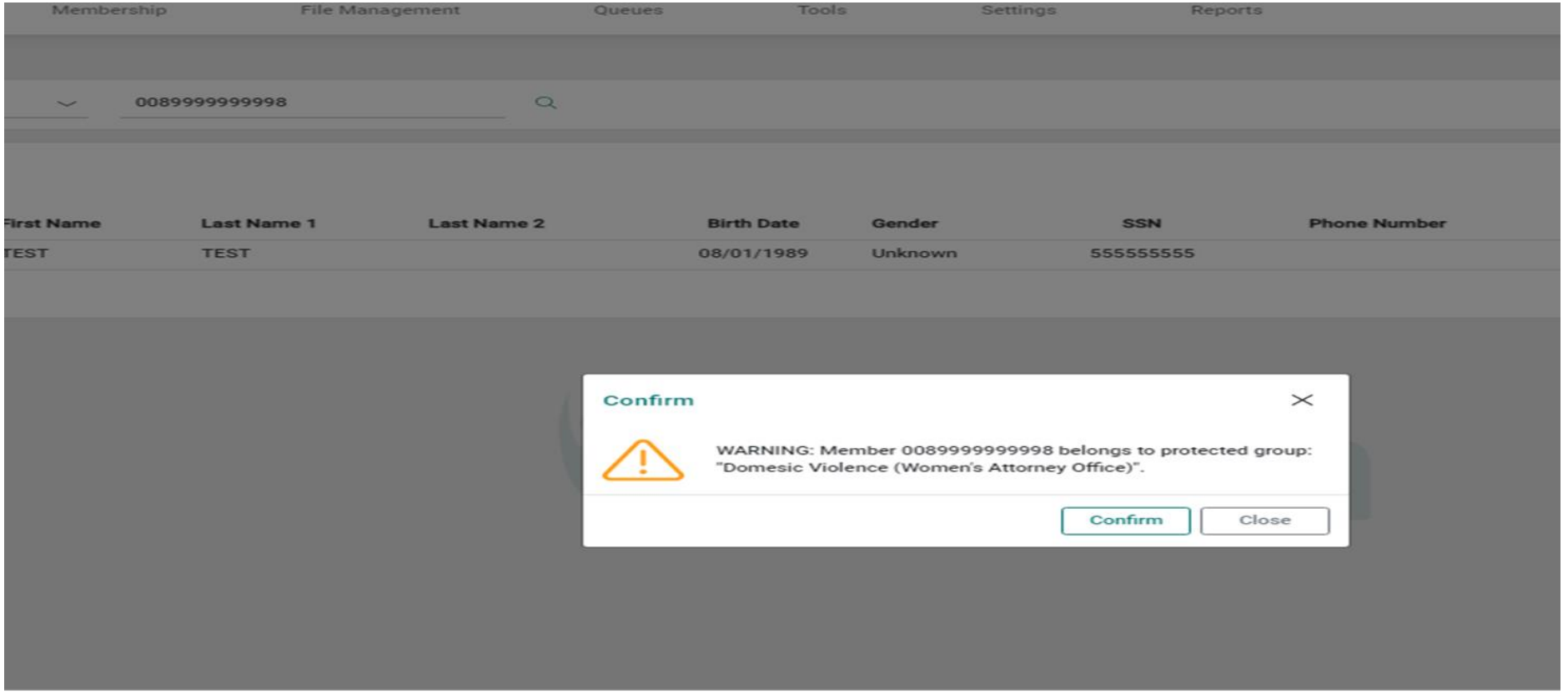
Information only be provided to authorized employees regarding these population

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

Confidentiality

See example of the message that will appear in the system.



Social Determinants of Health (SDH)

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.

Social Determinants of Health:

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.

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.

Interoperability Rule

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), in order to help them be the center of their own health care decisions, thus minimizing the risk of duplicating tests and other inefficiencies.

This access to health information exchange (interoperability) helps to guarantee that providers are allowed to see an individual's medical history 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.

Second Opinion

Second Opinion

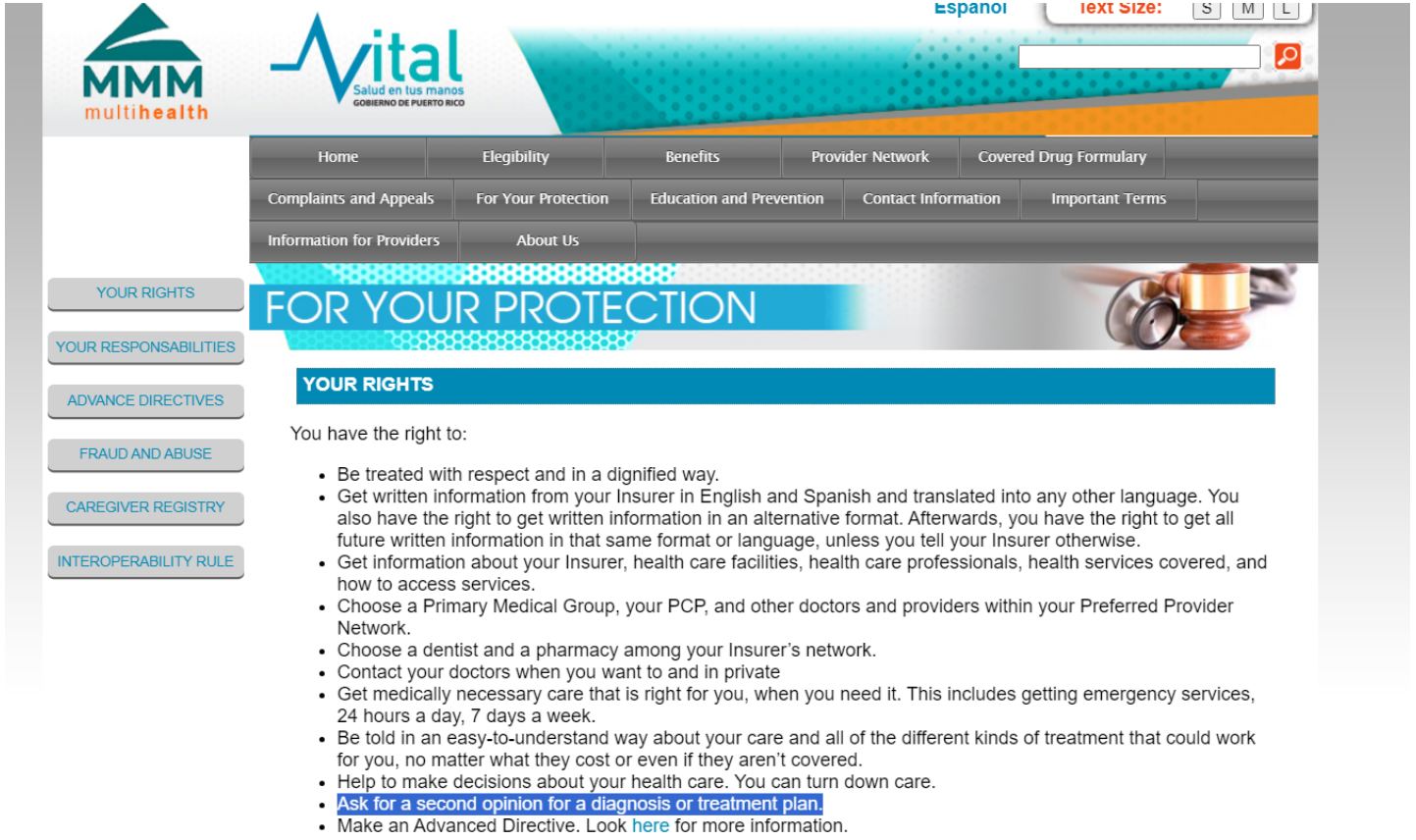
All beneficiaries under Vital Plan coverage have the right to request a medical second opinion;

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

Second Opinion

MMM MH has this information at

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



Medicaid Compliance Department

Vision

The Health Insurance Administration (ASES), as well as the Centers for Medicare and Medicaid Services ("CMS"), require training during the first ninety (90) days from the start of employment and then annual training on the Compliance, Integrity (Fraud, Waste and Abuse "FWA"), Corporate Code of Conduct, Privacy and Security programs for organizations and entities that provide and/or administer health care services.

MMM MH Vital is committed to ethics, corporate compliance and all laws, regulations and guidelines governing Medicaid Program requirements.

Compliance Officer–Medicaid
Liza Rivera Ortiz

Roles and Responsibilities of the Compliance Officer:
Be aware of regulatory changes and/or contractual amendments and inform all operational areas;
Maintain continuous and effective communication with regulatory entities;
Evaluate performance of operations and require corrective and disciplinary actions if necessary;
Keep MMM MH Vital senior management informed of all regulatory issues and requirements;
Identify, correct and follow up on aspects that may represent a level of corporate risk, which have been identified internally or externally;
Provide an "open door" environment for easy access by employees where they can refer and address regulatory issues without fear of retaliation.
Support all compliance efforts established throughout the company.

