First MEDICAL HEALTH PLAN, INC.

Compliance Program 2018

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MESSAGE FROM THE CHAIRMAN OF THE BOARD OF DIRECTORS AND FROM THE PRESIDENT OF FIRST MEDICAL HEALTH PLAN, INC.

First Medical Health Plan, Inc. (FMHP) is committed to complying with all applicable Federal and local rules and regulations. Since our foundation in 1977, integrity, honesty, fair dealing and full compliance with all applicable laws have guided our business practices. We support the establishment of this Corporate Compliance Program to provide a guidance to further our day-to-day commitment that our business operations comply with all applicable Federal and State laws and regulations and to promote adherence to, and allow for, the efficient monitoring of compliance with all applicable statutory, regulatory and Medicaid program requirements including fraud, waste and abuse and integrity program requirements.

We believe that the compliance efforts are fundamentally designed to establish a culture within the organization that promotes the prevention, detection and resolution of instances of conduct that do not conform to federal and state law, or to federal healthcare program requirements. Relevant and applicable requirements established by the Centers for Medicare & Medicaid Services (CMS), Health Insurance Portability and Accountability Act (HIPAA), Office of the Inspector General (OIG), Puerto Rico Health Insurance Administration (PRHIA) the Offices of State Insurance Commissioners, among others has been taken into consideration when developing these Corporate Compliance Program.

FMHP's Corporate Compliance Program provides for the existence of a Compliance Officer who has overall responsibility and accountability for compliance matters. However, FMHP's Board of Directors, employees, directors, contractors, subcontractors and delegated entities are responsible for understanding government regulations, complying with them and abide to the standards set forth herein, as well as FMHP's policies and procedures.

At FMHP your opinion is valued, and we stand for our Policy of open lines of communication. We encourage and enable the reporting of non-compliance issues without fear of retribution. If you have questions, concerns, or comments related to our Corporate Compliance Program, we appreciate that you contact the Compliance Officer. Each of you is a fundamental part of the success of our Compliance Program. Do it right first!

Cordially,

Eduardo Artau Gomez
Chairman of Board of Directors

Francisco J. Artau Feliciano
President

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COMPLIANCE PHILOSOPHY

First Medical Health Plan, Inc. (FMHP) is a native company at the service of our community. For over forty (40) years, FMHP has dedicated its efforts to improving the quality of life of our people through the planning and implementation of medical services coverage of the highest quality in a cost-effective manner. Compliance plays a critical role in the health care industry.

FMHP is committed to ensuring compliance with all applicable laws, regulations, and policies governing our daily business activities. Therefore, we have developed this Compliance Program to provide guidance in compliance requirements and to serve as mechanism to help prevent, detect and report any illegal, improper or unethical conduct within our company including fraud, waste and abuse and integrity program requirements.

It is the FMHP philosophy to: (1) assure compliance with the highest ethical standards and with all applicable state and federal laws and requirements, (2) educate employees, contractors, subcontractors, delegated entities and Board members on FMHP's Compliance Program, Code of Conduct and Ethics, and compliance requirements, (3) promote open lines of communications to report without retaliation any inappropriate, unlawful or non-compliant conduct.

We strive to promote a culture of compliance that harmonizes with our day to day business operations and enrollee's trust. It is our objective to continue to foster such a culture in order to conduct business in a way that is ethical and transparent. Compliance policies and procedures are clearly documented in our Compliance Policy and Procedures Manual. Overview training is provided to help you understand and become familiar with FMHP's internal policies and procedures. Our compliance structure will help you on achieving a strong and fair culture of compliance, proving assistance on compliance matters and ensure you are equipped to comply with healthcare industry's regulatory regime. Everyone employed and/or contracted by FMHP are required to comply with the FMHP's Compliance Program. **You do not have to fear for retaliation about reporting a noncompliance activity.**

While FMHP's Compliance Program is not intended to serve as the compliance program for our clients, contractors, subcontractors or delegated entities, it is important that they perform services in a manner that complies with federal and state laws and regulations. All of them should develop their own compliance program and incorporate certain provisions of FMHP's Compliance Program. However, it is the responsibility of clients, contractors, subcontractors and delegated entities to report any issue of non-compliance, Fraud Waste and Abuse and violations of laws/regulations to FMHP in a timely manner.

OUR MISION

Offering services of excellence in the field of medical plans, supported by the most advanced technology to achieve total satisfaction of our client.

OUR VISION

To be a known and a respected institution due to it continued commitment with the excellency.

OUR VALUES

- Serve our customers with honesty, integrity and human warmth.
- To offer excellent services quickly and efficiently.
- Work as a team, with enthusiasm and dedication.
- Be accessible and effective in our communication.
- Always give the best to fulfill our commitment to excellence.

INTRODUCTION

First Medical Health Plan, Inc. (FMHP) Corporate Compliance Program, was developed to ensure that the organization and its subsidiaries meet all relevant requirements mandated by the Centers for Medicare & Medicaid Services (CMS), Office of the Inspector General (OIG), Health Insurance Portability and Accountability Act (HIPAA), Puerto Rico Health Insurance Administration (PRHIA), 42 CFR §§ 455, Title V of the Civil Rights Act of 1964, the Office of the Advocate for Patient Bill of Rights of the Commonwealth of Puerto Rico, the Office of the Commissioner of Insurances of Puerto Rico, among others.

The Corporate Compliance Program is designed with the main goals towards;

i) Ensure compliance with applicable federal and state laws and regulations related to the provision of services to our plan participants;

ii) Education of employees, contractors and subcontractors, Board of Directors and delegated entities on its standards;

iii) Promote compliance with FMHP's Code of Conduct and Ethics and encourage employees to report potential problems that may be detrimental;

iv) Prevent, detect and report any illegal, improper or unethical conduct and to promote an ethical corporate culture;

v) Provide procedures for promptly and effectively conduct internal monitoring and auditing which may prevent non-compliance; and

vi) Prevention, Detection and Reporting Fraud, Waste and Abuse

The Corporate Compliance Program is intended to provide guidance for compliance efforts on an individual and organizational-wide basis. The Program applies to all employees, contractors, vendors, delegated entities and FMHP's Board of Directors. The main objective of the Corporate Compliance Program is to assure full compliance with all healthcare requirements, identify risk areas and preventing unethical misconduct and enhance operational functions while improving the quality of healthcare services.

The Compliance Program provides for the designation of a Compliance Officer who has overall responsibility and accountability for compliance matters. However, all FMHP employees, business associates, contractors and delegated entities are fully responsible and accountable for their compliance with the standards described in this Compliance Programs, applicable laws and regulations as well as Corporate and departmental policies and procedures.

It is the policy of FMHP that the Corporate Compliance Program must states the following specific objectives:

(1) Board of Directors members, FMHP's employees and contractors, subcontractors and Delegated Entities are instructed regarding applicable laws and trained in Compliance Policies and Procedures and Standards of Conduct.

(2) The responsibilities of the Compliance Officer and Compliance Committee must be clearly defined.
(3) Promote open lines of communication.
(4) Guarantee periodic auditing, monitoring, and oversight of compliance with applicable laws, regulations, and contract requirements.
(5) Develop an atmosphere to detected deficiencies that encourages the reporting of non-compliance issues without fear of retribution.
(6) Establish mechanisms to promptly investigate, discipline, and correct non-compliance issues.
(7) Enforcement of Disciplinary Standards.

FMHP Corporate Compliance Program is only effective if you commit to complying with standards describe in the Program. It is important that you understand and comply with the words written in this Compliance Program. If you have any doubt, ask your supervisor or call FMHP's Compliance Officer.

SECTION 1

DEVELOPMENT OF COMPLIANCE POLICIES AND PROCEDURES AND STANDARD OF CONDUCT

FMHP will have policies; procedures and standards of conduct that:

- Articulate commitment to comply with Federal and State standards;
- Describe compliance expectations;
- Implement operation of the Compliance Program;
- Provide guidance on dealing with compliance issues;
- Identify how to communicate compliance issues;
- Describe how compliance issues are investigated and resolved;
- Include policy of non-intimidation and non-retaliation.

Employees, contractors, subcontractor and delegated entities will be periodically trained regarding the Compliance Program, and new compliance policies and procedures that may, from time to time, be adopted. In general terms, all supervisors and directors may be involved in the processes related to the evaluation, preparation, or review of departmental policies and procedures. FMHP Board of Directors expects that our Management Staff to do the following.

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

Management will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Corporate Compliance Program or failing to detect violations of the Compliance Program where reasonable diligence would have led to the discovery of a non-compliance issue.

1.1 Policies and Procedures Development

Policies and Procedures are an important tool used in order to be able to perform our day to day activities. These include a detailed and specific process of an operational or risk area, are easy to read and comprehend and include the Federal or State requirement. The purpose of these is to provide all FMHP employees guidance in order to assure compliance with Federal and State guidelines.

