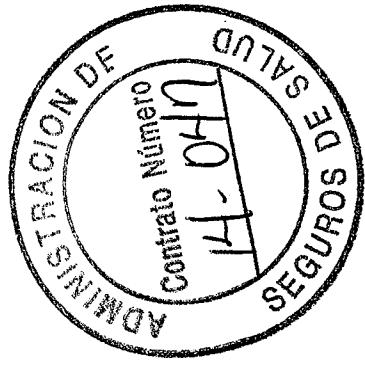
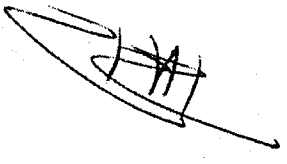
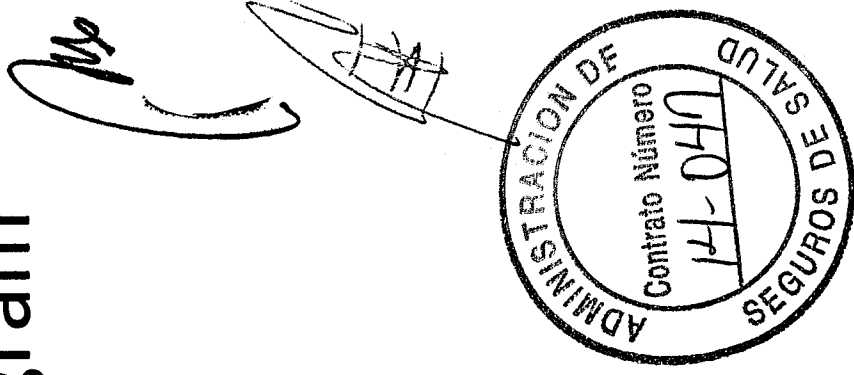


ATTACHMENT #14



Guidelines for the Development of Program Integrity Plan



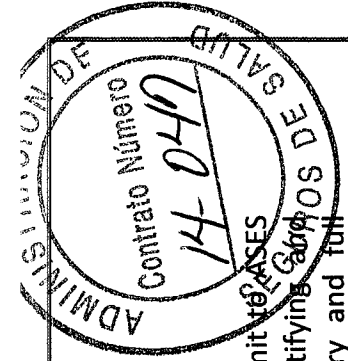
2013 – 2014

(This document is to be used by all contracted companies participating in the Commonwealth of Puerto Rico "MI Salud". The purpose of sharing information with contracted companies is to provide them guidelines with minimum requirements to formulate their own Plan Integrity Program for the Health Care Delivery System sponsored by the Commonwealth of Puerto Rico)

The Insurer shall comply with the following Medicaid Integrity requirements:

- A. 60 days after the dated of the agreement the Company must submit to the Compliance Office copy of the policies and procedures for identifying and tracking potential provider fraud cases, for conducting preliminary and full investigation and for referring cases of suspected fraud to an appropriate law enforcement agency. The Compliance Plan should be developed in accordance with 42 CFR 438.608.
- B. Each company must submit to the Administration's Compliance Office on a quarterly basis a report with the following information: preliminary and full investigations, audits performed, administrative actions against providers, overpayments identified and providers referred to the Department of Justice (if not submit a certification signed by the Compliance Director and the President or CEO).
- C. Each company must submit to the Compliance Office on a quarterly basis a report with the following information: fraud investigations pending, fraud investigations in process, fraud investigations finished and referrals to the Department of Justice or U.S. Attorney's Field Office (if there were no investigations, submit a certifications signed by the Compliance Director and the President or CEO).
- D. Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG.
- E. Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15.
- F. Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program.
- G. Each Company must review the credentialing forms of all providers and any fiscal agents they may use to ensure that they are in accordance with federal regulation 42 CFR 455.104.
- H. Each Company must require providers to fill out a complete ownership and control disclosures form. The Company is responsible to ensure compliance with regulation.
- I. Each Company must review providers agreement to incorporate appropriate business transaction language to ensure accordance with federal regulation 42 CFR 455.105.

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- J. Each Company must request providers to fulfill a business transactions form and verify compliance with regulation.
- K. Each Company must establish a method to capture criminal conviction information on owners, persons with control interest, agents, and managing employees of providers to ensure that is in accordance with federal regulation 42 CFR 455.106.
- L. Each Company must review the enrollment packages for all provider types to request criminal conviction information as stated before.
- M. Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the policies should be submitted to ASES Compliance Office.
- N. Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106.
- O. Each Company must comply with requirement in 42 CFR 455.20 and must document in a quarterly report compliance with regulation.
- P. Each Company must comply with requirement in 42 CFR 455.101.
- Q. Each Company must review the enrollment form and credentialing packages for all provider types to capture the identity of agents and managing employees.