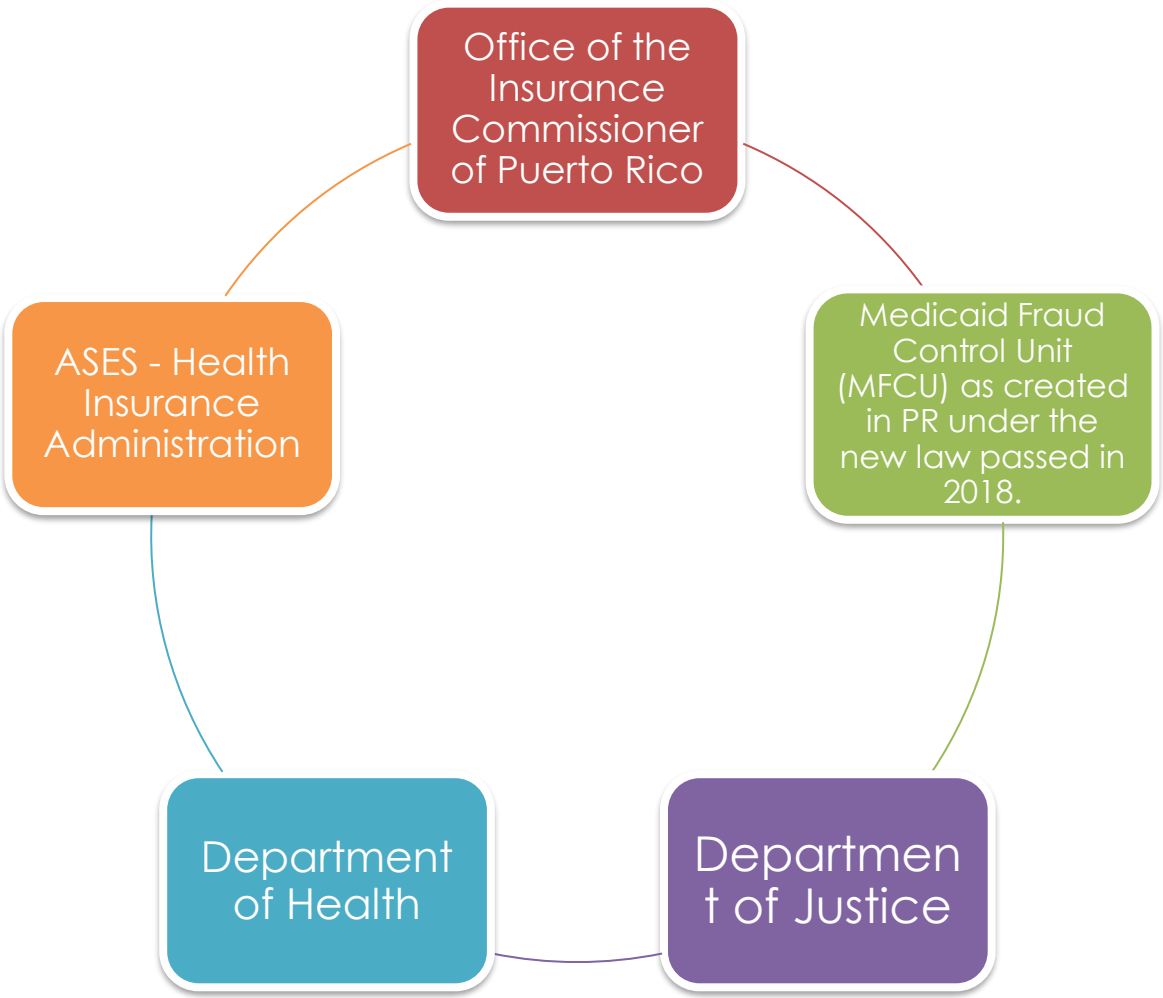
¿What is my responsibility as an Individual, Employee, Contractor or Subcontractor of MMM MH Vital?

Comply with all ASES and Medicaid requirements, statutes and regulations, corporate policies and procedures, and the corporate Code of Ethics and Conduct

Report any violations regarding unethical behavior, suspected fraud, waste, abuse, privacy or security to management and/or the Medicaid Compliance Officer

Comply with all operational, regulatory and compliance training that is part of PSG's Compliance and Integrity programs

Regulatory Agencies attentive to the FWA



How to report any situation of non-compliance if you are a beneficiary, provider, or FDRs?

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

Every employee has the responsibility to report Misconduct and Ethics Concerns;

Suspected or observed misconduct, including violations of the code, company policies and procedures, laws and regulations, or other ethical concerns, should be reported to Ethics Departments.
There are various channels to submit reports or ask questions;

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

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

Contact Information:

Compliance Department- Vital

Shahayra Aguilú Benítez

Compliance Manager- Medicaid

Cel.787-402-9737

Email: shahayra.aguilu@mmmhc.com

Liza Rivera-Ortiz

Compliance Officer- Medicaid

MMM Holdings, LLC

P.O. Box 71114

San Juan, PR 00936-8014

Cel. 787-918-7332

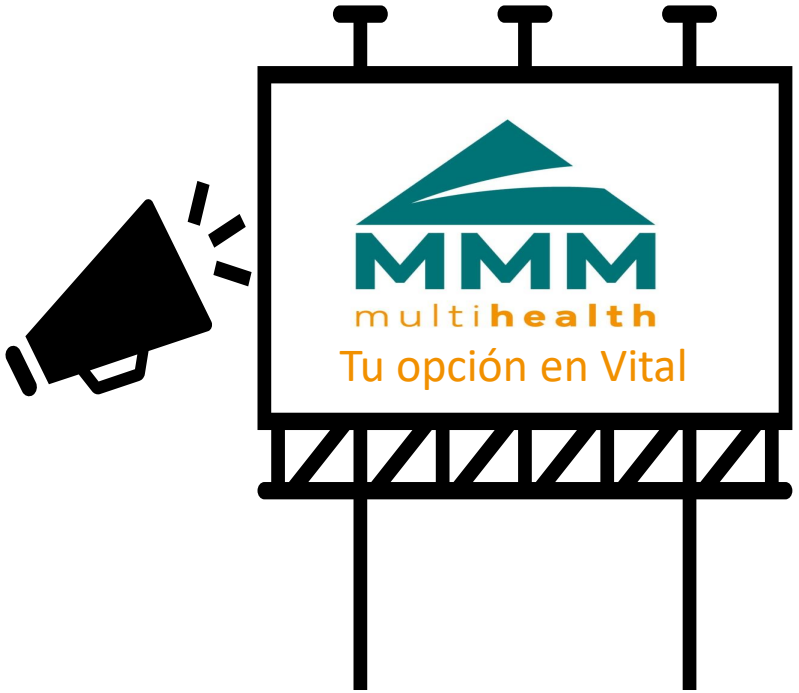
Email: liza.rivera@mmmhc.com

Marketing Materials

Marketing Material

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

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



Allowed Material/ Activities

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

Prohibited Material/ 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.

Marketing Material Approved Process

Marketing sends the Material

→

Compliance Department evaluates the material

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

→

ASES

- Evaluates the material, if it complies with the established requirements it is approved.
- Receives Approval Number 15 days are allowed to respond

↓

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

Forwards to Marketing to include approval #.

→

Marketing sends it back to Compliance with approval number.

→

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

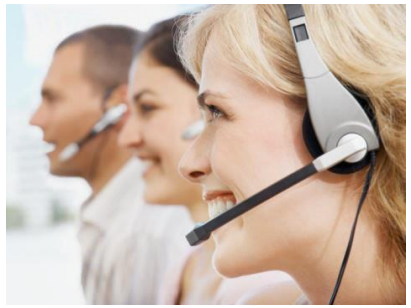
This description is only a summary and is not intended to be an exhaustive and detailed explanation of the process.*

Operations Vital Plan
MMM Multi Health

Vital Plan Service Lines

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

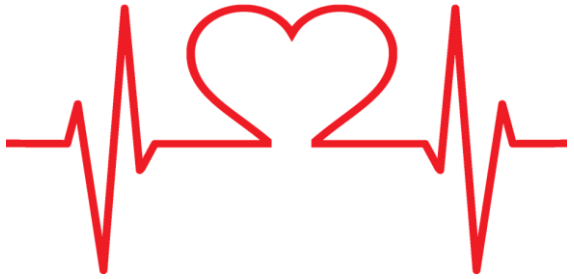
787-999-4411 TTY



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

Medical consultation line
Making Contact

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



24 hours/ 7 days a week

Customer Service Research Unit

- First link between the beneficiary and all MMM MH units.
- Coordination of appointments with specialists.
- Coordination of Medicaid Program recertification appointments.
- Satisfaction Surveys
- Support in membership retention strategies.
- Resolution of cases from the MMM MH's website, social networks and press.
- Exclusive service for cases received from ASES and Fortaleza.
- Management of the request for member's materials (Provider Directory, Member Manual, Letters, EOB, ID Cards).
- Customer Service

¡Contact us! PSG-Research-Team@mmmhc.com

Main Office of MMM Multi Health

Hato Rey

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

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

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

Service Offices (Atlantic)

Carolina

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.

Humacao

Boulevard Plaza Office Center

- Boulevard Del Río, Ramal 3
- Monday to Friday form 8:00 a.m. to 5:00 p.m.

Vieques

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.

Fajardo

- Street #3 km. 44.1 Local #2 Bo. Quebrada
- Monday to Friday from 8:00 a.m. to 5:00 p.m.

Manatí

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.

Service Offices (Caribbean)

Guayama

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.

Ponce

Street #2 Ponce by Pass
San Jorge Mall Building
- Monday to Friday from 8:00 a.m. to 5:00 p.m.

Orocovis

Borinquen Building
Street 155 km 15.3 Bo. Gato
- Monday to Firiday from 8:00 a.m. to 5:00 p.m.

Coamo

Ruiz Belvis street #24
- Monday to Friday from 8:00 a.m. to 5:00 p.m.

Mayagüez

Complejo Office Park III
Street # 2, KM 157
- Monday to Friday from 8:00 a.m. to 5:00 p.m.