The Corporate Compliance Program have policies for all risk areas to assure compliance including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH), conducting excluded persons monitoring, conducting investigations, responding to external investigations, providing conflicts of interest management, identity theft, whistleblower protections, non-retaliation, and reporting compliance concerns. The main function of FMHP's written policies, procedures and standards of conduct are:

- Describe FMHP's compliance expectations;
- Implement the operation of the Corporate Compliance Program;
- Articulate our commitment to comply with all applicable Federal and State standards;

- Provide guidance to employees and others on dealing with suspected, detected or reported compliance and potential FWA issues and how to communicate compliance issues to appropriate compliance personnel;
- Describe the Compliance, FWA and other regulatory trainings requirements;
- Describe the operation of the Alert Line of Fraud and Compliance (hotline) and FMHP's policy of non-intimidation and non-retaliation for good faith participation in the compliance program; and
- Describe how suspected, detected or reported non-compliance and FWA issues are investigated and resolved by the organization.

As mandated by the General Inspector Office, Policies and Procedures must be created and revised, due to changes in laws and requirements, on an annual basis or as needed. All department directors/managers/supervisors are responsible for developing, revising, updating, implementing and distributing their policies and procedures. All Policies and Procedures require at least a Department Director and/or Manager signature to be effective. The Compliance Department is responsible for reviewing and approving the Policies and Procedures and all employees are responsible for reviewing and understanding these policies and procedures.

1.2 Communicating Policies and Procedures

Policies and Procedures shall be communicated prior implementation or within ninety (90) days of hire and annually thereafter to all FMHP employees, including BOD, Directors, Managers, Supervisor and all regular and temporary employees. All FMHP Department managers shall ensure all Policies and Procedures are updated and readily accessible to all affected employees. Such information can be communicated verbally or via distribution of the approved Policy and Procedure.

1.3 Code of Conduct and Ethics

FMHP Corporate Compliance Program enforces compliance with the Code of Conduct Policy by communicating expectations to employees. As a result, FMHP continually provides standards through its Code of Conduct and Ethics approved by the Board and are distributed annually. All Board members, employees and subcontractors are required to review the Code of Conduct and Ethics, disclose any information that may result in a conflict of interest with its relationship

with FMHP and sign a form attesting to have received the Code of Conduct and Ethics. The Human Resources Department will maintain copies of the executed forms. This must be executed within ninety (90) days of hire or contracting and annually thereafter.

We each have the responsibility to adhere to the guidelines established in FMHP's Code of Conduct and Ethics, as well as to follow all Company policies and procedures. You must ensure that your job performance is consistent with this Code of Conduct and Ethics. If you have any doubt about a potential issue of non-compliance you must ask yourself the following questions when conducting business:

- It is the best for our Company?
- Is this the right thing to do?
- Is any law regulation being violated? The best for the company?
- Is this permitted under our Code of Ethics and Business Conduct and policies and procedures?

If you are aware, or become aware of suspected, potential or actual unethical practice or a violation of the Code of Ethics and Business Conduct, you must report it to your immediate supervisor and to the Compliance Department's management as soon as possible. Failure to abide by the Code of Conduct and Ethics or the guidelines for behavior that the Code represents may lead to disciplinary action. For alleged violations of the Code, FMHP will weigh relevant facts and circumstances, including, but not limited to, the extent to which the behavior was contrary to the express language or general intent of the Code, and other factors that FMHP deems relevant.

Compliance with this Code of Ethics and Business Conduct and other aspects of the Company's Corporate Compliance Program is a condition for employment. Discipline for failure to abide by the Code, at FMHP's discretion, range from oral warning up to termination. If you have questions, concerns or believe improper conduct is being demonstrated (your own or someone else's) you should contact the Compliance Officer or Human Resources Department.

1.4 Compliance with federal and state laws and regulations

FMHP is subject to a wide variety of laws and regulations. All FMHP's activities must be conducted by employees, contractors and/or delegated entities in compliance with all

applicable federal and local laws, as well as regulatory guidance and requirements. Company policies and procedures shall be reviewed at least annually, or on an as-needed basis to ensure compliance with new and/or revised Federal and local government mandates. Some of those laws/regulations address, for example, privacy and confidentiality concerns, accuracy and retention of records, antitrust, employment opportunities, discrimination, sexual harassment and fraud and abuse, among others.

Compliance department will forward the notice to the affected department managers and/or subcontractors to review and implement all applicable mandates and ensure Policies and Procedures support such changes. Department managers and subcontractors must confirm that changes were applied in writing to the Compliance Department.

FMHP must assure compliance with the following, but not limited to federal laws and regulations:

- Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119);
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191);
- False Claims Acts (31 U.S.C. §§ 3729-3733);
- Federal Criminal False Claims Statutes (18 U.S.C. §§ 287, 1001);
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b (b));
- Civil monetary penalties of the Social Security Act (42 U.S.C. § 1395w27 (g));
- Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn);
- Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act;
- Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 U.S.C. §1395w-27(g)(1)(G); and
- Fraud Enforcement and Recovery Act of 2009.

Each one of these plays an important role in ensuring compliance with policies and procedures and legal regulatory requirements. If you are concerned about possible or potential misconduct, you must report it immediately to your supervisor and to the Compliance Officer. The Compliance Officer is responsible to make sure your concern is appropriately handled.

Privacy and Confidentiality Information

FMHP employees are in possession of and have access to a broad variety of confidential and sensitive member Personal and Protected Health Information (PHI) and proprietary company information. We must maintain the confidentiality and privacy of PHI of plan participants and other confidential information in accordance with legal and ethical standards.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules protect the privacy and security of individually identifiable health information. Whether the information is on a computer, paper, or other media, you have responsibilities for safeguarding health information. The HIPAA Privacy Rule covers protected health information (PHI) in any medium, while the HIPAA Security Rule covers electronic protected health information (e-PHI). HIPAA Rules have detailed requirements regarding both privacy and security.

HIPAA Privacy Rule requirements:

- Apply to most health care providers, including those who do not have Electronic Health Records or do not participate in a CMS Electronic Health Records incentive program;
- Set a federal floor for protecting individually identifiable health information across all mediums (electronic, paper, and oral);
- Limit how covered entities may use and disclose individually identifiable health information they receive or create;
- Give individuals rights with respect to their protected health information, including a right to examine and obtain a copy of information in their medical records, and the right to ask covered entities to amend their medical record if information is inaccurate or incomplete;
- Impose administrative requirements for covered entities, such as training of employees with regard to the Privacy Rule; and
- Establish civil and criminal penalties.

FMHP employees, contractors and delegated entities have an obligation to protect and safeguard confidential and proprietary information to prevent the unauthorized disclosure of information. Also, FMHP's Business information, marketing ideas, financial data, payment and

reimbursement information, and information relating to negotiations (with employees or third parties) must be safeguard in strict confidence.

SECTION 2

RESPONSIBILITIES OF THE COMPLIANCE OFFICER & COMPLIANCE COMMITTEE

The Compliance Department is a service department for all FMHP Employees. The Compliance Department is responsible for overseeing the Compliance Program and to assure compliance with federal and state regulations and standards.

The Compliance Department will:

- Demonstrates its commitment to responsible Corporate Conduct.
- Assure compliance with government regulations and internal guidelines.
- Encourage FMHP employees to report potential problems.
- Ensure prompt thorough investigations of possible misconduct
- Ensure that all internal procedures are HIPAA compliant.
- Identify fraud and abuse, and other inappropriate activities.

2.1 Compliance Officer

The Compliance Officer is the individual assigned to enforce the implementation of this Corporate Compliance Program. With direct access to the Board of Directors, the Compliance Officer has the access and authority to ensure full compliance to the Program.

The Compliance Officer is assigned to report key compliance issues reviewed in the Compliance Committee meetings to the Board of Directors. Additionally, the Compliance Officer serves as liaison to federal and state government agencies. The Compliance Officer is responsible for:

- Serving as a liaison between FMHP and the PRHIA and regulatory agencies.
- Supervise, implement, evaluate and update the Compliance Program.
- Receive, analyze and disseminate federal and state regulations.
- Reporting key compliance issues reviewed in the Compliance Committee meetings and to the Board of Directors.
- Developing programs to encourage managers and employees to report non-compliance issues or other irregularities.
- Auditing and Monitoring operational areas and delegated entities.

- Facilitating investigations from regulatory agencies.
- Monitoring corrective action plans.
- Assuring that all employees receive and understand the Compliance Program.