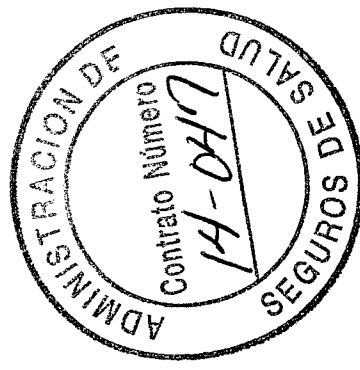
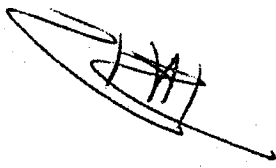


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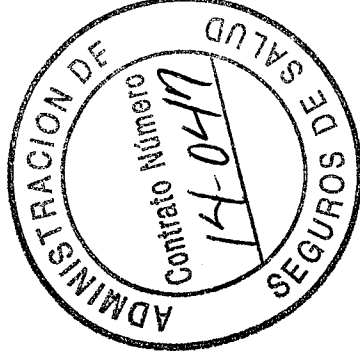
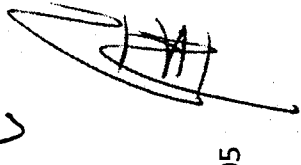

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Introduction

Under the authority of Sec. 1102 of the Social Security Act (42 U.S.C. 1302); as detailed in the 43 FR 45262, Sept. 29, 1978, the Medicaid Program must have a program to detect and investigate fraud, waste and abuse.

The Commonwealth of Puerto Rico Department of Health and its Office for the Medically Indigent, acting as the single state agency are responsible for the management of the Medicaid and SCHIP grant funds. These funds are transferred to the Puerto Rico Health Insurance Administration (ASES), to be combined with state funds to provide health benefit coverage to the medically indigent population under a managed care fully capitated health plan. Acting as a sub-grantee to the Office for the Medically Indigent Medicaid program, ASES establishes contracts with insurance companies and other organizations to facilitate the beneficiaries' access to the benefit coverage through out their provider's networks.

Integrity Program Basis and Scope

This document sets forth guidelines with minimum criteria for the compliance with Program Integrity Policies and Procedures that each organization (grantee, sub-grantee, insurance companies) must have for the administration of the Commonwealth of Puerto Rico's Medicaid and State Health Plans. This document includes guidelines for the elaboration of the 3 main sections in the organizations Program Integrity Plan (PIP):

1. Fraud Detection and Investigation
2. Providers and Fiscal Agents Disclosure of Information on Ownership and Control
3. Integrity Program

Regulation Citation

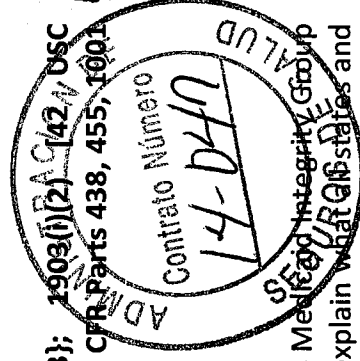
Sections 1902(a)(4) [42 USC 1396(a)(4)1, (61)2, (64)3]; 1903(i)(2) [42 USC 1396(b)(i)(2)]4 1936[42 USC 1396u-6]5 and regulations at 42 CFR Parts 438, 455, 1001 and 1002

Overall Requirement

All providers/contractors are required to comply with the CMS Medicaid Integrity Group State Medicaid Director Letters #08-003 and #09-001, which explain what CMS States and contractors should do in terms of checking for excluded parties. The letters provide guidance on where to check for excluded individuals as well as the consequences of contracting with individuals and entities that have been excluded from participating in federally funded programs.

Companies are also required to notify to the Department of Health and Human Services-Office of Inspector General (HHS-OIG) of any action it takes to limit the ability of an individual or entity to participate in its program as stated in 42 CFR 1002.3.

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Each contracted company must report actions it takes when it denies a provider enrollment based on program integrity concerns. Companies should report on each provider whom it has disenrolled, suspended, terminated or otherwise restricted from participation in the Medicaid program based on program integrity concerns. Companies are required to report affected providers directly to HHS-OIG while copying ASEs.

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Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider

Conviction or *Convicted* means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Disclosing Entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.


Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

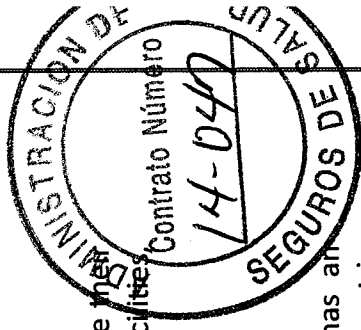
Group of practitioners means two or more health care practitioners who practice the profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in §438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or

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who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- (b) Any Medicare intermediary or carrier; and
- (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

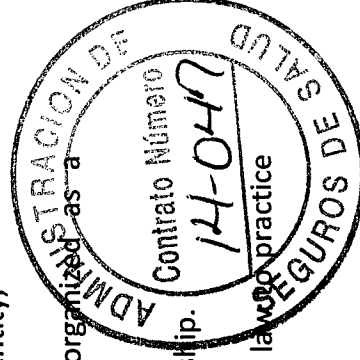
Person with an ownership or control interest means a person or corporation that—

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

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Program Integrity Plan (PIP) means the program, process or policy that each contracted company has to comply with integrity requirements. The plan should be developed in accordance with federal regulation.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.