Aguadilla

Plaza Victoria Shopping Center Street #2, KM 129.5
- Monday to Friday from 8:00 a.m. to 5:00 p.m.

Services available at regional and satellite offices

Materials Available 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.

- **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.

Eligibility

Eligibility

- Persons eligible under Law 72 of September 7, 1993:
- U.S. Citizens
- People with low or no income
- Federal Medicaid Population
- State Medicaid Population
- Children under the Children's Health Insurance Program (CHIP)
- Public employees, retirees and their dependents
- Puerto Rico police, their widows, widowers and surviving children
- Veterans
- Children in State Custody – Virtual Region
- Survivors of Domestic Violence - Virtual Region

Registration Process

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

Open Enrollment Period (OEP)

- The Open Enrollment Period (OEP) will be from January 1st through February 14, 2024.
- 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 Centers Number
Tel.: 787-474-3300 / 1-800-981-2737

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.

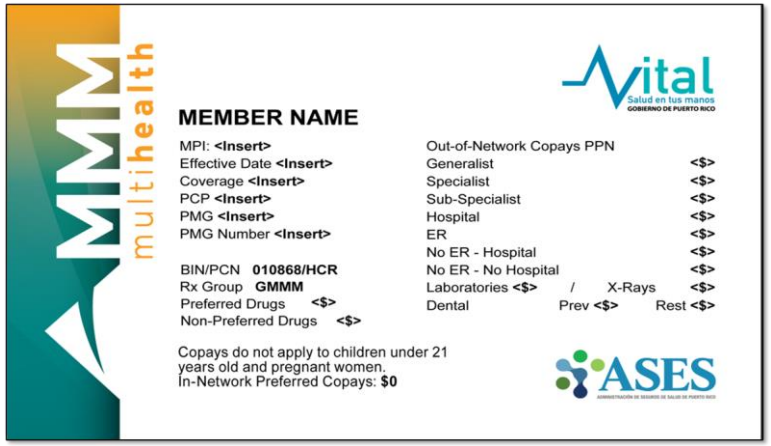
Vital's Card

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

Beneficiary's Card

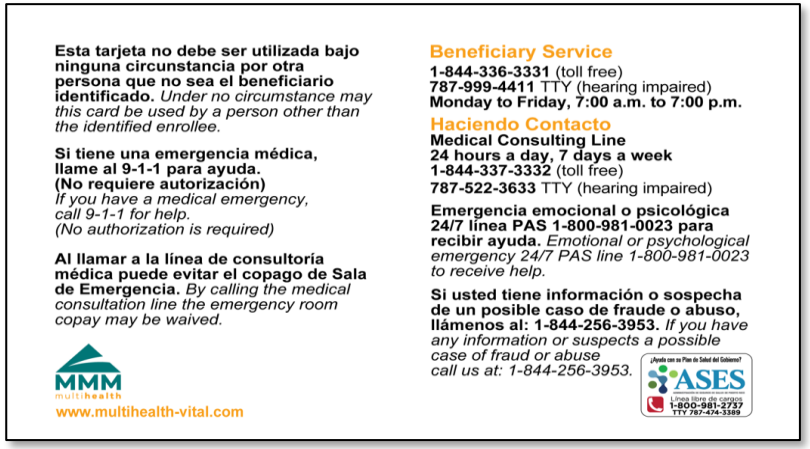
Front

- First and last name;
- Contract number;
- PCP and PMG
- Coverage;
- Co-payments and co-insurance



Back:

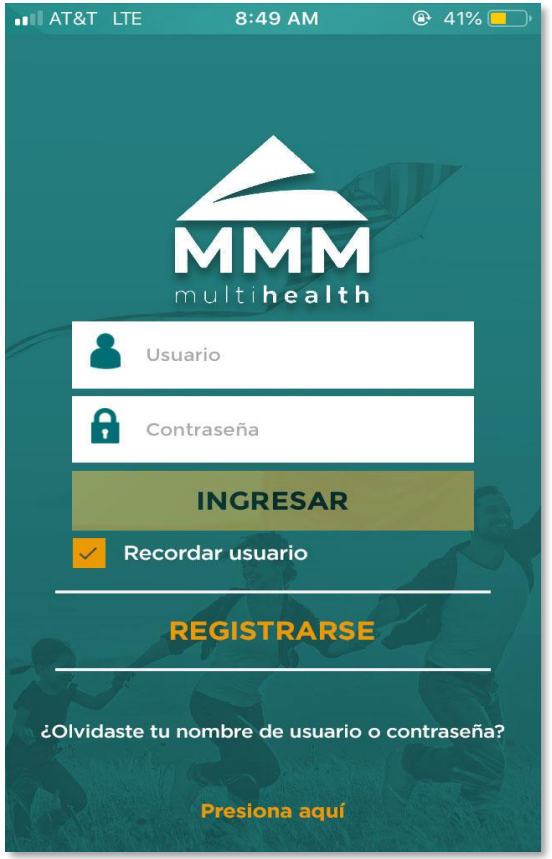
- Avoid fraudulent use of the card
- Health emergency
- Customer Service Number
- Haciendo Contacto Line (medical advice)
- PAS Line - emotional emergency



MMM multihealth

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.

MMM multihealth

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

Jeanette Fernández

Administrative Assistant

Tel (787) 622-3000 | Ext. 52542

Email: jeanette.fernandez@mmmhc.com

Héctor M Jové

Manager

Tel (787) 622-3000 | Ext. 53614

Cel. 787-918-5693

Email: hector.jovecalderon@mmmhc.com

Solange de Lahongrais

COO of Medicaid

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

Email: Solange.delahongrais@mmmhc.com

Transitional Period

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 Enrollee's medical records, as appropriate;
- Comply with any other necessary procedures specified by CMS or ASES to ensure continued access to services to prevent serious detriment to the beneficiary's health or reduce the risk of hospitalization or institutionalization.

Clinical Programs

Special Coverage

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

Special Coverage Conditions

- 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

Complex Case Management and Care Management Program

- 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.

Complex Case Management and Care Management Program

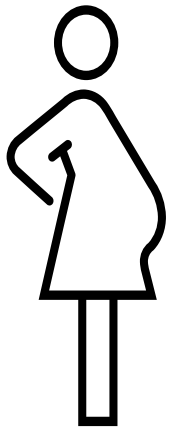
Specifically focused on:

- 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

Prenatal Program



Program to support women during their prenatal and postpartum period.

The Program is focused on:

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

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

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

¿What is EPSDT?

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

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

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

Pharmacy Coverage

Pharmacy Coverage

Vital beneficiaries have access to drug coverage 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.asespr.org/proveedores-2/farmacia/formularios-de-medicamentos/
  https://www.multihealth-vital.com/eng/formulary.html

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

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

Pharmacy Coverage

- 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.

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.

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 circumstance such as EPSDT and its policy.

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

MMM multihealth

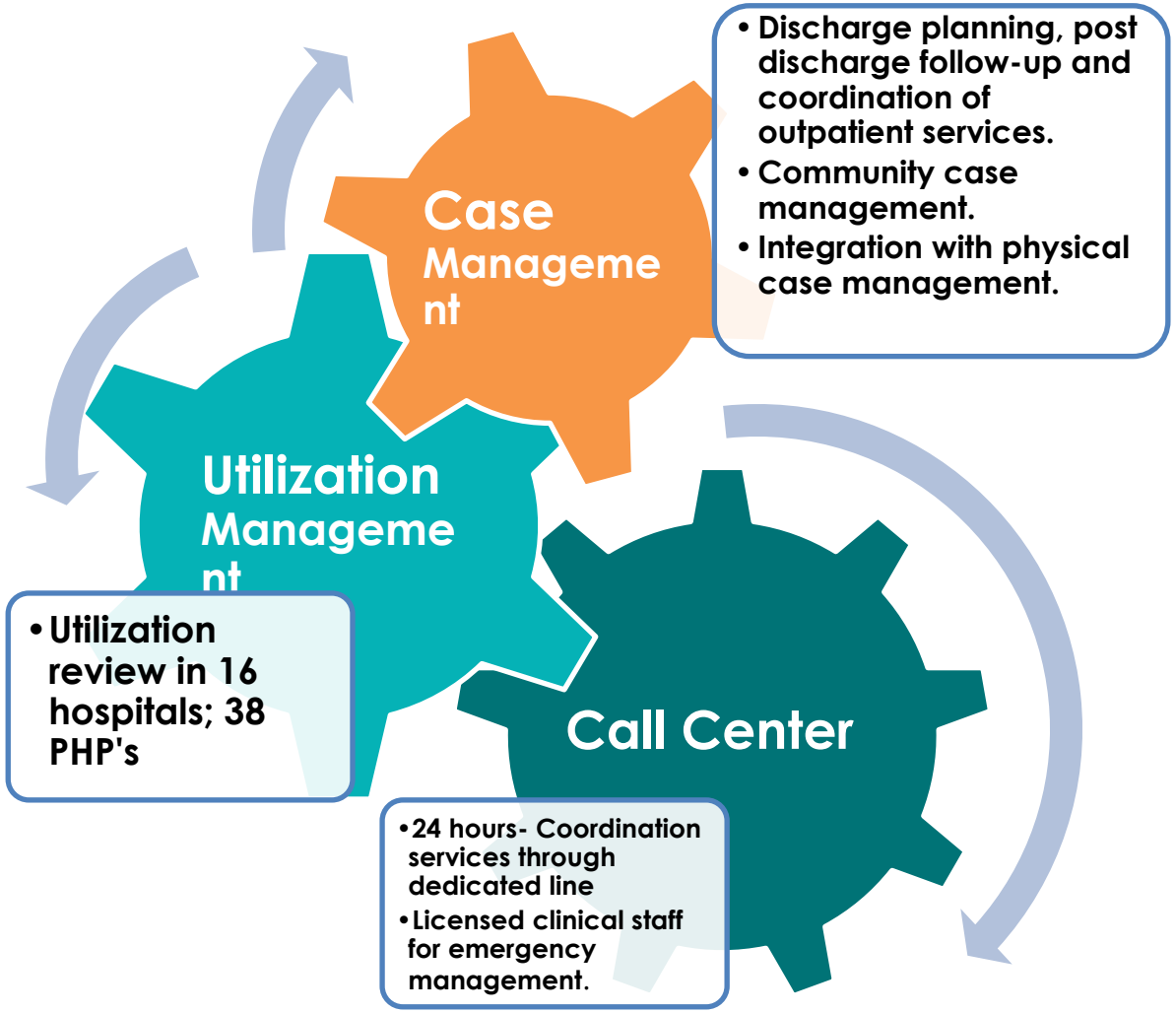
Mental Health

What does the Mental Health Department offer?