2.2 Board of Directors

FMHP's Board of Directors is responsible for reasonable oversight of the Compliance Programs overall effectiveness. The Board of Directors is responsible for:

- Setting the tone at the top, both internally and externally, and promulgating a compliance charter or values statement
- Approving the Standards of Conduct;
- Provide Strategic Guidance;
- Assist and oversee the implementation of the Program and Ethical Standards;
- Requires meaningful, substantive reporting on the organization's compliance and ethics activities;
- Maintain a deep understanding of the compliance monitoring, testing, and issue resolution processes;
- Understanding the whistleblower helpline process and taking active control when appropriate;
- Understanding the risks and key issues related to the Program;
- Aligning employee incentives;
- Receive reports of governmental compliance enforcement activity such as Notices of Non-Compliance, Warning Letters and/or more formal sanctions; request reports of List of Organizational Risks and examine how the organization's compliance plan addresses the most significant risks;
- Promote compliance by insisting on relevant, regular and substantive reporting to the board about the organization's compliance and ethics activities; and
- Monitor the performance of management against established compliance benchmarks and the effectiveness of the Program.

2.3 Communicating with the Board

To support the zero-tolerance philosophy, the Board of Directors will be kept abreast of all compliance issues and the status of the Program. The Compliance Director shall report directly

to the Board of Directors on a quarterly basis. Compliance will be a permanent agenda item in the Board meetings at least three times annually.

In the event the Compliance Director becomes aware of significant issues, he/she must notify the Board immediately. The Board shall kept Meeting Minutes which shall be sent to all members and approved during the next meeting.

2.4 Corporate Compliance Committee

The Compliance Committee is established by FMHP's Board of Directors (the "Board") with the purpose of: (1) assure the organization is in full compliance with the regulatory standards established by the Puerto Rico Health Insurance Administration (PRHIA), the Office of the Insurance Commissioner (OCS), as well as other applicable federal and state regulations and, (2) oversee the implementation of FMHP's Compliance Program and internal policies and procedures designed to respond to compliance and regulatory risks facing the Company.

The Compliance Committee ("Committee") shall assist FMHP's Senior Management in its responsibilities relating to the organization's operational compliance with applicable legal requirements and ethical standards and will act as an independent review and evaluation body to:

- Ensure Compliance Program's issues and concerns within the organization are being appropriately evaluated, investigated and resolved.
- Assist the Compliance Officer in fulfilling its oversight responsibility for the Company's compliance and ethics programs, policies and procedures.
- Performance of any other duties as directed by the Board of Directors.

Composition, Structure and Organization

The Compliance Committee and Compliance Officer are vested with the authority to discharge their oversight responsibility as hereafter described. A representative of FMHP's Board of Director shall be the Chair of the Compliance Committee. In the absence of a representative of the Board of Director, the Compliance Officer or the Vice-President of the Regulatory Affairs Division will serve as interim chairman of the Compliance Committee and will assume all duties and responsibilities.

Committee members are selected to assure an appropriate representation of all management departments and service centers. The Compliance Committee includes the following voting members:

1. At least two (2) Representatives of FMHP Board of Directors
2. Compliance Officer
3. Vice-President of Regulatory Affairs
4. Vice-President of Operations
5. Vice-President of Medical Affairs
6. Vice-President of Finance
7. Chief Legal Counsel and Director of SIU

Other individuals may be invited to join the Compliance Committee or participate in the committee meetings as determined by the Compliance Committee or Compliance Officer, as needed.

The Compliance Committee, as established by the Board of Directors will be responsible for:

- Meeting at least on a quarterly basis, or more frequently as necessary to oversee the integrity of the company's Annual Compliance Plan and the organization's compliance to such plan;
- Overseeing the company's compliance with Federal and State regulatory requirements.
- Overseeing the results of the company's Federal and State audits and internal audit functions;
- Overseeing the effectiveness of the Compliance Program;
- Developing strategies to promote compliance and the detection of any potential violations;
- Reviewing and approving compliance and FWA training, and ensuring that training and education are effective and appropriately completed;
- Assisting with the creation and implementation of the compliance risk assessment and of the compliance monitoring and auditing work plan;
- Assisting in the creation, implementation and monitoring of effective corrective actions;
- Supporting the compliance officer's needs for sufficient staff and resources to carry out his/her duties;

- Ensuring that the plan has appropriate, up-to-date compliance policies and procedures;
- Distributes written standards, including policies, that are readily understandable by all members and employees (including policies that have been translated into other languages, if necessary) to members of the workforce with a need to know the applicable Company standards; and,
- Ensuring that the plan has a system for employees, contractors and delegated entities to report potential instances of Medicare program noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation;
- Performs other functions as necessary to carry out the objectives of the Corporate Compliance Program.
- The Compliance Committee may also address other compliance related issues as they evolve.

In the event the Compliance Officer becomes aware of significant issues, he/she must notify the Board immediately.

2.5 Department Directors and/or Managers

All Department Directors and/or Managers are responsible for supporting the FMHP's Compliance Program by adhering to its requirements. Department Directors and/or Managers must review all Federal and State laws and regulations applicable to the healthcare industry and make all necessary modifications to ensure compliance.

In addition, the Department Director and/or Managers are responsible for:

- Reviewing and disseminating Federal and local government regulations to FMHP department staff.
- Developing Policies and Procedures that accurately reflect Federal and local government regulations.
- Responding timely to all audits and inquiries.
- Facilitating the process for employees to report suspected non-compliance and fraud, waste, abuse and other improprieties without fear of retaliation.

- Reporting suspected non-compliance and fraud, waste, abuse and other improprieties through the Fraud, Waste, and Abuse hotline or appropriate government entity and/or law enforcement agency.
- Conducting job-specific annual compliance training for FMHP employees.

2.6 FMHP Employees

The success of the FMHP's Compliance Program rests with the participation of all FMHP employees. All employees are responsible for recognizing and adhering to Federal and Local government regulations and company Policies. FMHP employees are responsible for recognizing and reporting potential fraud, waste, abuse, and other improprieties. In addition to those responsibilities listed in job descriptions, all employees are responsible for:

- Reviewing all applicable Federal and Local government regulations.
- Signing and adhering to the requirements of the Code of Conduct.
- Reporting Conflicts of Interests.
- Responding timely to all audits and inquiries.
- Reporting suspected non-compliance and fraud, waste, abuse and other improprieties through the Fraud, Waste, and Abuse hotline or appropriate government entity and/or law enforcement agency.
- Participating in training programs as mandated by this Program.

SECTION 3

TRAINING AND EDUCATION

FMHP's Corporate Compliance Program can be effective only if employees receive a proper education and training. Regulatory trainings are offer by the Knowledge Management Department to FMHP's employees and Delegated Entities on a routine basis to communicated and explained compliance expectations. Employees, including Senior Management, Directors and Managers; Board of Directors members; and delegated entities are trained early in their employment or contracting upon, and annually thereafter. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies and procedures set forth in this Compliance Program, and corporate code of conduct and ethics.

Training programs also include sessions highlighting this Compliance Program, summarizing fraud, waste and abuse laws, physician self-referral laws, and related business.

3.1 Training Attendance Requirement Policy

All FMH's employees, Board members, subcontractors, and employee of subcontractors, will be required to attend and participate in the Compliance Training Program. Attendance will be monitored through sign-in sheets and/or examinations. At a minimum, each employee, subcontractor, and employee of a subcontractor must demonstrate attendance at:

- Annual Compliance Training
- New Hire Compliance Training
- Specialized or Job-Specific Training

Attendance and participation in these training workshops are conditions of employment with FMHP.

3.2 New Hire Training

Compliance training sessions are conducted and documented for all new employees (including part-time, full-time, contracted or temporary employees), physician advisors and any other healthcare professional advisors within ninety (90) days of their hire date. The initial regulatory training includes, but not limited to:

- In-depth review of the Code of Conduct and Ethics;
- Compliance Program;
- HIPAA Privacy and Security;
- Fraud, Waste and Abuse

3.3 Annual Training

Annually all FMHP employees, including the President and Board of Directors, must complete the Compliance trainings which are, but not limited to:

- Code of Conduct;
- Compliance Program;
- HIPAA Privacy and Security; and
- Fraud, Waste and Abuse

3.4 Training Examination Requirements Policy

The purpose of the examination is to demonstrate the participant understands of the training workshop content. The examination must, at minimum, include compliance questions relative to workshop content. Training sessions require a knowledge verification examination, when possible, via online learning to demonstrate knowledge. A FMHP employee failing to successfully complete the training examination with an acceptable score of 85% will be subject to re-testing. Continued failure to pass the exam will require retraining. In such case, an attestation must be signed by the employee and facilitator documenting the retraining. When appropriate, the employee may be subject to further disciplinary action up to and including termination.

3.5 Regulatory Trainings

A. HIPAA Privacy Rule

FMHP employees are in possession of and have access to a broad variety of confidential and sensitive member Personal and Protected Health Information (PHI) and proprietary company information. We must maintain the confidentiality and privacy of PHI of plan participants and other confidential information in accordance with legal and ethical standards.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules protect the privacy and security of individually identifiable health information. Whether the information is on a computer, paper, or other media, you have the responsibility for safeguarding the health information. The HIPAA Privacy Rule covers protected health information (PHI) in any medium, while the HIPAA Security Rule covers electronic protected health information (e-PHI). HIPAA Rules have detailed requirements regarding both privacy and security.

