INTEGRITY PROGRAM

2024

First MEDICAL HEALTH PLAN, INC.

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INTRODUCTION

First Medical Health Plan, Inc. (FMHP) Fraud, Waste and Abuse Integrity Program, was developed to ensure that the organization and its employees, suppliers, providers, subcontractors and delegated entities 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 (PHRIE), 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 Insurance (OCS), among others.

FMHP's Fraud, Waste and Abuse Integrity Program goals and objectives include endeavors to monitor, audit, deter and prevent future fraud, waste and abuse, ensure the compliance with all federal and local rules, laws, regulations and other requirements. This program includes all employees, subcontractors, providers, suppliers, subscribers, and enrollees.

The nature of FMHP reviews, as well as the extent and frequency of fraud, waste and abuse monitoring and audits, 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 complies in all respects with OCS and ASES Guidelines for the Development of Integrity Program Plan, included on Attachment 14 of the ASES Contract. Regarding ASES, each year FMHP submits the Integrity Program for review and when ASES notifies any necessary revisions, FMHP will, within twenty (20) days of such notification, resubmit its Integrity Program for review and written approval by ASES. FMHP has an administrative and management structure to ensure compliance with the principles of integrity in the execution of its operations efficiently and effectively.

As part of the program performance evaluation, the Special Investigations Unit (SIU, for its acronym in English), generates monthly and quarterly reports that include statistics of all ongoing and closed investigations, financial recoupment, providers suspensions, among other statistics, in order to monitor performances 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 subscribers, (beneficiaries, state, and federal health programs), enrollees, 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, it includes waste or abuse. Also,

FMHP is not limited to cases of fraud, it includes misuse and abuse. In line with the above and through a thorough supplier credentialing process, in compliance with state and federal regulations, the FMHP Credentialing Department supports us by reinforcing our corporate policy of *zero tolerance* towards the FWA. This process includes verifying the provider applying to be part of our provider network as to their past or present association with providers who have been excluded from participating in the Medicaid program due to fraud, abuse, or misuse. (PPACA Section 6401, 6501, and 42 CFR Part 455, Subpart E.)

1. FRAUD, WASTE AND ABUSE (FWA):

1.1 DEFINITIONS:

- ***Fraud****:* An intentional deception or misrepresentation made by a person with the knowledge that the misrepresentation could result in some unauthorized benefit to themselves or some other persons. It includes any act that constitutes fraud under applicable Federal or State law.

- ***Waste****:* The thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government and/or FMHP resources. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

- ***Abuse****:* Excessive or improper use of a thing, or to use something in a manner contrary to the natural or legal rules for its use. This includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid Program and FMHP resources. Abuse can occur in financial or non-financial settings.

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 the 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.

1.2 THE SPECIAL INVESTIGATIONS UNIT STRUCTURE

FMHP has specialized personnel responsible for implementing and performing a systematic approach to data analysis. The Special Investigations Unit (SIU) is composed of a Director, Manager, Data Analysts and Researchers. The Director reports to the Chief

Legal Counsel and is responsible for the supervision and direction of the SIU. provides oversight and managerial direction for the SIU. The SIU Manager is responsible for the coordination and management of SIU data analysis and investigations.

The SIU analyst performs the data gathering and analysis for the investigations that will be conducted by the SIU Investigators. When results from the SIU analyst's preliminary investigation arrives, the investigators audit the medical records and perform final

investigations. Figure 1, shows the reporting relationships in the SIU.

Figure 1. Special Investigations Unit Structure.

The SIU provides analyses and investigations to address fraud, waste, and abuse at all levels, to deter unnecessary costs and to recoup funds for services that are not medically necessary and/or do not meet professionally recognized standards of care.

1.3 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 the guidelines for surveillance supervision and utilization control programs and procedures. These guidelines safeguard against over-utilization, unnecessary or inappropriate use of covered services and against excessive payments for covered services. This approach includes a post-payment review process, from FMHP personnel to develop and review enrollee utilization profiles, provider service profiles and, exceptions criteria. SIU identifies exceptions so that FMHP can correct and prevent inappropriate enrollee and provider practices. Any employee who identifies a potentially fraudulent provider or billing situation should report such activity via the fraud and compliance alert line or email address.

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 claims groups 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, subscriber or enrollee input, fraud alerts or reports from the CMS, OCS, 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 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 or create the greatest risk, establish baseline data to enable the recognition of unusual trends, changes in utilization over time or schemes to inappropriately maximize reimbursement.
d. Produce unique views of utilization or billing patterns to identify possible errors.
e. Identify program areas and/or specific providers for possible fraud investigations.
f. Monitor providers who have not submitted claims 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 with the previous 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, anomalies and individual variables that describe statistically significant time-series trends and the most significant anomalies or trends.