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

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

Integrated Mental Health Department: Operational Units



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.

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

Why an Integration Model?

- There is a significant number of beneficiaries with physical and mental conditions.
- Due to the number of beneficiaries with acute conditions, they must be treated under a single health scenario, preventing the beneficiary from moving from one place to another.
- The provision of health services should take place under a single scenario, allowing for a focus on the person.
- Case discussion and collaboration between providers is key to the success of the integrated model.

Integrated Model of Care

Colocation Model

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

Integrated Model of Care

Reverse 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 GMP.

Mental Health Parity Act

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

Coordination of Benefits

Coordination of Benefit

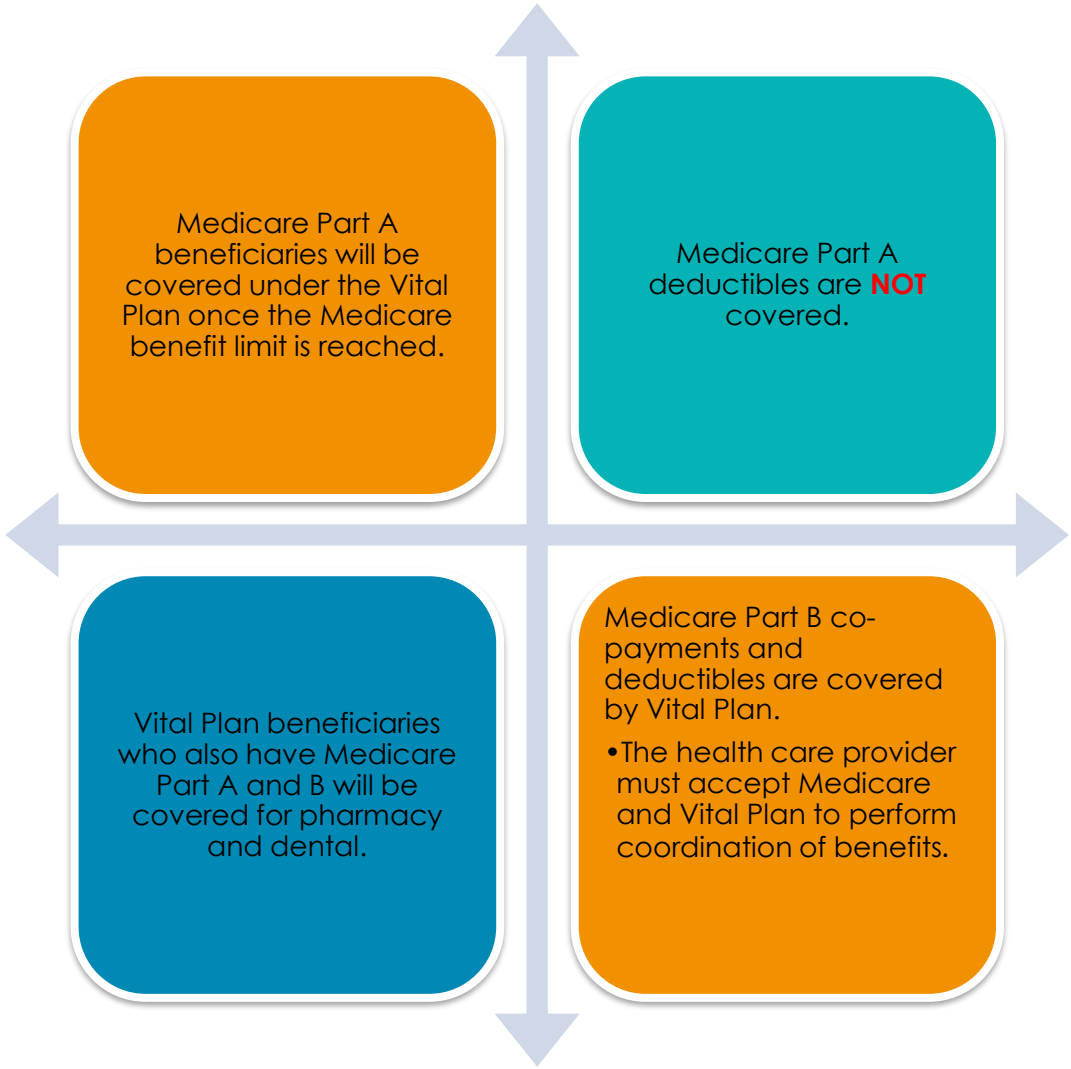
- Coordination of benefits is a method used by health insurers to determine payments for medical claims received by a beneficiary when there is more than one health insurer.
- The primary plan is the payer of covered services and will pay first according to established rules.
- The secondary plan will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

Primary vs. Secondary Payer

The primary plan pays up to the maximum of your coverage

The secondary plan pays if there are costs that the primary insurer did not cover.

Dual Eligibility (Medicare)



Pre-Authorizations

Pre-Authorizations

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

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

Categories

Expedited Category

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

Standard Category

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

TimeFrame

- Time parameters for offering a determination on pre-authorization for all services including Part B drugs are:

- Expedited will be processed on or before 24 hours.
- Standard will be processed on or before 72 hours.
- Extension-14 additional days if there is just cause on the part of the beneficiary

Pre-Authorization Request

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

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

Information and delivery methods

Supporting information

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

Complaints, Grievances & Appeals

What is a complaint, grievance, and appeal?

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

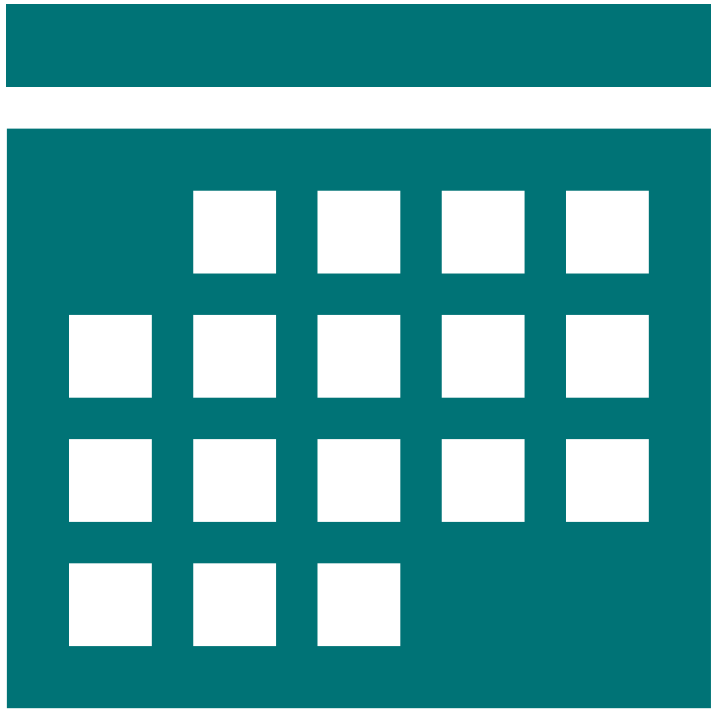
Grievance: An oral or written statement of dissatisfaction made by an insured to the MMM MH or its providers that relates to services received under the Vital Plan coverage or aspects of interpersonal relationships

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

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.



Terms established to respond to the beneficiary

Complaint

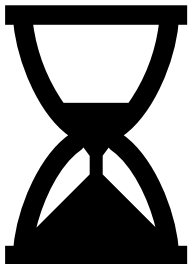
- It must be resolved within 72 hours from the date and time of receipt. If it cannot be resolved it will become a complaint

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.



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

Johanna Morales González

Supervisor

Phone (787) 622-3000 | Ext. 3542

Cel. (787) 403-7357

Email: johanna.Morales-Gonzalez@mso-pr.com

Michael Soto Maldonado

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Tel. (787) 622-3000 | Ext. 2513

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Janice Rodríguez Brea

Director

Tel. (787) 622-3000 | Ext. 2537

Cel. (939) 717-3509
Email:
janice.rodriguez@mmmhc.com

MMM multihealth

Quality Program

Quality and Performance Indicators

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

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

General Provisions

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

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

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

Provider's Network

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

What is A Primary Care Physician?

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

Their responsibilities are:

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

Who are considered Primary Care Physicians?

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

Group's Preferred Network/Primary Physician

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

General Provider Network

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

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

Thanks!