B. HIPAA Privacy Rule requirements:

- Apply to most health care providers, including those who do not have Electronic Health Records or do not participate in a CMS' Electronic Health Records incentive program;
- Set a federal floor for protecting individually identifiable health information across all mediums (electronic, paper, and oral);

- Limit how covered entities may use and disclose individually identifiable health information they receive or create;
- Give individuals rights with respect to their protected health information, including a right to examine and obtain a copy of information in their medical records, and the right to ask covered entities to amend their medical record if information is inaccurate or incomplete;
- Impose administrative requirements for covered entities, such as training of employees with regard to the Privacy Rule; and
- Establish civil and criminal penalties.
- FMHP will ensure compliance with HIPAA and applicable Federal and Puerto Rico laws and regulations that pertain to Enrollee rights, by requiring reasonable steps to limit access to the minimum necessary, avoiding unnecessary or inappropriate access, use or disclosure of PHI. FMHP employees, contractors, subcontractors and agents will have limited access to PHI to the minimum necessary in order to carry out the job duties, functions, and/or responsibilities. FMHP employees, contractors and delegated entities have an obligation to protect and safeguard confidential and proprietary information to prevent the unauthorized disclosure of information. Also, FMHP's Business information, marketing ideas, financial data, payment and reimbursement information, and information relating to negotiations (with employees or third parties) must be safeguard in strict confidence.

FMHP will publicize the criteria that govern the type of information about members that shall be safeguard and the legal sanctions imposed for improper use and disclosure of any of the following information:

- Names and addresses;
- Medical services provided;
- Social and economic conditions or circumstances;
- Agency evaluation of personal information;
- Medical data, including diagnosis and past history of disease or disability; and
- Any information received for verifying income eligibility and amount of medical assistance payments.

- Any information received in connection with the identification of legally liable third party resources.
- Social Security Numbers
- FMHP will provide copies of these provisions to members and to other persons and agencies to which information is disclosed and will place posters in strategic places visible to the general public informing the criteria that govern the confidentiality of the information. FMHP will include these provisions in the Enrollee Handbook.

C. Fraud, Waste and Abuse

Employees, Contractors, Board of Directors and Delegated Entities shall be trained on FMHP's commitment to make business in following the highest standards of ethics and fully compliance with all regulatory requirements. Training on Fraud, Waste and Abuse (FWA) emphasizes confidentiality, anonymity, and non-retaliation for compliance-related questions, or suspected or detected non-compliance or potential FWA.

We shall report to the Compliance Officer actual or suspected noncompliance or potential FWA. Training will provide us:

- Disciplinary guidelines for non-compliant or fraudulent behavior
- A review of potential conflicts of interest and FMHP’s disclosure/attestation form.
- Examples of reportable non-compliance that and employee might observe and report.
- Reviews of laws that govern the employee conduct under the Medicaid Program.
- Educational information on Fraud, Waste and Abuse is available for providers and beneficiaries on FMHP’s website. For beneficiaries, FMHP provides education on Fraud, Waste and Abuse through the Enrollee Handbook and the Explanation of Benefits.

FMHP will develop communication materials with Fraud, Waste and Abuse information. This for example might include but will not be limited to:

- Newsletters for employees, providers and general public.
- Display of posters or other materials in prominent places in FMHP’s facilities.
- FMHPS’s intranet portal is available for all employees where they can learn more about Compliance and Fraud, Waste and Abuse issues, as well as methods of reporting them.

D. Code of Conduct

The Compliance Program enforces the Code of Conduct Policy by communicating expectations to employees. As a result, FMHP continually provides standards through its Code of Conduct and Ethics which are approved by the Board of Directors. All Board members, employees and subcontractors are required to review the Code of Conduct and Ethics and disclose any information that may result in a conflict of interest with its relationship with FMHP. The Human Resources Department will maintain copies of the executed Forms. All Board members, employees and subcontractors shall sign a form attesting to have received the Code of Conduct and Ethics. Such must be executed within ninety (90) days of hire or contracting and annually thereafter.

Failure to abide by the Code of Conduct and Ethics or the guidelines for behavior that the Code represents may lead to disciplinary action. For alleged violations of the Code, FMHP will weigh relevant facts and circumstances, including, but not limited to, the extent to which the behavior was contrary to the express language or general intent of the Code, and other factors that FMHP deems relevant. Discipline for failure to abide by the Code, at FMHP discretion, range from oral warning up to termination.

E. Cultural Competency

In accordance with 42 CFR 438.206, FMHP has a Cultural Competency plan that ensures that services are provided in a culturally competent manner to all Enrollees.

What is cultural competency in health care?

In general, it is a set of skills that allows someone to increase their understanding and appreciation of cultural differences between groups. There are many different things that make up a person's cultural identity, including country of origin, language, race, ethnicity, education, family, spiritual traditions, traditional medical and dietary practices, and much more. In simple terms, cultural competency in health care is the ability to interact successfully with FMHP beneficiaries from various ethnic and/or cultural groups. In practice, this involves:

- Understanding and respecting each patient's cultural identity;

- Effective cross-cultural communication between the patient and the health care provider, including the availability of health-related language resources such as translators and translated educational material; and
- The ability of both the health care provider and the patient to access additional cultural support services when needed.

FMHP provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual Enrollees and protects and preserves the dignity of each individual. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

SECTION 4

OPEN LINES OF COMMUNICATIONS

4.1 Communications

In compliance with federal laws and regulations, PRHIA Guidance's, and the U.S. Sentencing Commission Guidelines among others and through a variety of methods, FMHP's Compliance Department will communicate to Board of Directors members, employees, contractors and subcontractors on FMHP's Compliance Policies and Procedures, the Code of Conduct and Ethics, regulatory guidelines, and/or changes in the law. Communication methods can include one-on-one conversations, broadcast emails, mailings to individual employee, Board Member or subcontractor, education sessions, small-and large-group meetings, periodic newsletters, and our intranet website.

All employees, contractors, subcontractors and delegated entities have the responsibility to comply with all applicable laws and regulations and report any real or perceived acts of non-compliance. Any of them who know of a non-compliant act and fail to report them will be subject to discipline. FMHP has an active policy to keep open lines of communications and will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any member, provider, employee, subcontractors who exercises any of his/her rights or

provides information of inappropriate, unlawful or non-compliant conduct. Reports can be made anonymously through the help line if the caller desires.

4.2 Internal Communications

FMHP has developed several methods of internal communication to provide orientation and guidance on issues related to compliance and fraud, waste and abuse, emphasizing the importance of detection, prevention and correction of inefficiencies.

- Distribution of letters.
- Corporate Newsletters.
- Training Material.
- Posters or other materials located at key office locations.

FMHP has established an island wide, toll-free telephone line (Whistleblower Hotline) to provide you with the necessary tools to report instances of potential fraud, waste or abuse and non-compliance issues mainly affecting our beneficiaries, our providers and subcontractors. Employees, Providers, Beneficiaries and Subcontractors can communicate directly by calling the **Fraud and Compliance Alert Line at 1-866-933-9336.**

An additional mechanism to address concerns in writing via email to alertafraude@firstmedicalpr.com to report possible or actual situations related to fraud, misuse and abuse. Or to alertacumplimiento@firstmedicalpr.com to promptly and effectively receive, retain and treat concerns and complaints of any incident of wrongdoing.

Calls and emails may be submitted anonymously or otherwise. All communications made to the Hotline shall be kept with outmost confidentiality at all times. Employees may also direct questions or concerns to their Supervisor, FMHP Compliance Officer or the Special Investigations Unit Personnel.

The informant needs to provide the Special Investigations Unit ("SIU") with as much detail as possible on the incident. If available, should provide:

- Description of the incident.
- When informant became aware of the incident.

- Date(s) the incident occurred.
- Specific individuals involved in the incident.
- If available, provide documentation/evidence.

FMHP's members, providers and subcontractors can report suspected cases of fraud, waste, abuse and overpayments via one of the following methods:

Fraud and Compliance Alert Line	
1-866-933-9336 **24 hours/7 days**	In writing to: **First Medical Health Plan, Inc.** **PO Box 191580** **San Juan, PR 00918-1580**
alertacumplimiento@firstmedicalpr.com alertafraude@firstmedicalpr.com	

Also, FMHP's employees, members, providers and subcontractors can report suspected cases of fraud, was and abuse to the applicable federal and state regulatory agency as specified in the Medicaid contract and/or applicable law, including but not limited to the U.S. Department of Health & Human Services Office of Inspector General:

U.S. Department of Health & Human Services Office of Inspector General ATTN OIG HOTLINE OPERATIONS PO Box 23489 Washington, DC 20026	Telephone: 1-800-HHS-TIPS (1-800-447-8477)	email: HHSTips@oig.hhs.gov Online: oig.hhs.gov/report-fraud
	Fax: 1-800-223-8164 TTY: 1-800-377-4950	

4.3 Integrating Federal and Local Government Mandates

All FMHP Policies and Procedures shall be reviewed at least annually, or on an as-needed basis to ensure compliance with new and/or revised Federal and local government mandates relating to the Medicaid program. This includes, but is not limited to: the Anti-Kickback statute and the False Claims Act.