Also, FMHP establishes a monthly methodology and sampling process to verify with enrollees whether services billed by providers have been received. FMHP randomly selects paid claims for enrollees' service verification. This methodology includes criteria for identifying "high risk" services and provider types. The medical and pharmacy claims generated by providers under these vulnerability areas will be the provider types included in the sampling methodology.

FMHP acknowledges that it is not practical 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,

these will state with a certain level of confidence that the inferences apply to the population. A SIU analyst's 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 samples 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.

2. APPROACHES TO FRAUD, WASTE AND ABUSE PREVENTION AND DETECTION:

2.1 GOALS

The goal of the FMHP Integrity Program is to eliminate fraud, waste and abuse in the delivery of health services. The elements that integrate the program are the following:

1. *Pursuing fraud, waste, and abuse recovery directly from Enrollees and Providers after a fraudulent payment is confirmed*. FMHP's 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 Commercial line of business (Commercial) or Government Health Program (GHP). If FMHP determines that fraud or misrepresentation is clear and forceful, it may withhold payments without the need to notify the provider of its intention to withhold such payments.

2. *Use of systems that apply payment rules to detect and avoid the payment of duplicate claims.* Claims that successfully enter the claims processing system are assigned with 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 services covered by the corresponding line of business, whether commercial or GHP, that are medically necessary services, and services properly adjudicated. The claims processing system and the claims editing program identify possible duplicate services and are accurately based on the provider, beneficiary, date of service, and service codes. The claim editing program adds an element of additional duplication check by identifying the same date of service and the same service codes billed by the same contractor, but for different providers.

3. *Use of systems that apply payment rules to detect and avoid encryption is excessive.*

The claims editing software applies to national correct coding initiatives (NCCI), American Medical Association (AMA), plus Medicare and Medicaid claims editing rules which include identification of unbundling and up-coding, gender/age edits, including surgical follow-up visits, mutually exclusive and frequency outliers among others.

4. *Post-processing review of claims*. FMHP has developed and implemented a post-processing review of claims that allows SIU to monitor enrollee utilization profiles and provider service profiles to identify exceptions so FMHP can improve enrollees and providers' utilization of services, reducing the amount of unnecessary services. FMHP utilizes a claims 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, billing outliers, E&M utilization and DME rental review.

5. *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.

6. *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.

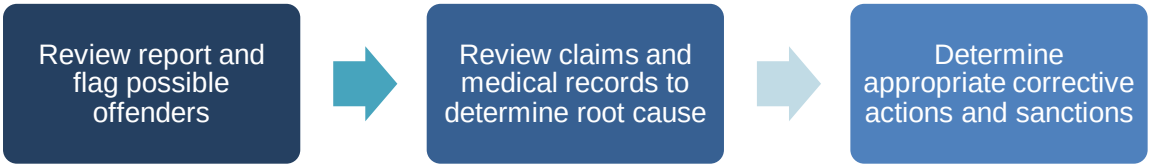
7. *Process to verify with enrollees whether services billed by providers were received (SIU's Policies and Procedure).* FMPH has established a methodology and sampling process in accordance with 42 CFR 408.608(a)(5) and 42 CFR 455.20.

FMHP performs claims audits to detect potential fraud, waste and abuse. Audits of provider claims are based on objective and documented criteria. FMHP uses reports generated from our database to score and profile providers' 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, subscriber 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, FMHP provides an orientation to the provider on billing guidelines and documentation. The SIU may conduct further investigation and act 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.

2.2 POLICIES AND PROCEDURES

FMHP has established policies and procedures that are made available and provided to staff regarding the Department's Guidelines for the detection, prevention, identification, investigation and correction of potential cases involving fraud, waste and abuse. Activities involving fraud, waste and abuse may be identified by other departments following the guidelines contained in the policies and procedures. FMHP can also identify situations of fraud, waste and abuse through calls received through the **FRAUD AND COMPLIANCE ALERT LINE** 1-800-933-9336, available 24 hours a day, 7 days a week, and the email address alertafraudeycumplimiento@firstmedicalpr.com created to encourage reporting of potential fraud, waste and abuse.

2.3 DATA ANALYSIS

Data analysis is an essential first step in determining whether patterns of claim submission and payments indicate potential problems. Data analysis includes simple identification of irregularities in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment. Data analysis itself is part of general surveillance and review of submitted claims conducted in response to complaints, grievance and appeal trends, provider, enrollee or subscriber input and fraud alerts. Some of the methods of detection and data sources to identify FWA are in Table 1.