Subcontractor means—

- (a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Stakeholder means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid beneficiaries

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

Termination means—

(1) For a—

- (i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
- (ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges ~~revoked~~ for cause which may include, but is not limited to—

- (i) Fraud;
- (ii) Integrity; or
- (iii) Quality.



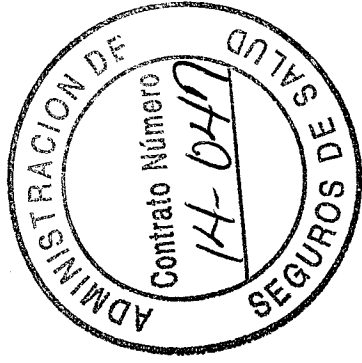
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Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider

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Section A

Fraud Detection and Investigation sub part represents each one of the elements that must be included as part of the integrity program activities, although they are not necessarily the only elements that come into play.

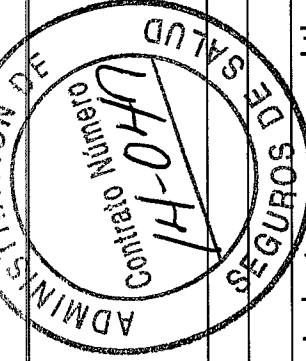
All contracted plans must have an integrity program with their own structure, policies and procedures. Among other areas, they should have written policies and procedures on methods for the identification, investigation and referral of suspected cases; procedure to perform preliminary investigations as well as full investigations; procedures to address resolution of full investigations; procedures to comply with reporting requirements; provider's statements on claims form (if applicable); provider's statement on checks; cooperation with the Commonwealth of Puerto Rico Office for the Medically Indigent fraud control unit and procedure to withhold payments in case of fraud or willful misrepresentation. Contracted companies are required to submit to ASES Compliance Office copy of their integrity programs for evaluation. The plan should be developed in accordance with 42 CFR 438.608.

Each one of the Guidelines under section A includes the name or title of the guideline, scope, purpose, process and general information to identify the creation date, creator, and revisions or updates. This document will be attached to the contract each organization holds with the Puerto Rico Insurance Administration; while each one of the contracted organization should have at least a minimum set of policies and procedures to address the guidelines included.

The Program Integrity Plan (PIP) of each organization is to be monitored by the sub-grantee on periodic basis. An annual report will be issued reporting data and findings.



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 Program Integrity Plan 2013 - 2014



Title SA1.1	State Plan Requirements
Scope	Applies to Single State Agency and Sub-Grantee
Purpose	This guideline describes the commitment of the single state agency and the sub-grantee in adhering to the statute rules and regulations and the implementation of a Program Integrity Plan for the Medicaid Program
General	The grantee and the sub-grantee will abide by the following guidelines on how to manage the integrity program activities in the whole service delivery system.
Guidelines	<ol style="list-style-type: none"> 1. The single state agency and sub-grantee acknowledge the need to adhere to a Medicaid Integrity Program as defined in the state plan. 2. The grantee and sub-grantee agree to establish a structure to manage Program Integrity Plan (PIP) activities. 3. The organization structure to perform above mentioned activities is furnished with a Program Integrity Plan (PIP) of members representing the single state agency, the sub-grantee and each contracted organization. 4. The PIP leads the efforts toward achieving compliance with state plan requirements regulation by establishing the minimum criteria of required PI program policies and procedures. 5. The PIP monitors contracted companies plan compliance on regular basis. 6. The PIP chairman develops the meeting calendar each year, develops the committee agenda, and keeps minutes of all meetings and call for meetings. 7. Sub-grantee facilitates the development and update of the Program Integrity Plan guidelines, reports and notification to guarantee its distribution and final acceptance among contracted companies and regulatory agencies. 8. Sub-grantee review performance of each organization, level of adherence to policies and recommend corrective action plan development for areas that must be improved. 9. Sub-grantee develops an annual report that is to be submitted to the Medicaid Program Integrity Group and to the CMS region 2. The report will include the areas and companies reviewed during the period and the findings of each company, if any. 10. The PIP provides guidance and guarantees that each contracted companies develop and implement policies and procedures in their organizations. 11. The PIP guidelines are integrated into each contracted organization Program Integrity Plan Policies and Procedures; and are assumed as a standard operating procedure to prevent fraud, waste and abuse in the management of Medicaid funds and health plan benefit coverage for the indigent population.