Upon receipt of Federal and local government documents (i.e., PRHIA notices, CMS updates, etc.), the Compliance Department will forward the notice to the affected department managers and/or subcontractors to review and implement all applicable mandates and ensure Policies

and Procedures support such changes. Department managers and subcontractors must confirm that changes were applied in writing to the Compliance Department.

4.4 Reporting Organization Changes to Agencies

FMHP must notify all Federal, State, and applicable accrediting entities in writing within thirty (30) days of any significant organizational, operational or financial changes including, but not limited to:

- Changes in the organization such as mergers, change in majority interest, consolidation, name change, additional services or locations, major renovations,
- Any interruption in service that exceeds 30 calendar days,
- Changes in state license or federal certification or qualifying status,
- Significant change in managed care enrollment, significant changes in a managed care delivery system or staff membership,
- Bankruptcy, or other significant change in the financial viability of the organization,
- Any government investigation, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers.

SECTION 5

ENFORCEMENT OF DISCIPLINARY STANDARDS

The main functions of FMHP's written policies, procedures and standards of conduct are:

- Describe FMHP's compliance expectations;
- Articulate our commitment to comply with all applicable all Federal and State standards;
- Provide guidance to employees and others on dealing with suspected, detected or reported compliance and potential FWA issues and how to communicate compliance issues to appropriate compliance personnel;

It is FMHP's policy to establish an appropriate discipline for failure of any Company personnel to comply with the Code of Ethics and Business Conduct, policies, and procedures set forth in, or adopted pursuant to, this Compliance Program or any federal or state laws or regulations.

Employees who violate the Code of Conduct and Ethics are subject to disciplinary sanctions, including but not limited to, termination of employment. All FMHP employees found to be involved in violations of FMHP's policies and procedure, the Compliance Program, or any inappropriate activities will be subject to disciplinary action depending on the severity of the activity. A FMHP employee engaging in activities deemed by FMHP as inappropriate is subject to immediate disciplinary action based on the seriousness of the activity. Fraudulent activities are subject to immediate termination.

Disciplinary action is taken against employees who authorize or participate directly in a violation of applicable state to federal law, the Code of Conduct and Ethics, or Policies and Procedures, and any employees who have deliberately failed to report such a violation or who hinders an investigations. FMHP will discipline any employee who has deliberately withheld relevant and material information concerning a violation of applicable state and/or federal law, the Code of Conduct and ethics or the applicable Policies and Procedures and takes appropriate action to prevent reoccurrence.

FMHP shall review the DHHS-OIG list of excluded individuals and entities and the GSA Excluded Parties Lists System (EPLS) web-based System for Award Management (SAM) Exclusion Database, and applicable estate exclusion lists prior to hiring and monthly thereafter, for names of excluded employees, contractors, providers, subcontractors and vendors barred from participation in Medicare, Medicaid, other health care programs, federal contracts and state health care programs. Any individual or entity ineligible for Federal program participation will be immediately terminated.

FMHP will not knowingly contract with or retain on its behalf, any person or entity which has been:

1) Convicted of a criminal offense related to health care (unless such person or entity has implemented a compliance program as part of an agreement with the federal government); or
2) Listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation or receipt of federal funds.

Excluded, terminated, suspended individuals or entities are not hired, employees or contracted by FMHP or its subcontractors to provide services or items to Medicaid members.

SECTION 6

INTERNAL MONITORING AND AUDITING

FMHP's Compliance Officer is responsible of the establishment and implementation of a routine monitoring plan for the identification of compliance risks. This work plan includes internal and external monitoring and audits to evaluate FMHP's departments, subcontractors and delegated entities compliance with federal and state requirements, policies and procedures and the overall effectiveness of the Compliance Program.

The Audit and Monitoring Unit must deliver regular reports to the Compliance Officer showing results of the auditing and monitoring activities and the status and effectiveness of corrective actions taken. It is the responsibility of the Compliance Officer to provide updates on monitoring and auditing results to the Compliance Committee, Quality Committee and the Board of Directors. If the Audit and Monitoring Unit identifies a potential offenses or a possible fraud, waste and/or abuse, the unit must notify the Special Investigations Unit immediately to investigate and take the applicable corrective actions.

6.1 Internal Audit Monitoring

An annual risk assessment will be conducted (by the Internal Audit Department) to identify major risk areas for compliance factors that will be considered for determining risk level include but are not limited to:

a. Financial impact
b. Regulatory impact (Compliance, Law and Government Regulations)
c. Reputational impact (Complaints. Dissatisfied customers, breaches of policies or standards)

Assessment includes marketing and enrollment violations, agent/broker misrepresentation, credentialing, appeals and grievance procedures, utilization management, accuracy of claims processing, among others. A monitoring and auditing work plan will be developed for issues on non-compliance.

6.2 Delegated Entities Audit and Monitoring

The Compliance Department's Delegation Oversight Unit oversees compliance of FMHP's delegated functions. The Compliance Department's Audit and Monitoring Work plan includes activities to monitor the delegated entities. The delegated entities will have a pre-delegation audit and at least an annual monitoring/audit activity. The pre-delegation audit shall be performed during the contract negotiations with the entity. The results of the monitoring and audit activities will be reported to the Delegation Oversight Committee (DOC) and the Compliance Committee. The Compliance Committee will determine and inform to the Board of Directors the recommendation to delegate with action plan and not delegate FMHP functions to an entity.

6.3 Compliance Program Effectiveness

The Compliance Officer must assure the effectiveness of the Compliance Program. To guarantee this effectiveness, the Compliance Program must be audited at least annually. The Compliance Department will to monitor the compliance program effectiveness self-assessment tool; dashboards or scorecards. The Compliance Officer will share results with the Compliance Committee, senior management and Board of Directors.

6.4 Compliance Investigations

An investigation of a particular practice or suspected violation must involve a review and analysis of the relevant documentation and records, interviews, and applicable laws and regulations, as well as review of data and medical/claims records. All investigations must be conducted under the evaluation of the VP of Regulatory Affairs. The VP of Regulatory Affairs and the Compliance Officer may recommend administrative decisions to Compliance Committee and Board of Directors.

The results of any investigation must be thoroughly documented and retain until final disposition is approved by the VP of Regulatory Affairs and Legal Counsel.

SECTION 7

RESPONSE TO DETECTED DEFICIENCIES

FMHP recognize that the success of the Compliance Program is related to the integrity of our associates and their commitment to compliance. FMHP's Compliance Program includes Policies and Procedures to screen potential associate's independent contractors, and vendors against the Office of Inspector General's list of excluded individuals/entities (LEIE) report and/or the General Services Administration (GSA) exclusion lists. FMHP will not hire persons who have been convicted of a criminal offense related to healthcare or have been excluded, debarred, suspended, or are otherwise ineligible to participate in Federal healthcare programs. Human Resources Department shall investigate the background of all employees and contractors prior to hiring by checking with all applicable licensing and certification authorities that any requisite licenses and certifications are valid.

Demonstrated non-compliance with federal and state regulations or Fraud, Waste, and Abuse by a contractor, subcontractor, and employee of a contractor or subcontractor will result in further corrective action including contract termination with FMHP. Pending of the resolution of any federal criminal charges or proposed debarment or exclusion of a current employee, that employee shall be removed from the direct responsibility for or involvement in any coding or billing processes, and any other activity related to a federal healthcare program. Although each situation is considered on a case-by-case basis, FMHP will consistently undertake appropriate disciplinary action to address inappropriate conduct and deter future violations.

Additionally, reports of potential or actual compliance issues related to FMHP's Medicaid program must be reported to the PRHIA, Centers for Medicare & Medicaid Services (CMS) and/or Office of the Inspector General (OIG) for further investigation.

SECTION 8

WHISTLEBLOWER PROTECTION AND NON RETALIATION POLICY

FMHP complies with all state and federal requirements for government-sponsored programs, including the Federal False Claims Act, the Deficit reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, applicable Whistleblower Protection laws, and any applicable state laws.

FMHP will not tolerate harassment or victimization and will take action to protect those who raise a concern in good faith. FMHP will do its best to protect an individual's identity when he

or she raises a concern and does not want their name to be disclosed. It must be appreciated, however, that the investigation process may reveal the source of the information and a statement by the individual may be required as part of the evidence. If an allegation is made in good faith, but it is not confirmed by the investigation, no action will be taken against the originator. However, individuals make malicious or vexatious allegations, action may be considered against the individual making the allegation.