Table 1. FMHP Uses Multiple Methods and Sources of Fraud Detection.

By using multiple methods and sources we improve our ability to detect and stop fraud.

Fraud Detection Methods		Sources of Detection
• Electronic Data Exchanges • Data mining, Profiling, Targeted Procedures • Claims registry/ Reconciliation	• Fraud Email Box, Fax, & Hotline • Fraud Reporting Form • Letters or in-person reporting	• SIU or Employee Referral/Discovery • Alerts & Media Articles • Medicaid Integrity Group & Task Force Meetings

3. INVESTIGATIONS:

3.1 INVESTIGATION ANALYSIS

The cases are assigned to a Fraud Analyst who shall conduct a preliminary investigation and depend on the results. It will be assigned to the SIU Investigator. The research process involves the use of objective methods to identify potential cases of fraud and conducting detailed intervention. These include the following processes:

- Opening and documenting 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 SIU Analyst 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, subscriber 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 has concluded, the case is referred to relevant agencies, when mandatory or necessary, 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 includes investigative steps to work fraud cases in conjunction with our Legal Department, State and Federal authorities, which include, but are not limited to the OCS, PRHIA, the Department of Justice, Medicaid Fraud and Control Unit (MFCU), Department of the Health and/or the OIG.

3.2 PRELIMINARY INVESTIGATION PROCESS

The cases of potential fraud, waste and abuse reported through the **FRAUD AND COMPLIANCE ALERT LINE 1-866-933-9336** and the email address alertafraudeycumplimiento@firstmedicalpr.com will be registered at the compliance log for reference during the investigation process. Calls to the Fraud and Compliance Alert Line and emails could be presented anonymously, or in another way. All communications given to the Fraud Alert and Compliance Hotline will be maintained with the maximum confidentiality. Concerns sent to the dedicated email address will be received by the SIU representative. The SIU also receives written communications through mail. Those cases that are referred to by management personnel, supervisors, any employee or other sources outside the institution will be treated with the most confidentiality and documented before starting the research process.

Once the SIU understands all the case circumstances, it proceeds to prepare an action plan or audit program, which consists of establishing a record properly identified, the procedure to locate all information relevant to the case, such as but not limited to: socio-demographic information of the subscriber or enrollees, if is a service provider SIU will produce a provider payment history, copies of the provider's contract, correspondence sent and received, provider's professional credentials, a summary of claims in payment process and the detailed intervention plan. The preliminary investigation minimum requirements when evaluating providers, subscribers and enrollees/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 their results. As soon as a potential case of fraud, waste and/or abuse is identified or a request for investigation is received, it is registered on the AutoAudit platform detailing, at a minimum, 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).
- Informant's telephone number and address (if provided)
- Type of organization involved, if required.
- On the date on which the investigation was opened.
- Brief description of suspected fraud or abuse
- Brief description of suspected fraud or abuse.
- On the date on which the investigation was closed.
- Name of the employee that performed the investigation.
- Disposition and resolution of the investigation.
- The nature of the investigated allegations.
- Implemented Corrective Actions, if any.
- Brief description of suspected fraud or abuse

After a case is included in the FWA Log, 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 a SIU analyst who, along with the SIU manager, should conduct the preliminary inquiry or full investigation following the investigation protocol.

Fraud, Waste and Abuse suspected cases related to pharmacy services or complaints from subscribers or enrollees related to pharmacy services will be forwarded to the Pharmacy Benefit Manager (PBM) and to PRHIA.

If the finding of the preliminary investigation provides FMHP with reason to believe that a potential incident of fraud, waste and abuse may have occurred, FMHP must take appropriate action, and conduct a full investigation.

3.3 FULL INVESTIGATIONS PROCESS

The full investigation steps and processes performed by SIU are explained below:

- When a case requires a full investigation, it must be done in accordance with contractual requirements, State and Federal regulations and FMHP policies and procedures.
- If it is appropriate, the SIU will notify the provider, the provider services corporation or the subscriber in writing, when it applies, about the investigative process.
- If the process requires the interview of witnesses, or the recipient of the medical-hospital service, the SIU will proceed accordingly.
- In complex clinical cases, the SIU will incorporate into the investigation those necessary external resources, such as a specialized physician, a forensic expert from the health area or a legal advisor.
- The investigative fieldwork could be done in the office of the provider investigating or at FMHP corporate offices. In any case, the SIU will have all available resources to do the intervention as expeditiously as possible.
- Once the field work has completed, SIU will proceed with the organization and tabulation of all data available at the office level; research will be completed and be written in the draft report containing all findings and recommendations on the case investigated.
- If the case requires or warrants consulting the recommendations of the SIU, the SIU director will consult with the Management of FMHP for its possible implications or economic impact. When applicable, the SIU will recommend with the approval of FMHP Human Resources Department a precautionary suspension if it is believed that an employee is involved in fraudulent activities or improper behavior and the presence of such employee at the workplace might jeopardize any investigation into alleged misconduct or endanger the wellbeing or safety of any person or company's property.