MMM
multihealth

Compliance and Integrity Program Training for Providers and Delegated Entities

Vital Plan - 2024

Compliance Program

- As an Individual, Provider or Entity providing health care services to Medicaid beneficiaries under the Vital Plan,
- **Every action you take has the potential to affect beneficiaries.**

Vision

The Health Insurance Administration (ASES), as well as the Centers for Medicare and Medicaid Services ("CMS"), require training during the first ninety (90) days from the start of employment and then annual training on the Compliance, Integrity (Fraud, Waste and Abuse "FWA"), Privacy and Security programs for organizations and entities that provide and/or administer health care services.

MMM MH Vital is committed to ethics, corporate compliance and all laws, regulations and guidelines governing Medicaid Program requirements.

What is my responsibility as a Provider, Contractor or Subcontractor of MMM Multihealth Vital Plan?

Comply with all ASES and Medicaid requirements, statutes and regulations

Report any violations regarding unethical behavior, suspected fraud, waste, abuse, privacy or security to management and/or the Medicaid Compliance Officer

Comply with all operational, regulatory and compliance training that is part of PSG's Compliance and Integrity programs

What is a Compliance Program?

A Compliance Program is a set of internal controls and measures to ensure that entities follow applicable rules and regulations governing federal programs such as Medicare and Medicaid.

The adoption of a Compliance Program significantly reduces the risk of fraud, waste and abuse, while ensuring access to quality services and patient care.

7 Elements of an Effective Compliance Program

Policies, Procedures and Standards of Conduct: Develop and maintain written policies and procedures

Compliance Officer, Compliance Committee and senior management communication: Designation of an Officer and Committee that have the responsibility and authority to operate and monitor the Compliance Program.

Effective Training and Education: Development and implementation of effective ongoing training and education.

Effective System for Auditing and Ongoing Monitoring and Identification of Compliance Risks: Use of risk assessment techniques and audits to monitor compliance and help reduce situations identified in the area

7 Elements of an Effective Compliance Program

Adequately published Discipline Mechanisms: Policies to establish disciplinary actions and consistently enforce standards.

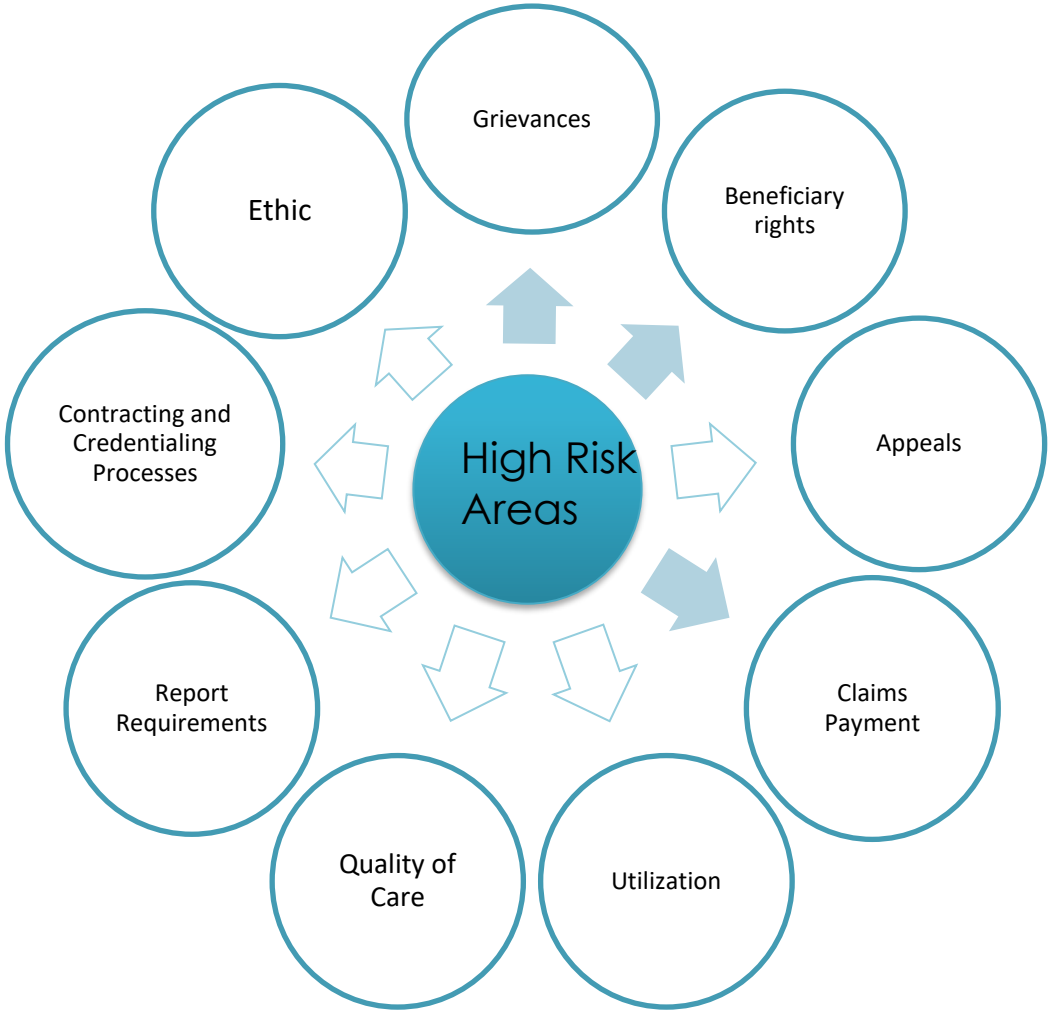
Effective lines of communication: Between the Compliance Officer, employees and management of the organization, as well as with contractors, subcontractors and related entities.

There should be a system in place to respond to regulatory inquiries, reports or situations with potential for non-compliance; Each person should have the tools to report suspected non-compliance confidentially and anonymously.

Procedures for prompt and timely response to compliance situations: Policies for immediate response and corrective action to prevent and avoid similar situations in the future.

What is considered non-compliant?

- Non-compliance is illegal or contrary to the regulation and/or policies of the organization conduct.
- Non-compliance has a direct impact in the services we give to our Providers and Beneficiaries of the Government.



No Retaliation Policy

There will be no retaliation against you for reporting a good faith suspect of non-compliance.

MMM MH Vital offers methods to report, these are:

- Confidentiality
- Anonymous
- Without Retaliation

How to report any situation of non-compliance if you are a beneficiary, provider, or FDRs?

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

How to prevent Non-Compliance recurrence?

- Once non-compliance is detected and corrected, a process of evaluation is very important to avoid recurrence.
- Monitoring of activities are regular revisions to assure compliance and also to confirm that corrective actions are effectively performed.
- Auditing is a formal revision of compliance with a set of particular standards (e.g. policies and procedures, laws and regulations) used as a baseline.

Ethic – Do what is correct!

It is important to keep an ethic and legal culture.
It is about doing what is correct!

- Act with Justice and Honesty
- Comply with the law spirit
- Adhere to the most ethic standards in everything you do
- Report suspected violation

Conflict of Interest Policy

- It is required to avoid those situations where personal interests can cause conflict or appear conflict with the interests of the company.

- If you find yourself in a situation where you believe that a conflict of interest may exist, you must report it to your Supervisor and/or the Compliance Officer.

Conflict of Interest Policy

Examples:

- Presents and Entertainment;
  - Cannot accept gifts or unusual favors from clients, competition o suppliers;
  - Gifts to clients-nominal value of $15
- Supervise a family member;
- Do business with a family member employed by a Provider or Supplier;
- Financial relations with entities that actually have or that in the future may have relation with the company;
- Be member of the Board of Directors of another company;
- Perform any function or offer services for the competition or suppliers, without the consent of the company

Integrity Program

Fraud, Waste and Abuse (FWA)

Why it is important to be trained about Fraud, Waste and Abuse?

- You are part of the solution.
- You should be alert to any activity that may appear suspicious

How can I prevent FWA?

- Be sure to keep up with laws, regulations and policies;
- Make sure your data and billing are accurate and timely;
- Verify the information provided;
- Stay alert to any activity that may appear suspicious , be alert to patterns, schemes or trends presented by Providers and suppliers.

Definitions

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or article to defraud any healthcare benefit program or to obtain (by means or false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit.

Waste

The overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally nor considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

This includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid program, improper payment and payment for services that fail to meet professionally recognized standards of care or services that are not medically necessary.

Differences between Fraud, Waste and Abuse

The main difference is the intention and knowledge.

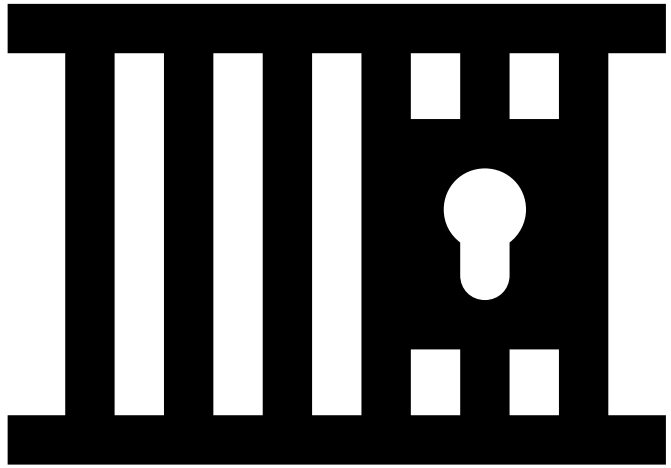
Fraud requires that the person has the intention to obtain the payment and the knowledge that the action is incorrect.