FMHP recognizes that the decision to report a concern can be a difficult one to make, as it can generate a negative reaction from those responsible for the malpractice. FMHP will not tolerate harassment or victimization and will take action to protect those who raise a concern in good faith.

FMHP protects the individual's identity when he or she raises a concern and does not want their name to be disclosed. It must be considered, however, that the investigation process may reveal the source of the information and a statement by the individual may be required as part of the evidence. In addition, FMHP has an island wide toll free Whistleblower Alert Line (1-866-933-9336) to report instances of potential fraud, waste or abuse and non-compliance issues mainly affecting our beneficiaries, employees, our provider, and first tier, downstream and related entities. FMHP included in its employee handbook a specific discussion of the False Claims Act and on the enrollee handbooks protections in place for the whistleblowers. If an allegation is made in good faith, but it is not confirmed by the investigation, no action will be taken against the originator. If, however, individuals make malicious or inappropriate allegations, action may be considered against the individual making the allegation.

Also, any private person ("Qui Tam Relator") may bring a civil action for any False Claim (itemized above) in the name of the United States government. The federal government gets an opportunity to review the complaint and the disclosure of substantially all of the material evidence and information the person possesses to decide whether to intervene. If the federal government decides to intervene, then it has the primary responsibility for prosecuting the action for the False Claims, and the person, who originally brought the action, the Qui Tam Relator, may receive from 15% to 25% of the proceeds of the action or settlement of the claim. If the federal government does not proceed with the action and the Qui Tam Relator continues

with the action or settles the claim, he or she may receive an amount from 25% to 30% of the proceeds of the action or settlement. The Qui Tam Relator may also receive an amount for reasonable expenses, including reasonable attorney fees and costs incurred in connection with bringing the lawsuit.

FMHP abides by the federal law which protects individuals who investigate or report possible False Claims made by their employer against discharge or discrimination in employment because of such investigation. FMHP will not discriminate and will protect Employees from retaliation. Employees, who are discriminated against based on whistleblowing activities may sue in court for damages.

Under the federal law, any employer who violates the whistleblower protection law is liable to the employee for:

1) Reinstatement of the employee's position without loss of seniority;
2) Two (2) times the amount of lost back pay; and
3) Compensation for any special damages.

Therefore, it's FMHP's commitment to protect individuals who report violations or suspected activities and comply with regulatory requirements to not discriminate against employees for its direct or indirect participation on Fraud, Waste and Abuse investigations.
For all whistleblower allegations received through a preliminary investigation will be carry out to determine the authenticity of the allegations. In the alleged fraud, waste or abuse is substantiated; a formal full investigation is initiated by the Special Investigations Unit ("SIU"). The allegations can be received from the Alert Line, email, letter or any other source.

SECTION 9

FRAUD, WASTE AND ABUSE

FMHP's Integrity and Compliance Program's goals and objectives includes endeavors to monitor, audit, and evaluate compliance with FMHP's policies and procedures, including efforts to monitor the activities of subcontractors and vendors as well as follow all federal and local rules, laws, regulations and other requirements, deter and prevent future fraud, waste and

abuse, ensure the highest quality of care for our beneficiaries This program scope all employees, subcontractors, providers, suppliers and beneficiaries.

The nature of FMHP's reviews as well as the extent and frequency of FMHP compliance monitoring and auditing varies according to a variety of factors, including new regulatory requirements, changes in business practices, and other considerations. FMHP will continue to identify new and emerging risk areas and address these risks. FMHP's comply in all respects with Puerto Rico Health Insurance Administration's (PRHIA) Guidelines for the Development of Program Integrity Plan, included on Attachment 14 of PRHIA's Contract.

As part of the program performance evaluation, the Special Investigations Unit generate a monthly and quarterly report that includes statistics of all ongoing and closed investigations, financial recoupment, providers suspensions, etc. and report it to PRHIA. Administration personnel track these scores in order to monitor performance and identify improvement measures.

FMHP maintains a strict *zero-tolerance* policy toward fraud, waste and abuse. The purpose of investigating these activities is to protect the beneficiary, government, and/or FMHP from paying more for a service than it is obligated to pay. However, FMHP's *zero-tolerance* policy is not limited to cases of fraud, waste, or abuse. FMHP also investigates instances of waste as well as any inappropriate activities.

Fraud, Waste and Abuse policies and procedures, as well as the Compliance Plan and Program Integrity Plan will be submitted to PRHIA for prior written approval. Any changes on these policies and procedure will be submitted to PRHIA for approval within fifteen (15) calendar days before its implementation date. The changes will not get into effect until PRHIA provides written approval.

9.1 Definitions: Fraud, Waste and Abuse ("FWA")

- ***Fraud****:* is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to 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. 18 U.S.C. § 1347.

- ***Waste****:* is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- ***Abuse****:* includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Abuse also involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

9.2 Investigation Analysis

These cases are assigned to a Fraud Analyst who shall conduct a preliminary investigation and depending on the results it will be assigned to the Fraud Investigator.

The research process involves the use of objective methods to identify potential cases of fraud and conducting a detailed intervention. These include the following processes:

- Opening and document the case;
- Initiate the process to obtain pertinent information;
- Medical Record Analysis;
- Perform interviews to verify the information obtained;
- Prepare the finding report;
- Refer case to the next level; and
- Close the case.

As part of our commitment to prevent, detect and correct fraud, waste and abuse, the Fraud Analyst of the Special Investigations Unit hereinafter ("SIU") proactively uses various methods

generally accepted in auditing processes for the identification, investigation and referrals in cases where there are overtones of fraud or suspected fraud, without interfering with the rights of the provider or enrollee.

The intervention plan of the SIU Department also includes a systematic approach using the data analysis process. This integrated analysis process is a very effective component in the activity of detecting and preventing fraud. In this process the following elements protrude:

- Red Flag
- Identification of cause
- Retention of Payments
- Establishment of actions and sanctions

Once the research phase concluded, the case is referred to relevant agencies, whether the case is resolved or has been closed. FMHP maintains within its organizational structure necessary procedures to refer cases of fraud to governmental agencies and law enforcement.

The protocol of the SIU Department contains investigative steps to work fraud cases in conjunction with our Legal Department, State and Federal authorities, among which include, but are not limited to the Puerto Rico Health Insurance Administration ("PRHIA"), the Department of Justice, Medicaid Fraud and Control Unit, ("MFCU"), Department of the Health and/or the Office of Inspector General (OIG).

As part of our commitment to prevent, detect and correct fraud, waste and abuse, the Fraud Analyst of the Special Investigations Unit hereinafter ("SIU") proactively uses various methods generally accepted in auditing processes for the identification, investigation and referrals in cases where there are overtones of fraud or suspected fraud, without interfering with the rights of the provider or enrollee.

The Compliance Officer has the authority to report pressing issues directly to FMHP's Board of Directors. If the case to be reported to the Board is of such magnitude that it cannot wait for the next programmed Board Meeting, the Compliance Officer may request an extraordinary Board Meeting. Said request must include a brief summary of the urgent matter to be discussed. The Board will review the request and will notify their availability.

9.3 Preliminary Investigation Process

When the SIU Department receives a complaint regarding the GHP Medicaid Program regarding fraud, waste and abuse from any source or identifies any questionable practice, it performs a preliminary investigation following the guidelines and processes mentioned below:

- FMHP must notify PRHIA within a two (2) days period of any preliminary investigation undertaken for a suspected complaint or scheme of fraud, waste and abuse involving a provider, a beneficiary or others.
- FMHP must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
- FMHP must immediately notify PRHIA of pending Provider Network investigations, suspensions and debarment and from any other person, within one business day.
- These cases shall be notified to the Anti-Fraud Unit of PRHIA.
- Those cases of possible fraud involving eligibility will be referred directly to the Puerto Rico Regional Medicaid Office and will be included in the quarterly report of FWA to PRHIA.
- The preliminary investigation minimum requirements when evaluating providers and beneficiaries includes:
    - Source of information;
    - Identification method;
    - Cause for investigation;
    - Case documentation;
    - Analysis of data and documents;
    - Report of findings; and
    - Recommend Action.
- FMHP has implemented procedures to keep track of all preliminary investigations and results. As soon as a potential case of fraud, waste and abuse case is detected or received in confidence or request for investigation, it's included in a register called FWA Log. The register shall contain at least the following information:
    - Number assigned to the case.
    - Who files the petition or confidence (if it is anonymous or known)?

- Form in which the case was received (i.e.: email, hotline, by mail or in person).
- Type of organization involved, if required.
- Date in which the investigation was opened.
- Date in which the investigation was closed.
- Name of the employee that performed the investigation.
- Disposition and resolution of the investigation.
- Nature of the investigated allegations.
- Implemented Corrective Actions, if any.