- If necessary, the case investigated by the SIU will be discussed with the Fraud, Waste and Abuse Committee and subsequently submitted with the consent or modifications of this working group for consideration of final disposition.

Any full investigation must continue until:

- Appropriate legal action is initiated.
- The case was 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 resolve 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 (PPACA Section 6501)
    - Seeking recovery of payments made to the provider; or
    - Imposing other sanctions provided under the FMHP Program Integrity Plan. (42 CFR Part 455 Sub Part E.)

3.4 CONTENTIOUS CASES THAT INVOLVE CRIMINAL CONDUCT

Regarding contentious cases, SIU will also consult with the company's Legal Division, and subsequently refer to the Board of Directors, to establish the position of the company and for them to require a full review of internal controls and procedures to determine how such incidents can be detected in the future.

FMHP 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 meetings, providing requested information, access to records, 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 legal prosecution.

Such cooperation shall also include providing personnel to testify at any hearings, trials, or other legal proceedings on an as-needed basis.

4. RISK MANAGEMENT:

Through the Risk Management Program, FMHP can properly establish the Fraud, Waste and Abuse prevention and detection targets. Further, it is best practice for companies to revisit their risk assessment once a year to evaluate the effect of internal and external changes on the company and the marketplace.

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 identifying and evaluating risks associated with the achievement of FMHP's objectives, compliance with laws and regulations, and effectiveness of business processes and internal controls. Risk evaluation and analysis are used to create the Annual Internal Audit Plan, which is reviewed by the Audit Committee of the Board of Directors. The results of the risk assessment are provided to executive management for consideration during strategic planning.

FMHP identifies the entities that could be responsible for fraud, waste and abuse incidents, such as Enrollees, Subscribers, 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 in 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 medical records.	• Double billing by providers
• Billing on behalf of deceased persons.	• Stolen identity in order to obtain prescriptions.
• Doctor shopping where beneficiaries visit several providers 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 and subscribers.
- Doctor shopping, where enrollees visit several providers and/or pharmacies to obtain multiple prescriptions. In particular, target opioid based medications.
- Lack of documentation on medical records.

FMHP's Risk Assessment has outlined an action plan to detect and mitigate the vulnerable areas which are described under Section 1.3, Detection and Mitigation of potential fraud, waste, and abuse of this FWA Program.

5. EDUCATION / TRAINING FOR ENROLLEES, PROVIDERS, AND EMPLOYEES:

The Director of the SIU or its designee shall develop a series of seminars and internal workshops. Such workshops will include Basic Techniques of Detection and Investigation of Fraud Theory; Confidentiality during the Investigative Process; Exposition to Act Num. 77, Puerto Rico Insurance Code, 26 LPRA §§ 2701-2740 (1957) as amended; Interview Techniques; and a presentation of a case template for investigation into fictional situations. Attendance and participation in these training workshops are a mandatory condition of employment with FMHP, including management and officers.

All FMHP employees, managers, President and other senior administrators, as well as subcontractors, shall receive FWA training, regardless of whether they are full-time, part-time, temporary, volunteer or otherwise. Training will include, at a minimum:

- Review of the possible types of FWA that can occur and process for reporting suspected FWA to FMHP.

- Identifying and combating FWA, including employee responsibilities under FMHP's anti-fraud policies such as requesting compliance clarification and reporting potential noncompliance.
- Overview of the FWA laws and regulations
- Emphasis on confidentiality, anonymity, and non-retaliation for all compliance related with questions or reports of potential noncompliance or FWA.

6. COOPERATION AND PARTNERSHIPS:

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

The reporting and partnerships plan FMHP is responsible for implementing to detect potential fraud, waste and abuse (FWA) targets includes FMHP attendance to the Medicaid Integrity Group (MIG) meetings sponsored by PRHIA, OIG Task force, MFCU Task force and *"Asociación de Compañías de Seguros de Puerto Rico"* (By its Spanish acronym, ACODESE). During these meetings, MCO's representatives present current cases, 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. FMHP has an additional partnership with its subcontractors. FMHP's delegated entities follow the Medicaid Program Integrity guidelines, OCS guidelines, the PR Insurance Code and provide FMHP with the appropriate reporting information in order to prevent and detect fraud.

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