Waste and Abuse could involve payment for items or services, but do not require that the individual has knowingly and/or intentionally, misrepresented facts to obtain payment.

Applicable Laws and Regulations

The False Claims Act prohibits that any person:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government.
- Conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government.



Penalties:

- Under the Federal False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government are liable for three times the government's damages plus civil penalties of $21,563 per false claim.

Applicable Laws and Regulations

Anti-Kickback Statute

The Federal Anti-Kickback Statute makes it a felony for healthcare professionals, entities and vendors to knowingly offer, pay, solicit or receive remuneration of any kind to induce or reward referrals or to otherwise influence business activity covered under a federal healthcare program. Remuneration includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The reward may be acceptable in some industries, but not for federal health programs. Consequences:

Over-utilization, Unfair competition and others. For example, a pharmaceutical company sent home gift cards and continually waived co-payments from beneficiaries to generate referrals. This company had to pay $ 5 million for damages and penalties.

Applicable Laws and Regulations

“Whistleblower

Anyone who has evidence that fraud is being committed against the government is authorized to act as a whistleblower under the False Claims Act.

Federal law prohibits an employer from discriminating against an employee because the employee reports suspected fraud in good faith or initiates or assists in a false claims action on behalf of the government.

Applicable Laws and Regulations

Penalties for violation of the Anti-kickback Statute

- Civil penalties may include fines up to $73,588 per violation plus three times the amount of the remuneration.
- Criminal penalties include fines, imprisonment or both.

Stark Statute or Self-Referral Law

- Prohibits; A Physician from referring patients for certain types of Health Services to an entity in which the Physician (or a member of his or her immediate family) owns or has any financial interest or compensation arrangement (exceptions apply).

Applicable Laws and Regulation

- **Stark Law Damages and Penalties**

- Penalties for violating the Stark Law include,
- Up to a $23,863 fine for each service provided.
- Recovery of claims and,
- The possibility of exclusion from Federal health care programs.

- **Exclusion**

No Federal health program payment may be made for any item or service performed, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. § 1395 (e) (1)

42 C.F.R. § 1001.1901

Applicable Laws and Regulations

Contract with ASES

This contract was established between MMM MH Vital and ASES to define the requirements and responsibilities acquired by being part of the Health Plans selected by Medicaid to manage the Health services of the beneficiaries they serve. They have state and federal requirements that each Health Plan must comply with.

List of Excluded Individuals and Entities (LEIE)

Excluded Physicians may not charge directly for the treatment of Medicare and Medicaid patients, nor can they bill their services indirectly through an employer or a medical group.

Providers are also responsible for not employing or hiring excluded individuals or entities, whether in a clinic, or in any health care setting where federal funding payments are received. This requires that all current and potential employees and contractors be evaluated against the List of Excluded Individuals and Entities of the Office of Inspector General.

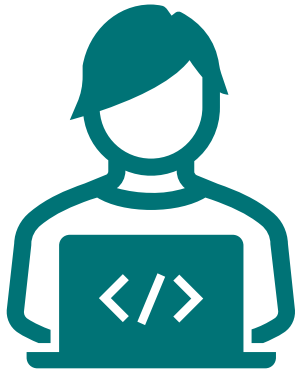
Examples of potential FWA

Upcoding

Billing for services at a level of complexity that is higher than the service actually provided or documented, to receive a higher reimbursement.

Unbundling

Unbundling is billing separately for services or items that should be billed together at a lower overall rate. For example, in laboratory tests or services within a global surgical procedure code that cover pre and post-operative procedures.



Eligibility Fraud

Medicaid Beneficiaries can also participate in fraud and abuse. Eligibility fraud involves misrepresenting one's circumstances in order to obtain program coverage for which one does not qualify.

Falsification of Credentials of healthcare Providers

Forging credentials from providers may put patients at risk because they may be receiving treatment from an unqualified, or unlicensed, provider. And result in improper payments for services from an individual that does not meet the required professional qualifications.

Examples of potential FWA

False Representation

A Provider submits false claims by falsely representing the person who actually provided the service. In these cases the person who provided the service is prevented from receiving the payment, for example, because he is not licensed, or because he is excluded by OIG.

Non-Medically Necessary Services

For example, bill for expensive therapies, surgeries, home health services or equipment that the patient does not need.

Fraud and Abuse of Beneficiaries

Beneficiaries may abuse the system through the inappropriate use of services, such as the sale of prescription drugs or medical equipment. Other forms of fraud may include lending a medical plan card to an ineligible person so that person can receive health services to which he or she is not entitled.

FWA Key Indicators

A medical order, progress note, preauthorization request, result, or other document that appears to be altered or falsified.

The services are not supported by Beneficiary's medical history.

A Provider that bills services much more than other Providers of the same specialty and/or region.

A Provider who prescribes mainly controlled medications.

A Beneficiary with various narcotic orders, high doses and different prescribers.

Medical records have no evidence of the results of billed studies.

A Provider with a pattern of misuse of modifiers.

Measures to Prevent FWA

Provider Enrollment and Contractual Requirements:.	• Processes have been established to validate that Contracted Providers comply with State requirements, licensure, disclosures of interest in property and criminal convictions, among others
Education of Beneficiaries and Providers:	• MMM MH Vital must ensure that Beneficiaries, Providers and their employees are effectively educated about fraud and abuse, and how and where to report it.
Mechanisms to Report Suspected Fraudulent Activity :	• MMM MH Vital has several mechanisms to report suspicious situations confidentially "hotline", "Ethics Point", email and postal mail. MMM MH Vital prohibit retaliation against any Employee who, in good faith, refers a possible FWA case.
Exclusion Screening:	• MMM MH Vital has implemented policies and procedures to review the lists of individuals or entities excluded by OIG before hiring a Provider, Employee or Contractor, and then monthly.

What can Beneficiaries do to prevent FWA?

- Protect information from the health plan ID card: never offer plan information to strangers or callers;
- Relate to the terms of your cover;
- Save copies of laboratory results and studies to avoid duplicity;
- Verify the information before signing any health insurance or claim for health services;
- Review the summary of services received by the Beneficiary;
- Do not give money to someone who offers to perform or accelerate some management at ASES or the Medicaid office.

Don’t forget!

Report FWA

You do not have to determine whether the situation is fraud, waste or abuse. Report any concerns to the MMM MH Vitals’ Medicaid Compliance Department.

The Medicaid Compliance Department will investigate and make the appropriate determination.

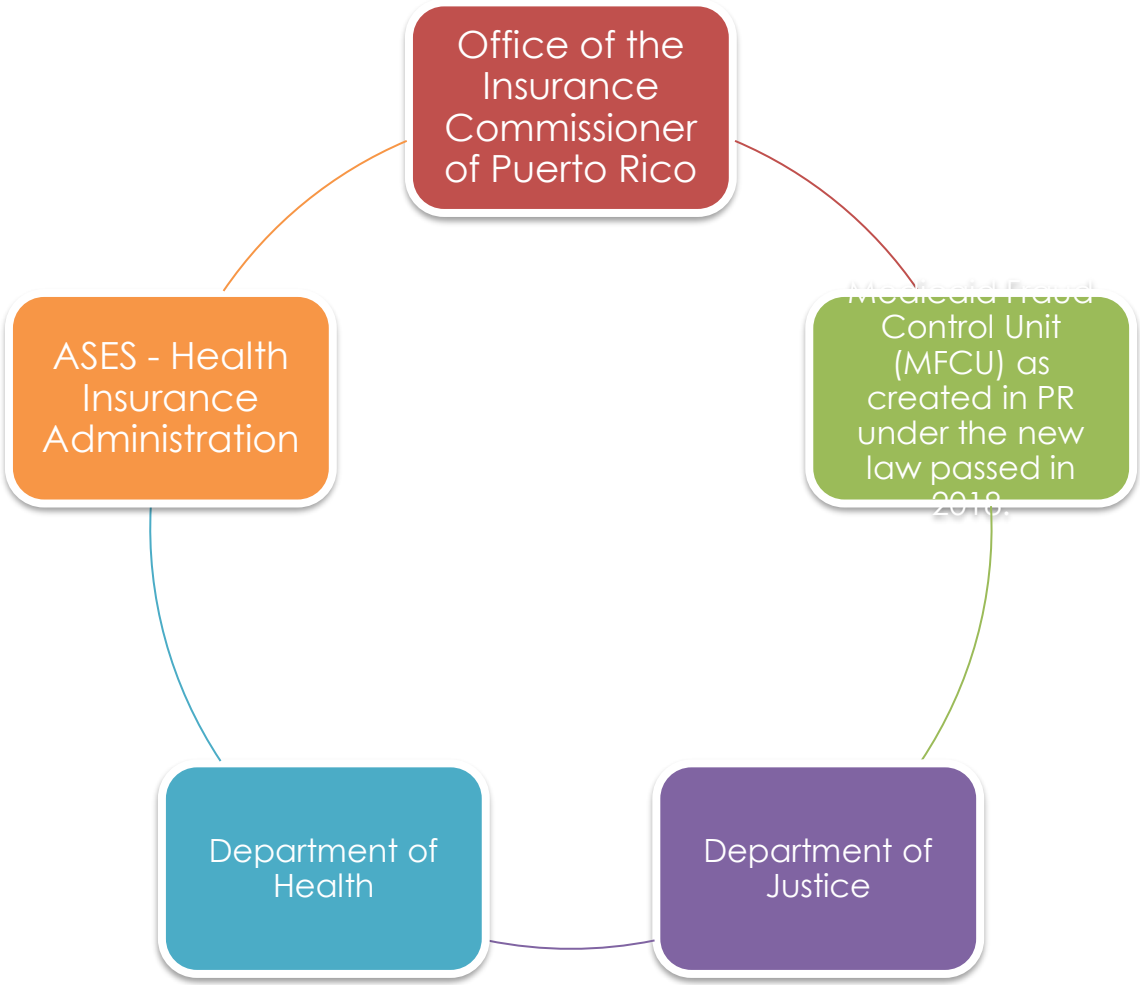
Consequences of committing FWA:

- **Consequences of committing FWA:**
- The following are potential penalties. The actual consequences will depend on the violation.
  - – Civil Money Penalties;
  - – Conviction/criminal penalties;
  - – Civil lawsuit;
  - – Incarceration;
  - – Loss of licenses;
  - – Exclusion of Federal Health Programs.