- After a case was included in the registry, SIU proceeds to open a case file with all available information, which may contain:
  - Who files the information (if it is an anonymous source, indicated so in the file)
  - Informant telephone and address (if provided)
  - Brief description of suspected fraud, waste or abuse.
- These cases are assigned to an SIU Investigator who, along with the SIU Analyst, shall conduct the preliminary inquiry or full investigation following the investigation protocol.
- Fraud, Waste and Abuse suspected cases related to pharmacy services or complaints from beneficiaries related to pharmacy services will be forwarded to the Pharmacy Benefit Manager (PBM) and to PRHIA.
- FMHP shall subsequently prepare a preliminary investigation report within ten (10) business days since the moment the potential Fraud, Waste, or Abuse was identified.
- FMHP shall subsequently report preliminary results of such investigations activities in writing to PRHIA within two (2) Business Days of completing the preliminary investigation.
- FMHP might request time extension request, if necessary, to complete a preliminary investigation.
  - To request this extension, FMHP is required to submit to PRHIA a written justification before the initial ten (10) day period expires.
  - This request must be sent via electronic mail at **asesprogramintegrity@asespr.org** to the Compliance Officer of PRHIA.
  - Once the request for extension is evaluated and justified, PRHIA might grant such extension request for up to fifteen (15) business days.

- PRHIA’s reply should be received by FMHP via electronic mail within two (2) business days after requested.
- If the extension is not grantee FMHP should furnish the Preliminary Report.

If the finding of the preliminary investigation provides FMHP reason to believe that an incident of fraud, waste and abuse has occurred in the Medicaid program, FMHP must take appropriate action, and conduct a full investigation. If FMHP does not recommend a full investigation, PRHIA might still request the completion of a full investigation.

9.4 Full Investigations Process

After notifying PRHIA of the preliminary investigation findings, FMHP shall conduct a full investigation. The Full Investigation steps and processes are explained below:

- Specify and conduct when a case requires a full investigation.
- Full investigations must be done in accordance with federal regulation and based in FMHP policies and procedures.
- For case referral to appropriate Law and Governmental Agencies, FMHP will refer to the appropriate law enforcement agency and PRHIA when there is a reason:
    1) To suspect a provider has engaged in fraud or abuse of the program.
    2) To suspect a member is defrauding the program.
    3) To suspect a member has abused the Medicaid program.
- FMHP will cooperate with all duly authorized Federal and Puerto Rico agencies and representatives in reporting, investigating and prosecuting Fraud, Waste and Abuse.
- FMHP shall have thirty (30) calendar days to complete the full investigation.
- If the full investigation is not completed within thirty (30) calendar days, FMPH must submit a Full Investigation Status Report every thirty (30) days. For any investigation that extends more than ninety (90) calendar days, FMHP must request, via email, a meeting with PRHIA.
- FMHP will provide the results of its full investigations in writing to PRHIA within five (5) Business Days of completing the investigation. This report shall include any referrals made to the US Attorney's Field Office, HHS-OIG and actions taken by FMHP.
- FMHP and its Subcontractors will cooperate fully with Federal and Puerto Rico agencies in Fraud, Waste, and Abuse investigations and subsequent legal actions, whether

administrative, civil, or criminal. Such cooperation shall include actively participating in meeting, providing request Information, access to record, and access to interviews with employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical matters or in any matter related to an investigation or prosecution. Such cooperation shall also include providing personnel to testify at any hearings, trials, or other legal proceedings on as-needed basis.

- Any full investigation must continue until:
  - Appropriate legal action is initiated.
  - The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse.
  - In case of any allegations and possible fraud, waste or abuse, FMHP will resolved the matter in accordance to established regulations by PRHIA, Federal and Local Laws and Regulations.
  - After receiving PRHIA's approval, the matter is resolved between FMHP and the provider:
    - During the discussion of audit findings
    - 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 FMHP Program Integrity Plan.

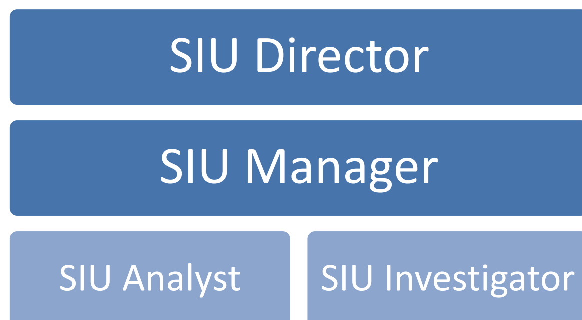
9.5 SIU Structure

The structure of the Special Investigations Unit-Integrity Department is as follows:

- **Director**: Reports directly to the Chief Legal Counsel and provides direction for the Unit.
- **Manager**: Reports directly to the SIU Director and is responsible of coordinate, supervises and oversees day to day SIU investigations.
- **SIU Investigators**: Reports directly to the SIU Manager. Investigate the results from the fraud analyst preliminary investigation, audit the medical records and perform the final investigations.

- **SIU Analyst:** Reports directly to the SIU Manager. Perform analysis and investigations activities on potential fraud issues related to providers and members and reviews claims scored high to detect different patterns.

Table1. SIU Structure- Organizational Chart



9.6 Approaches to Fraud, Waste and Abuse Prevention and Detection

FMHP program's goal is to combat fraud. Program elements include the following:

1. Pursuing fraud, waste and abuse recovery directly from Enrollees and Providers after a fraudulent payment is confirmed. FMHP's Special Investigations Unit hereinafter ("SIU") aggressively pursues recoveries of any amounts paid by FMHP related to identified fraud and abuse activities. FMHP may withhold payments to service providers in total or in part after receiving credible evidence that the facts giving scope to the need for retention involves fraud or willful misrepresentation under the Medicaid program. If FMHP determines that fraud or misrepresentation is clear and forceful, may withhold payments without the need to notify the provider of its intention to withhold such payments.
2. Claims edits to prevent payment of duplicate claims. Claims that successfully enter the claims processing system are assigned an internal control number that is used to track processing, adjudication decisions and payment information. Claims accepted for

processing are subjected to prepayment reviews such as verification of duplicate claims. The system will ensure that the services listed on a claim are: covered Medicaid services, medically necessary services, and services properly adjudicated.

Possible and exact duplicate service identification is made in the claims processing system as well as the claim editing software based on provider, enrollee, and service date and service codes. The claim editing software adds an additional layer of duplicate checking by identifying same service date and service codes billed by the same vendor but different providers.

3. Claims edits to address and correct up-coding. The claims editing software applies national correct coding initiatives (NCCI), American Medical Association (AMA), plus Medicare claims editing rules which include identification of unbundling and up-coding, gender/age edits, included surgical follow-up visits, mutually exclusive and frequency outliers among others.
4. Other claim edits to prevent fraud and abuse. The claims editing software applies national correct coding initiatives (NCCI), American Medical Association (AMA), plus Medicare claims editing rules which include identification of unbundling and up-coding, gender/age edits, included surgical follow-up visits, mutually exclusive and frequency outliers among others.
5. Post-processing review of claims. FMHP has developed and implemented a post-processing review of claims that allows us to monitor enrollee utilization profiles and provider service profiles to identify exceptions so that we can improve enrollees and providers utilization of services reducing the amount of unnecessary services. FMHP utilizes an editing tool for claims that creates outlier reports that include but not limited to Coding provider summary, unbundling top 40 cases and misrepresentation: double billing, churning outliers, E&M utilization and DME rental review.
6. Utilization analysis. FMHP has in place a unique and comprehensive Anti-Fraud Program to audit Medicaid claims. The objective of the program is to verify the accuracy and appropriateness of claims processing, to detect errors, abuses, atypical utilization patterns, wrongful utilization of covered services and to evaluate the services rendered by the participating provider. For identification of cases, the SIU Analyst can review reports by enrollee, date of service, provider or CPT codes. Some of these methods include: Electronic Data Exchanges; Data mining; Claims registry/reconciliation; Target procedures; Profiling.
7. Provider profiling and credentialing to address issues of abuse and patterns of up-coding. Provider profiling is a method used primarily to compare the practice patterns of providers

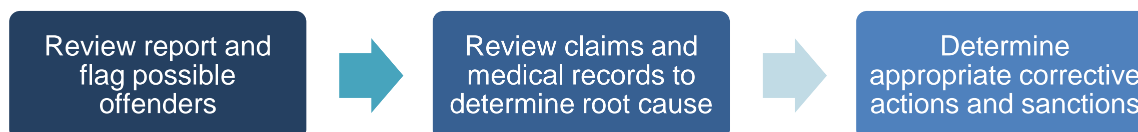
on specific measures of cost and quality. Profiling is usually accomplished retrospectively using claims or administrative data.

8. Process to verify with enrollees whether services billed by providers were received (SIU's Policies and Procedure). FMPH has established a methodology and sampling process in accordance with 42 CFR 408.608(a)(5) and 42 CFR 455.20.