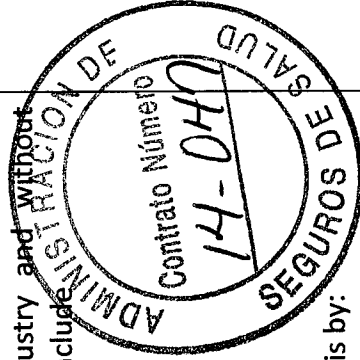
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Commonwealth of Puerto Rico
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Title SA02.1	Methods for identification, investigation, and referral
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	This guide describes what the organization must include in their PIP to guarantee the use of methods for the identification, investigation, and referral of suspected fraud and abuse cases.
General	The organization must establish methods for the identification, investigation and referral of suspected cases, that guarantees the use of a consistent and objective approach to address fraud, waste and abuse when performing PIP activities.
Guidelines	<p>The PIP must include an explicit definition of methods to perform identification of cases suspected of fraud, waste and abuse</p> <ol style="list-style-type: none"> what is fraud, waste and abuse how is detected fraud, waste and abuse who performs the identification when preliminary, full investigation and resolutions are done <p>The PIP must have a detailed process to perform investigations on each suspected case guaranteeing objective methods to identify potential cases and perform investigations</p> <ol style="list-style-type: none"> open and documents the case initiate data gathering process follow a protocol to verify information issue a report of findings refer case to next level close the case
	<p>The PIP must include a variety of methods for the identification, investigation and referral of suspected cases, accepted in the industry and without infringing provider or beneficiary rights. Methods might include:</p> <ol style="list-style-type: none"> electronic data exchanges data mining claims registries / reconciliation targeted procedures profiling <p>The PIP must include a systematic approach of data analysis by:</p> <ol style="list-style-type: none"> flagging the case identifying cause for flagging (i.e. over-under payment) establishing actions and sanctions <p>The PIP must have procedures in placed for referring suspect fraud cases to law enforcement officials, at a minimum:</p>

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Guidelines	<ul style="list-style-type: none">a. an organizational structure to address the reports.b. a due process that includes but is not limited to: case identification, complete record with supporting materials, notification letter to suspect, notification letter to single state agency, documentation of entrance and exit interviews, and if necessary copy of referral letters and case resolution letter to and from legal authorities.c. a flowchart to work in cooperation with the grantee and sub-grantee as well as with the state legal authorities such as: Organization's Legal Affairs Department, ASES, Single State Agency – Department of Health Legal Department, State Department of Justice, and the Office of Inspector General.d. a follow up process to work with legal authorities each case of fraud, waste and abuse suspicion until final disposition and notification to the single state agency.
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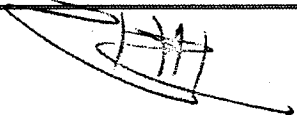
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Title SA03	Preliminary Investigations
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	To provide guidance on how to perform a preliminary investigation when the agency receives a complaint of fraud or abuse from any source or identifies any questionable practices.
General	The organization must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
Guidelines	<p>The PIP defines a standard operating procedure to complete a preliminary investigation of all suspect cases of fraud, waste and abuse.</p> <p>The PIP identifies the requirements to complete the preliminary investigation when evaluating providers and beneficiaries. It should include at least:</p> <ol style="list-style-type: none"> Source of information Identification method (how the case is detected) Cause for investigation Case documentation Analysis of Data and documents Report of Findings Action Taken (Recommended Action) <p>The PIP includes a mechanism to keep tracking of all preliminary investigations and results.</p> <p>The PIP establishes a mechanism to report preliminary investigations activity to the sub-grantee (ASES) which will be in charge of reporting activity to the single state agency (Office for the Medically Indigent).</p>

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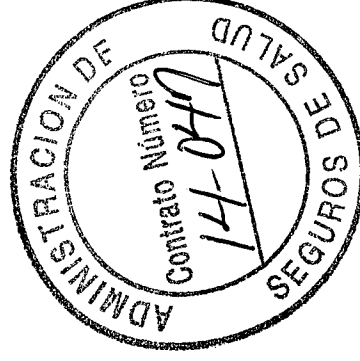
Title SA04	Full Investigations
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	To provide guidance and minimum set of elements in the PIP to perform full investigations on incidents of fraud and abuse.
General	If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occur in the Medicaid program, the organization must take the appropriate actions.
Guidelines	<p>The PIP must define the process to conduct a full investigation and specify when a case requires the full investigation. Full investigations must be done in accordance with federal regulation and based in the company written policy. The company must submit copy of the written policies to ASES for review and approval.</p> <p>The PIP must define the process to refer the cases to the companies fraud liaison (i.e. companies compliance office), the appropriate law enforcement agency / sub-grantee when there is a reason:</p> <ol style="list-style-type: none"> a. to suspect a provider has engaged in fraud or abuse of the program. b. to suspect a recipient is defrauding the program. c. to suspect a recipient has abused the Medicaid program. <p>The PIP must have a mechanism to keep tracking of all full investigations performed in progress and closed.</p> <p>The PIP must have a mechanism to report the sub-grantee (ASES) informed full investigations in progress, conducted and results.</p>