How to report any situation of non-compliance if you are a beneficiary, provider, or FDRs?

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

Regulatory Agencies attentive to the FWA



Privacy and Security
HIPAA

Health Insurance Portability and Accountability Act

HIPAA Law

- HIPAA is a federal law that all health plans and health care providers must comply with to protect the **privacy and security** of an individual's health information.

- HIPAA is overseen by the Department of Health and Human Services (HHS) and enforced by the Office for Civil Rights (OCR).

What is HIPAA?

It's acronym means:

- Health
- Insurance
- Portability and
- Accountability
- Act of 1996

H I P A A

Was created to grant more access to health insurance, protect privacy of health information, and promote standardization and efficiency in healthcare industry.

The section of Privacy consists of **establishing safeguards to** prevent not authorized access to protected health information and establishes the rights of the individual with respect their protected health information.

As individuals who have access to protected health information, you are **responsible of adhering to HIPAA**.

HIPAA

- Signed on August 21st 1996;
- Total validity from April 14th 2003;
- Applies to electronic and paper health information;
- HIPAA has (3) components: Administrative Simplification, Security and Privacy.
- Seeks to improve efficiency and effectiveness of the medical attention system unifying and protecting medical information;
- Promotes development of an information system through the adoption of standards for the electronic transmission of certain medical information;
    - Uniformed standards for claims and other financial and administrative transactions;
    - Privacy and security standards to manage healthcare personal identifiable information.

HIPAA Privacy Rules

Purpose:

Protects the confidentiality of the PHI in all formats (paper, verbal and electronic).

Grants the members understanding and control on how their PHI is used..

Ensures that PHI is used for health purposes only..

Establishes that protected health information (PHI) can only be disclosed for treatment, payment or health care operations (TPO) or with the consent (valid authorization) of the individual. .

Establishes individual's rights respect to their health information. .

Establishes the notification process for HIPAA Breaches.

Relationship of HIPAA to the laws of Puerto Rico

- By express provision of the United States Congress, the Act applies to the states and territories, including Puerto Rico. "State means any of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands and Guam".
- Provides that only any present or future local legislation that is stricter and provides greater rights to individuals regarding their health information can preempt HIPAA.
- It occupies the state field; it displaces, supersedes and prevails over any local law that is contrary to HIPAA.

HIPAA

HIPAA Covered Entities:

- Health Plans;
- "Healthcare Clearinghouses" (these are central institutions that set up transactions);
- Healthcare providers (physicians, hospitals, pharmacies, etc.).

Minimum Necessary Standard:

- HIPAA requires the covered entity to use or disclose PHI in a limited manner, only the information necessary to accomplish the purpose of the disclosure to the person requesting it. (Minimum Necessary Standard).

Genetic Information Nondiscrimination Act

- The Genetic Information Nondiscrimination Act (GINA) - became law on May 21, 2008
- GINA protects individuals from discrimination based on their genetic information in health coverage and employment.
- GINA is divided into two sections or titles. Title I of GINA prohibits discrimination based on genetic information in health coverage. Title II of GINA prohibits discrimination based on genetic information in employment.
- In the proposed rule issued on October 1, 2009, OCR proposes to amend the Privacy Rule to clarify that genetic information is health information and to prohibit the use and disclosure of genetic information by covered health plans for underwriting purposes, including eligibility determinations, premium calculations. The proposed rule would prohibit the use and disclosure of genetic information by covered health plans for underwriting purposes, including eligibility determinations, premium calculations, requests for pre-existing condition exclusions, and any other activity related to the creation, renewal, or replacement of a health insurance contract or health benefits.
- OCR published this proposed rule with a 60-day public comment period.

“PHI”- Protected Health Information

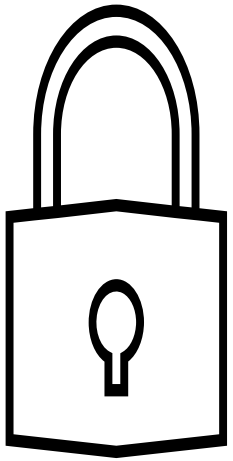
PHI should only be seen by authorized persons to see the information

PHI should be seen only by persons authorized to see the information..

PHI should be transmitted or shared only with persons authorized to receive or share the information..

“PII - Personally Identifiable Information: Personally identifiable information must also be protected and limited to authorized persons only.

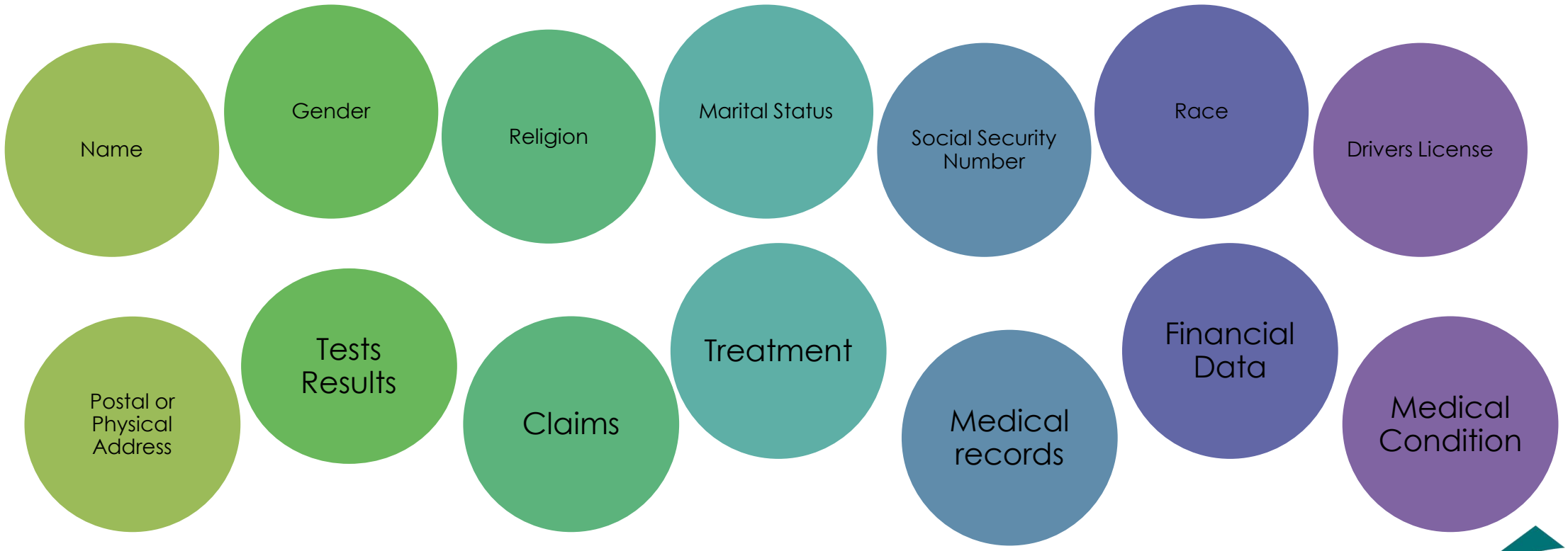
“PHI”



- PHI is individually identifiable health information collected from an individual, created or received by a covered entity; and
- That relates to the past, present or future physical or mental health or condition of the individual; or to the provision of health care to an individual; or to the past, present or future payment for health care services to the individual; and
- That identifies an individual or can identify an individual.
- That may be transmitted or maintained electronically, as well as by any other means.

What does HIPAA protect?

Examples of Protected Health Information (PHI)



Difference between use and disclose

- **Use**

The sharing, application, examination or analysis of PHI within the covered entity.

- **Disclose**

The release, transfer, provision of access to, or otherwise disclosure of PHI outside of the covered entity

PHI Authorization of Disclousure

No authorization is needed for an Individual to use and/or disclose his/her PHI for **Treatment, Payment** and/or **Health surgery.**

In some instances **the law allows** disclosing PHI **without** authorization of the individual, ex. For audit purposes for governmental entities.

Any other use requires authorization

The insurance has a PHI Authorization Form available so that Beneficiaries add persons of their preference to receive their PHI.

PHI Disclosure to Relatives and/or Guardians of Emancipated and not Emancipated Minors

- The parents or legal tutors of the not emancipated minors have the right to have disclosed protected health information (PHI) of such minors.

- The parent or tutor will be the personal representative of the minor, without the necessity of requiring a PHI authorization to disclose his/her information.
- The legal representatives of minors, others than their parents (e.g. legal guardians) must present evidence of their authority to the plan, prior any disclosure of information.

Disclosure of PHI to Relatives and/or Guardians of Emancipated and Non-Emancipated Minors:

If the minor is emancipated: (by reason of marriage, because the parents or a court emancipated the minor) then the minor may choose to whom his or her PHI is disclosed.