FMHP performs claims audits to detect potential fraud, waste and abuse. These audits of provider billings are based on objective and documented criteria. FMHP will use reports generated from our database to score and profile providers and enrollees billing behavior and patterns. The claims editing software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or enrollee's prior billing history.

The claims editing software statistically identifies and compares provider peers in the same geographical area for the analysis of overutilization and up coding. FMHP will inform the provider of the billing irregularities and request an explanation of the billing practices. Also, we provide an orientation to the provider on billing guidelines and documentation. The SIU may conduct further investigation and take action as needed.

The SIU also conducts data mining on claims experience to identify outliers in trends, overutilization, and repetitive billing abuses. This process includes the following steps:



Special Investigations Data Mining Process

Our procedure results in reliable findings and actionable recommendations.

FMHP successfully detects, prevents and mitigates fraud waste and abuse using the approach described.

9.7 Risk Management

FMHP recognizes that for any Compliance Program to be successful, it must be supported by a comprehensive Risk Management Program. Through the Risk Management Program, FMHP can properly establish the Fraud, Waste and Abuse prevention and detection targets.

Further, it is a best practice for companies to revisit their risk assessment once a year to evaluate the effect of internal and external changes to the company and the marketplace. Therefore, FMHP has included risk management as a focus for its Compliance Program.

The Internal Audit Department conducts an Annual Risk Assessment to evaluate the effectiveness of risk management, control, and governance processes across the organization. The Annual Risk Assessment is a systematic approach to identify and evaluate risks associated with the achievement of First Medical's objectives, compliance with laws and regulations, and effectiveness of business processes and internal controls. The risk assessment is one of the tools utilized to create the Annual Internal Audit Plan, which is reviewed by the Audit Committee of the Board of Directors. Results of the risk assessment are also provided to executive leadership for consideration during strategic planning.

FMHP identifies the entities that could be responsible for fraud, waste and abuse incidents, such as: Beneficiaries, Subcontractors, Employees and Providers, including but not limited to Hospitals, Physicians & Mental Health Professionals, Durable Medical Equipment suppliers and Pharmacies.

Specific vulnerable areas for potential fraud, waste and abuse are mentioned the table below.

FMHP's Specific Vulnerable Areas

Clearly identified risks enable us to implement effective prevention and detection methods.

Risks for Potential FWA	
• Billing for medical services not provided or not related to treatment.	• Ordering of excessive services, especially diagnostic/genetic tests.
• Billing services for a higher charge than the ones rendered (up coding or unbundling).	• Provide services inconsistent with the diagnosis and treatment of the enrollee.
• Falsification of medical records or billing records to obtain a greater refund.	• Render or order services that are not medically necessary.
• Billing for services rendered by non-certified or unlicensed personnel.	• Provide medical service of poor quality or unsatisfactory to an enrollee.
• Receive bribes for the referral of patients.	• Billing to the patient for a balance remaining after the payment of the medical plan (balance billing).
• Lack of documentation on the medical record.	• Double billing by providers
• Billing on behalf of deceased persons.	• Stolen identity in order to obtain prescriptions.

• Doctor shopping under which beneficiaries visits several provider and/or pharmacies to obtain multiple prescriptions. In particular, target opioid based medications.	• Drug prescription diversion, in order to sell medications to someone else.

According to the Risk Management findings and gatherings, FMHP will identify the top three vulnerable areas and outline action plans to mitigate such risks. Based on the data collected over the last few years and experience, the top three (3) areas of vulnerability identified by FMHP are:

- Provide services inconsistent with the diagnosis and treatment of the enrollee.
- Doctor shopping under which beneficiaries visits several provider and/or pharmacies to obtain multiple prescriptions. In particular, target opioid based medications.
- Lack of documentation on the medical record.

FMHP's Risk Assessment has outlined an action plan to detect and mitigate the vulnerable areas which are described under Section 9.9, Detection and Mitigation of potential fraud, waste and abuse, of this Compliance Program.

9.8 Cooperation and Partnerships

FMHP shares its Fraud, Waste and Abuse policies, procedures and guidelines, as well as its Integrity Program, with its subcontractors, including the Pharmacy Benefit Manager for the Government Health Plan to ensure full cooperation with its detection and prevention efforts.

As part of the reporting and partnerships plan that FMHP has to meet potential fraud, waste and abuse ("FWA") targets, FMHP participates on the Medicaid Integrity Group ("MIG") meetings sponsored by PRHIA. The MIG is composed of representatives of PRHIA; MCO's participating on the GHP program, OIG federal agents and District Attorney from the Department of Justice (DOJ). During the meetings, MCO representatives present current cases to the government agencies, share detection and prevention strategies and outline swift actions taken to mitigate FWA cases presented. Through these meetings, the government agencies have been able to gather information to begin investigations related to healthcare fraud by enrollees and providers. An additional partnership that FMHP has is with its subcontractors. FMHP's delegated entities follow the Medicaid Program Integrity guidelines

and provide FMHP with the appropriate reporting information in order to prevent and detect fraud.

9.9 Detection and Mitigation of potential fraud, waste and abuse

FMHP maintains current policies and procedures that identify, detect, prevent and mitigate potential fraud, waste and abuse. Departmental Guidelines for potential cases involving fraud, waste and abuse may be identified by other departments following guidelines listed below for Surveillance and Utilization control programs and procedures. These guidelines safeguard against under-utilization, unnecessary or inappropriate use of covered services and against excess payments for covered services. This approach includes post-payment review process for FMHP personnel to develop and review enrollee utilization profiles; provider services profiles and exceptions criteria. SIU identifies exceptions so that FMHP correct and prevent inappropriate enrollee and provider practices. Any employee that identifies a potentially fraudulent provider or billing situation must complete the Special Investigation Unit Referral Form and refer to the appropriate channels.

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis should include simple identification of anomalies in billing patterns within claims or groups of claims that might suggest improper billing or payment. Data analysis itself shall be undertaken as part of general surveillance and review of submitted claims or shall be conducted in response to information about specific problems stemming from complaints, provider or enrollee input, fraud alerts or reports from the Center for Medicaid and Medicare Services ("CMS") and PRHIA including other government and non-governmental agencies. As part of the process to identify overpayments and manage recovery efforts, the SIU performs the following initiatives:

a. Analyze data to compare claim information and other related data to identify potential errors and/or potential fraud by claim characteristics (e.g., diagnoses, procedures, providers or enrollees) individually or in the aggregate. Data analysis is an integrated, on-going component of FMHP Program Integrity activity.
b. Use research and experience to develop new data analysis approaches and techniques.
c. Perform data mining to identify which areas of potential errors that pose the greatest risk, establish baseline data to enable the recognition of unusual trends, changes in

utilization over time or schemes to inappropriately maximize reimbursement identify where there is a need for clarification of Coverage Determinations.

d. Produce unique views of utilization or billing patterns to illuminate possible errors.
e. Identify program areas and/or specific providers for possible fraud investigations; and this data analysis program may involve an analysis of national data furnished by CMS or PRHIA as well as review of internal billing utilization and payment data to identify potential errors.
f. Monitoring billing of inactive providers in the past twelve (12) months for prompt terminations.

The frequency and methodology of the data analysis is crucial to these initiatives. SIU analyzes a minimum of 18 months of data but typically reviews 36 months of information. SIU compares the current 6-month period to the previous 6-month period to detect changes in providers' current billing patterns and to identify trends in new services. When dealing with very large volumes of data, data summaries or valid samples can be used. FMHP develops indicators that will be used to identify norms, abnormalities and individual variables that describe statistically significant time-series trends and the most significant abnormalities or trends. FMHP acknowledges that it is usually impractical or impossible to review all items or files when examining claims data especially if the volume of information is large, therefore SIU uses sampling methodologies to observe a random subset to learn about the multitude of items from which they are drawn. Upon drawing statistical inferences from this subset, they will state with a certain level of confidence that the inferences apply to the population as a whole. An SIU analyst choice of a sampling method depends on the specific objectives of the supervisory activity. Sometimes, the SIU analyst may choose a sampling method that is not statistical. That is, they may want to rely on judgment or specific knowledge about a population in selecting files for review, except for results from judgmentally derived sample to draw conclusions about a larger population.

Once data analysis and processes are complete, SIU follows established policies and procedures for preliminary and full investigations.

CONTACTS

Regulatory Affairs Department Jessica Losa Robles, MPH, MHSA, PHD Regulatory Affairs Vice president (787) 625-9557, ext. 2548 j.losa@firstmedicalpr.com
Compliance Department Nelly Cuevas Santiago, MSEM Corporate Compliance Director and Compliance Officer (787) 625-9557, ext. 2529 n.cuevas@firstmedicalpr.com/compliance@firstmedicalpr.com
Legal Affairs Carlos Santana Marrero, Esq. Chief Legal Counsel (787) 474-3999, ext. 2151 c.santana@firstmedicalpr.com