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Title SA05	Resolution of full investigation
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on minimum actions that must be taken in order to complete the process of a full investigation.
General	The full investigations must continue until the cases are referred, solved or closed.
Guidelines	<p>The PIP must include the process to guarantee that a full investigation must continue until:</p> <ol style="list-style-type: none"> appropriate legal action is initiated. the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse. the matter is resolved between the organization and the provider or recipient <ul style="list-style-type: none"> ✓ the resolution may include but is not limited to: <ol style="list-style-type: none"> Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action; Suspending or terminating the provider from participation in the Medicaid program; Seeking recovery of payments made to the provider; or Imposing other sanctions provided under the organization PIP plan. <p>The PIP must guarantee that there is a mechanism to keep tracking of all full investigations until resolution.</p>



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Title SA06	Reporting Requirements
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to adhere to a minimum set of elements that must be included in the process to report fraud and abuse information to the appropriate organizations officials.
General	The organization must submit a progress report the fraud and abuse information and statistics to the appropriate department / grantee / sub-grantee on quarterly basis.
Guidelines	<p>The PIP must describe the mechanism to report fraud and abuse data to the appropriate fraud liaison, organization structure, sub-grantee (ASES) and grantee (Office for the Medically Indigent).</p> <p>The PIP progress report must include at least the following information:</p> <ol style="list-style-type: none"> a. # of complaints on fraud and abuse received. b. # of complaints that warrant preliminary investigation. c. Detailed information for each case of suspected provider fraud and abuse that warrants a full investigation: <ul style="list-style-type: none"> ✓ Provider's name and id number ✓ Source of the complaint ✓ Type of the provider ✓ Nature of the complaint ✓ Estimate amount of money involved ✓ Legal and administrative disposition of the case and actions taken by the law enforcement officials to whom the case has been referred. <p>Suspected fraud cases must be reported immediately in a written format to ASES Compliance Office.</p> <p>The PIP reports must be submitted in electronic format to facilitate its inclusion in the Commonwealth of Puerto Rico Medicaid Program PI Annual Report.</p>

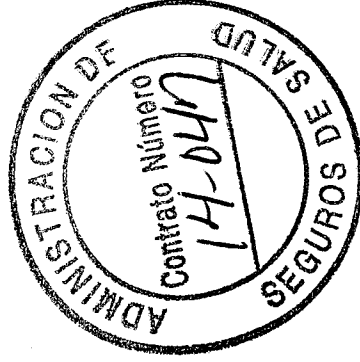
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 Program Integrity Plan 2013 - 2014

Title SA07	Provider's statements on claims forms
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on claims forms.
General	The organization may print that all provider claims forms be imprinted in boldface type with the following statement, or with alternate wording that is approved by the Regional CMS Administration.
Guidelines	<p>The PIP must include that providers are required to attest in the claim forms that they agree with the following statement:</p> <ul style="list-style-type: none"> ✓ "This is to certify that the foregoing information is true accurate and complete". ✓ "I understand that payment of this claim will be from federal and state funds and that any falsification or concealment of a material fact maybe prosecutes under federal and state laws". <p>For electronic claims, providers must attest that they agree with the following statements:</p> <ul style="list-style-type: none"> ✓ "This is to certify the truthfulness of the foregoing information and certify that is true, accurate, complete and that the service was provided". <p>The statements may be printed above the claimant's signature or, if they are printed on the revenue of the form, a reference to the statements must appear immediately preceding the claimant's signature.</p>

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 Program Integrity Plan 2013 - 2014

Title SA08	Provider's statements on check
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on check.
General	The organization may print the following wording above the claimant's endorsement on the reverse of checks or warrants payable to each provider.
Guidelines	<p>The PIP must include that providers are required to attest (in addition to the statements required in providers claims form) that they agree with the following statement either by having it written on checks or temporarily in a legal document as an affidavit:</p> <p>✓ "I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws".</p> <p>The above attestation must be included in electronic and checks payment.</p> <p>The PIP must indicate frequency and responsible for conducting spot checks to guarantee the organization complies with the provider's statements and / or the provider signature appears on a legal document attesting compliance.</p>

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Title SA09	Recipient verification procedure
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To verify that the services listed on claims forms have been rendered.
General	The organization must have a method for verifying with recipients whether services billed by providers were received.
Guidelines	<p>The PIP must include a description of how the organization performs claims matches with medical records to guarantee adequacy of billing.</p> <p>The PIP must define the mechanism to monitor frequency of encounters and services rendered to patients billed by providers.</p> <p>The PIP will provide periodic up dates on reconciliation findings report to the sub-grantee and grantee.</p> <p>The sub-grantee will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries.</p>

Note: All contracted companies are required to comply with Law 114 which require that the beneficiaries must receive an Evidence of Medical Benefits with a detailed of the services and expenses incurred during a quarter. ASES compliance office will review the compliance with the Law.