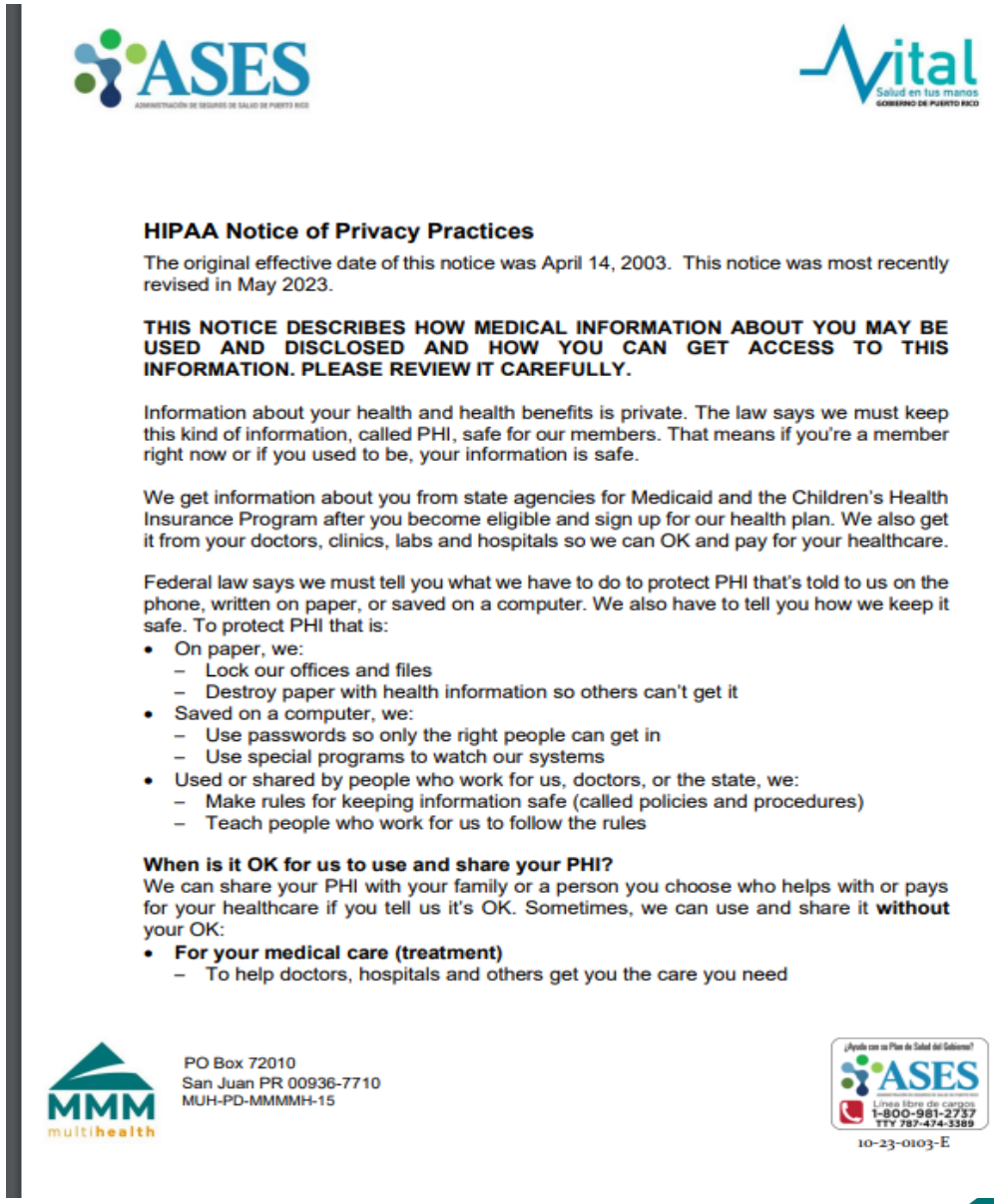
When permitted by law, parents or legal guardians may not obtain PHI from the unemancipated minor when:
the health care service does not require parental or guardian consent and;
the minor and a court or other person authorized by law consent to such health care service.

Also, the parent or legal guardian may consent to a confidentiality agreement between a Health Care Provider and the minor regarding a medical service.

Notice of Privacy Practices (NPP)

- It is a document that explains the rights of individuals to their PHI, the legal duties and privacy practices of the covered entity (e.g., MMM MH) with respect to individuals' health information, and the ways in which the covered entity may use or disclose such information.

- A health plan must distribute its notice of privacy practices to each new enrollee upon enrollment and send a reminder to each enrollee at least one every three years that the notice is available upon request.



ASES

Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in May 2023.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information about your health and health benefits is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what we have to do to protect PHI that's told to us on the phone, written on paper, or saved on a computer. We also have to tell you how we keep it safe. To protect PHI that is:

- On paper, we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer, we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors, or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care (treatment)**
  - To help doctors, hospitals and others get you the care you need

MMM multihealth

PO Box 72010
San Juan PR 00936-7710
MUH-PD-MMMMH-15

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ASES
Línea libre de cargos
1-800-981-2737
TTY 787-474-3389

10-23-0103-E

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What is a “’Breach”
45 CFR 164.402

A breach is an unauthorized acquisition, access, use or disclosure of unsecured PHI that compromises the privacy and security of the PHI. Use and disclosure of PHI not authorized by HIPAA is presumed to be a breach unless the covered entity or business associate demonstrates that there is a low probability that the PHI has been compromised

All HIPAA breaches must be reported to affected individuals within 60 days of discovery of the breach or from the date the breach should have been discovered.

In addition, the company must notify HHS and the press of the breach. The timing of that notification will depend on the number of individuals affected by the breach.

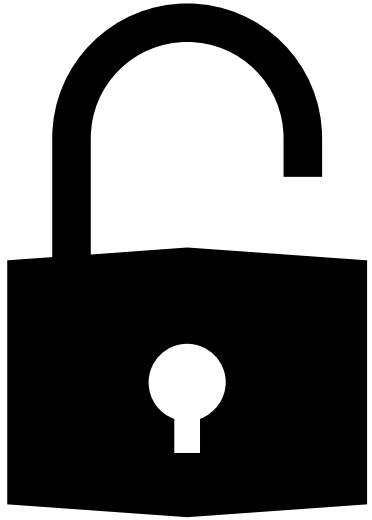
- 500 or more affected individuals: the notification to the press and HHS must be within 60 days of when the violation was discovered or should have been discovered.
- 499 or fewer affected individuals: violations must be reported to HHS in the next calendar year.

HIPAA'S Security Rules

Purpose:

- The Security Rule requires covered entities to protect PHI in electronic form (ePHI). It establishes controls to safeguard the confidentiality, integrity, and availability of ePHI. Confidentiality: ensuring that ePHI is not available or disclosed to unauthorized persons. Integrity: ensure that today's ePHI entry is the ePHI that will be retrieved in the future (ePHI has not been altered or destroyed in an unauthorized manner).
- Availability: ensure that ePHI is available to those who need it, when they need it.
- It is intended to protect ePHI from any reasonably anticipated threats or hazards, and from improper use or disclosure.

Security Incidents



Security incidents should be reported immediately

Examples of Security Incident:				
Malware (virus/trojan) infections	Discovery of an unauthorized user account	Theft / loss of equipment	Improper use of systems	Abuse of privileges in a network environment.

Consider that…

- Improper storage, transmission or handling of PHI may result in theft or loss of the information and access to unauthorized individuals called a breach.
- If you become aware of an unauthorized disclosure of PHI, you should immediately contact MMM Compliance Office.
- To comply with the law, any unauthorized access to PHI must be notified to the affected individuals, ASES and the Office for Civil Rights within the required timeframes.
- Any Beneficiary has the right to file HIPAA non-compliance complaints if he/she feels that his/her information has not been handled appropriately.

Consider that…

- The complaint may be filed with MMM MH Vital, the Office of Civil Rights of the Federal Department of Health and Human Services, ASES, or the Office of the Patient Advocate.

- Penalties for violations of HIPAA standards include but are not limited to;
- Fines
- Prision

- This training applies not only to MMM MH Vital employees, but also to its contracted Providers, Contractors and Subcontractors, including their employees.

Remember…

- Follow the procedure for proper disposal of sensitive information using locked recycling boxes.
- Keep laptops, smart phones, USB and any other memory sticks or documents containing PHI in a secure location.
- Be sure not to leave documents containing PHI on printers or fax machines.
- Never leave PHI in plain sight on your desk.
- Use strong passwords. Keep your ID and password confidential and secure. Never share your password or user name (User ID).
- Do not access PHI that you do not need to access.
- Never share your corporate ID with anyone..

Remember…

- Immediately inform your supervisor if your corporate ID is lost or stolen.
- Visitors must have visitor identification before entering company premises and must be escorted by a supervisor or manager at all times.
- If you observe an unfamiliar or suspicious person in your work area, notify your supervisor immediately.
- Do not leave documentation with PHI, laptop, cell phone, USB or any portable storage device in the car.
- Do not open emails with attachments from unidentified contacts.
- Before leaving your computer unattended, press Ctrl + Alt + Delete and lock it.
- Do not install applications unless approved by the MMM IT Department.
- Do not surf the Internet for personal use.

How to report any situation of non-compliance if you are a beneficiary, provider, or FDRs?

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- HotLine **1-844-256-3953**
- Email: **VitalSIU@mmmhc.com**

ASES
ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO

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Salud en tus manos
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¡Thanks !

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