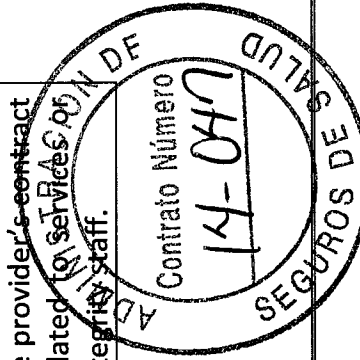


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Title SA10	Cooperation with Medicaid Fraud Control Units
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to communicate findings and to cooperate with any Puerto Rico or federal law enforcement agency. To request that all contracted companies must communicate preliminary findings to ASES.
General	The organization must have a mechanism to provide information to the regulatory and legal authorities on cases, investigations, schemes and any other activity where intention to commit fraud, abuse and waste of services occur.
Guidelines	<p>The PIP must demonstrate it has an effective mechanism to cooperate with the Medicaid anti fraud unit as well as with other program divisions in charge of preventing and prosecuting cases related to fraud, waste and abuse of services under the Medicaid program.</p> <p>The PIP must establish a process to guarantee the organization complies with the following:</p> <ul style="list-style-type: none"> ✓ All cases of suspected provider fraud are referred to the anti fraud / integrity organization's unit. ✓ If the anti fraud / integrity unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for -- <ol style="list-style-type: none"> i. Access to, and free copies of, any records or information kept by the organization or its contractors; ii. Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit; iii. Access to any information kept by providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of recipients; ✓ Communicate to ASES preliminary findings; and ✓ On referral from the unit, coordinate with ASES or appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a provider. <p>The PIP must recommend the organization to have in the provider's contract a disclaimer that as a contracted provider any data related to services or payments provided must be available for review of the integrity staff.</p>

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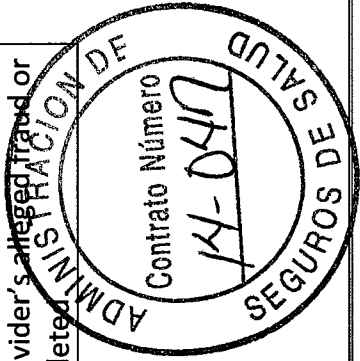


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Title SA11	Withholding of payments in cases of fraud or willful misrepresentations
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on elements to be considered when withholding of payments to providers who committed fraud or willful misrepresentation.
General	The organization should consider withholding payments to providers as a mechanism to prevent wrong disbursement of payments when suspect of fraud.
Guidelines	<p>The PIP will establish a mechanism and adhere to the following recommendations when considering withholding of payments:</p> <p>(a) <i>Basis for withholding.</i> The organization may withhold capitation or claims payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. The organization may withhold payments without first notifying the provider of its intention to withhold such payments. A provider may request, and must be granted, administrative review where State law so requires.</p> <p>(b) <i>Notice of withholding.</i> The organization must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must:</p> <ul style="list-style-type: none"> ✓ State that payments are being withheld in accordance with this provision; ✓ State that the withholding is for a temporary period, and cite the circumstances under which withholding will be terminated; ✓ Specify, when appropriate, to which type or types of payment (capitation or claims) withholding is effective; and ✓ Inform the provider of the right to submit written evidence for consideration by the agency. <p>(c) <i>Duration of withholding.</i> All withholding of payment actions under this section will be temporary and will not continue after:</p> <ul style="list-style-type: none"> ✓ The agency or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider; or ✓ Legal proceedings related to the provider's alleged fraud or willful misrepresentations are completed.

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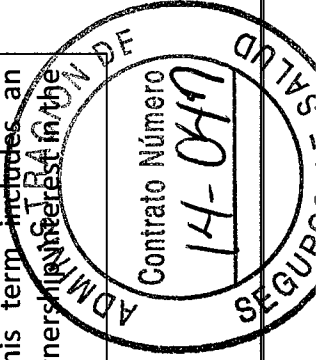


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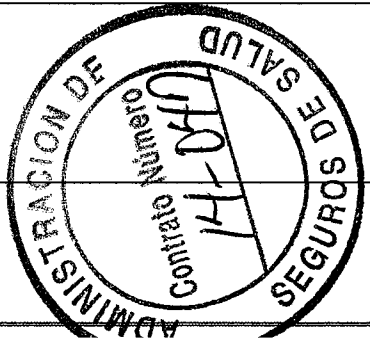
Title SA12	Disclosure of Information by Providers and Fiscal Agents
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide definition of concepts in order to fully adhere to the regulation on providers control and ownership of facilities.
General	The organization must adhere to standard definitions when dealing with disclosure of information by providers and fiscal agents when establishing mechanism to regulate providers control and ownership of facilities.
Guidelines	<p>The PIP will adhere to the following <u>definitions</u> of concepts to keep consistency with federal regulation and application of law:</p> <p><i>Agent</i> means any person who has been delegated the authority to obligate or act on behalf of a provider.</p> <p><i>Disclosing entity</i> means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.</p> <p><i>Other disclosing entity</i> means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the federal programs (Medicaid, SCHIP, FQHC's). This includes:</p> <ul style="list-style-type: none"> (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. <p><i>Fiscal agent</i> means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.</p> <p><i>Group of practitioners</i> means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).</p> <p><i>Indirect ownership interest</i> means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in the disclosing entity that has an indirect ownership interest in any entity that has an indirect ownership interest in the disclosing entity.</p>

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Guideline	
	<p><i>Managing employee</i> means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.</p> <p><i>Ownership interest</i> means the possession of equity in the capital, the stock, or the profits of the disclosing entity.</p> <p><i>Person with an ownership or control interest</i> means a person or corporation that –</p> <ul style="list-style-type: none">(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;(e) Is an officer or director of a disclosing entity that is organized as a corporation; or(f) Is a partner in a disclosing entity that is organized as a partnership. <p><i>Significant business transaction</i> means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.</p> <p><i>Subcontractor</i> means –</p> <ul style="list-style-type: none">(a) An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement. <p><i>Supplier</i> means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).</p>

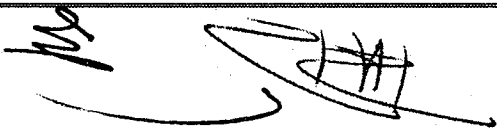


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Guideline	<i>Wholly owned supplier</i> means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.
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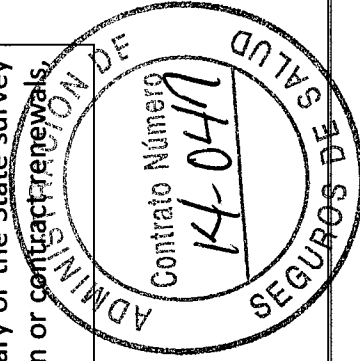
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Title SA13	Disclosure by disclosing entities: Information on ownership and control.
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidelines on what information must be disclosed by entities that have ownership and control over facilities.
General	The organization must have a mechanism to monitor on a timely manner the providers and fiscal agents that owns or control facilities where Medicaid beneficiaries receive services.
Guidelines	<p>The PIP must require each disclosing entity to disclose the following information in a timely manner:</p> <p>(a) <i>Type of Information that must be disclosed.</i></p> <ul style="list-style-type: none"> ✓ The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more; ✓ Whether any of the persons named is related to another as spouse, parent, child, or sibling. ✓ The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must – <ul style="list-style-type: none"> (i) Keep copies of all these requests and the responses to them; (ii) Make them available to the Secretary or the Medicaid agency upon request; and (iii) Advise the Medicaid agency when there is no response to a request. <p>(b) <i>Time and manner of disclosure.</i></p> <ul style="list-style-type: none"> ✓ Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified to the organization. ✓ Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified. <p>Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.</p>

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Guidelines

(c) *Provider agreements and fiscal agent contracts.* The organization shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

The PIP will include the process to provide an annual report to the grantee and sub-grantee on above information and data.

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Title SA14	Disclosure by providers: Information related to business transactions.
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	The organization must establish a mechanism to facilitate the providers disclose information related to their business transactions when own or control facilities where Medicaid beneficiaries received services.
Guidelines	<p>The PIP must describe the mechanism to allow providers owning or controlling facilities disclose information related to business transactions.</p> <p>The PIP must attest the organization abide by the following regulation:</p> <p>(a) <i>Provider agreements.</i> The organization must enter into an agreement with each provider or provider group under which the provider agrees to furnish to it or to the grantee / sub-grantee on request, information related to business transactions.</p> <p>(b) <i>Information that must be submitted.</i> A provider must submit, within 35 days of the date on a request by the organization full and complete information about –</p> <ul style="list-style-type: none"> ✓ The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and ✓ Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request. <p>The PIP must include withholding of payment processes and procedures to enforce above guideline.</p>

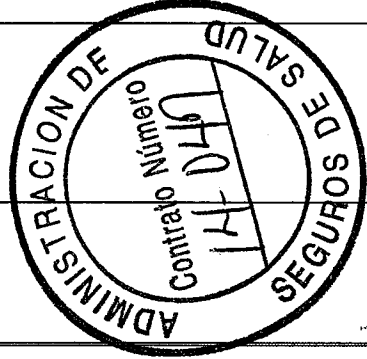
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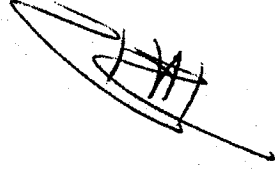
Title SA15	Disclosure by providers: Information on persons convicted of crimes
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on type of information providers must report in compliance with integrity program.
General	The organization is obliged to request providers to report any conviction of crimes or any other in the program integrity regulation.
Guidelines	<p>The PIP must include a mechanism to confirm information included below is considered as part of the integrity activities.</p> <p>(c) <i>Information that must be disclosed.</i> Before the organization enters into or renews a provider agreement, or at any time upon written request by the organization, the provider must disclose to the organization the identity of any person who:</p> <ol style="list-style-type: none"> (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. <p>(b) <i>Notification to Inspector General.</i></p> <ol style="list-style-type: none"> (1) The organization must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information. (2) The organization must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program. <p>(c) <i>Denial or termination of provider participation.</i></p> <ol style="list-style-type: none"> (1) The organization may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. (2) The organization may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.



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ATTACHMENT #15



ATTACHMENT 15
ELECTRONIC HEALTH RECORD SPECIFICATIONS

1. **Overview:** Primary Care Physicians (PCPs) and physician specialists within the Preferred provider Network (PPN) shall have and operational Electronic Health Record ("EHR") system in their practice in place on or before July 1, 2013. The EHR system must be certified by (i) an Office of the National Coordinator Authorized Testing and Certification Body ("OCN-ATCB") and (ii) the Certification Commission for Healthcare Information Technology ("CCHIT") to participate in the MI Salud Program. The purpose of implementing an EHR is to: (i) become a Meaningful User of Health Information Technology (HIT); (ii) improve quality of care; (iii) maximize cost-efficiency; (iv) connect with a Health Information Exchange ("HIE") hub; and (v) allow patients to access their personal health information through a mechanism such as Personal Health Record (PHR).

2. **HER System Specifications:** To comply with technological as well as MI Salud model of care requirements, the EHR system shall:

Be certified by an ONC-ATCB

2.2 Be certified by the CCHIT

2.3 Be capable to perform SureScripts-certified ePrescribing

2.4 Be supported by one of the major drug-databases such as:

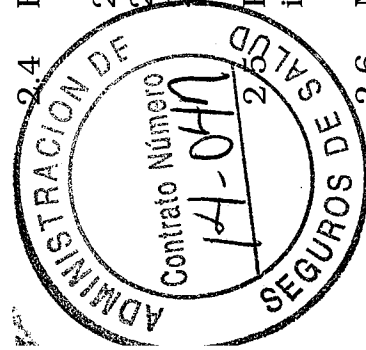
- 2.4.1.1 First DataBank;
- 2.4.1.2 MediSpan; or
- 2.4.1.3 Multum

Provide for ePrescribing Clinical Decision Support ("CDS") interaction checks.

2.6 Meet federal meaningful use objectives and measures in force at any given time. For example, during stage 1, must implement, at minimum, the capacity to detect drug-drug and drug-allergy interactions, as well as drug-formulary checks.

2.7 Support applicable (according to practice) federally mandated transactions and code-sets standards, as follows:

2.7.1 Transactions CCD, CDA, HL7, X12, NCPDP, and others.



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2.7.2 Code-Sets ICD, CPT, HCPCS, NDC, CDT, LOINC, and SNOMED.

- 2.8 Be certified by, and connected to, the Puerto Rico Health Information Network ("PRHIN"), the ONC-supported and the state-designated entity or organization for HIE, as its services are made available. The EHR system must also be able to connect to other alternative hubs and be capable of reading and importing CCD files.
- 2.9 Support compliance and reporting of CMS quality measures.
- 2.10 Provide electronic copy of health information or clinical summaries to patients and other providers.
- 2.11 Support electronic submittal of public health and/or reportable-disease/conditions data as these capabilities are made available in Puerto Rico.
- 2.12 Be capable of quality monitoring.
- 2.13 Be capable of prospective-preventive services management.
- 2.14 Have mental and physical health integration capabilities.
- 2.15 Have screening capabilities according to age group, gender and risks factors.
- 2.16 Have an EPSDT prospective tracking system.
- 2.17 Have the capacity to register members on Special Coverage.
- 2.18 Have the capacity to generate an electronic referral.
- 2.19 Have the capacity to update MI Salud's drug formulary.
- 2.20 Provide electronic referral to the Contractor's clinical programs.
- 2.21 Document Enrollee's Advance Directive preferences.
- 2.22 Document Enrollee's moral or religious objections.
- 2.23 Generate a Prior Authorization request to the Contractor.
- 2.24 Provide access to a Network Provider's education module.



3. **Contractor's Certification Program:** The Contractor will develop and implement a Certification Program for Electronic Medical Record ("EMR") with technological requirements as well as MI Salud model of care requirements. Compliance with the established requirements will be taken into consideration to determine PCP qualification for the Physician Incentive Plan, as defined in Section 10.7 of the Contract.

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