MSO Provider Education

Model of Care 2020

Learning Objectives

- Background
- Products and Model of Coordinated Care
- Components of the Model of Care
- Essential role of the Provider in the Model of Care

Provider Education

Model of Care
Training

Developed to meet the Centers for Medicare & Medicaid Services* guidelines

Every MAO MUST CONDUCT and document training on SNP Model of Care for all employed and contracted personnel and providers:

- Initial and annual training
- Methodology may be:
  - Face-to-face
  - Interactive (web-based, audio/video conference)
  - Self-study (printed materials, electronic media)

Provider Education

* CMS

Background

Incorporated in the year 2000

In 2001: CMS approved to begin providing services as the first Medicare Advantage plan in Puerto Rico.

Focus:

Quality service
Prevention
Quality of life

Provider Education

Background

The only Medicare Advantage plan in Puerto Rico, with:

Accreditation of the National Committee of Quality Assurance (NCQA)

4.5 stars under the Medicare Star Rating Program *

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* Each year, Medicare evaluates plans based on a 5 Star Rating System.

What is the Coordinated Model of Care?

* Structure for processes and systems
* Beneficiaries with special needs

* Essential tool:

-Improves quality

-Ensures that needs are met under SNP

Provider Education

SNP Products 2020

MMM

Model of Care 2020	D-SNPs
	
	Members eligible for Medicare and Medicaid.
		C-SNPs
		
		Members that meet the following chronic or disabling conditions:
		
		• Diabetes
		• Chronic Heart Failure (CHF)
		• Cardiovascular disease:
		  ○ Cardiac Arrhythmias
		  ○ Peripheral Vascular Disease
		  ○ Coronary Artery Disease
		  ○ Chronic venous thromboembolic disorder

MMM Supremo (HMO-SNP)		√
MMM Diamante Platino (HMO-SNP)	√	
MMM Completo Platino (HMO-SNP)	√	
MMM Relax Platino (HMO-SNP)	√	
MMM Valor Platino (HMO-SNP)	√	
MMM Bienestar Platino (HMO-SNP)	√	
PMC Premier Platino (HMO-SNP)	√	

MOC Elements

- Special Needs Population (*SNP*) Description
- Coordinated Care
  - Mandatory assessment of health risks and reevaluation (HRA)
  - Individual Care Plan (ICP)
  - Interdisciplinary Team (ICT)
- Provider network
- Quality metrics and Performance improvements

Provider Education

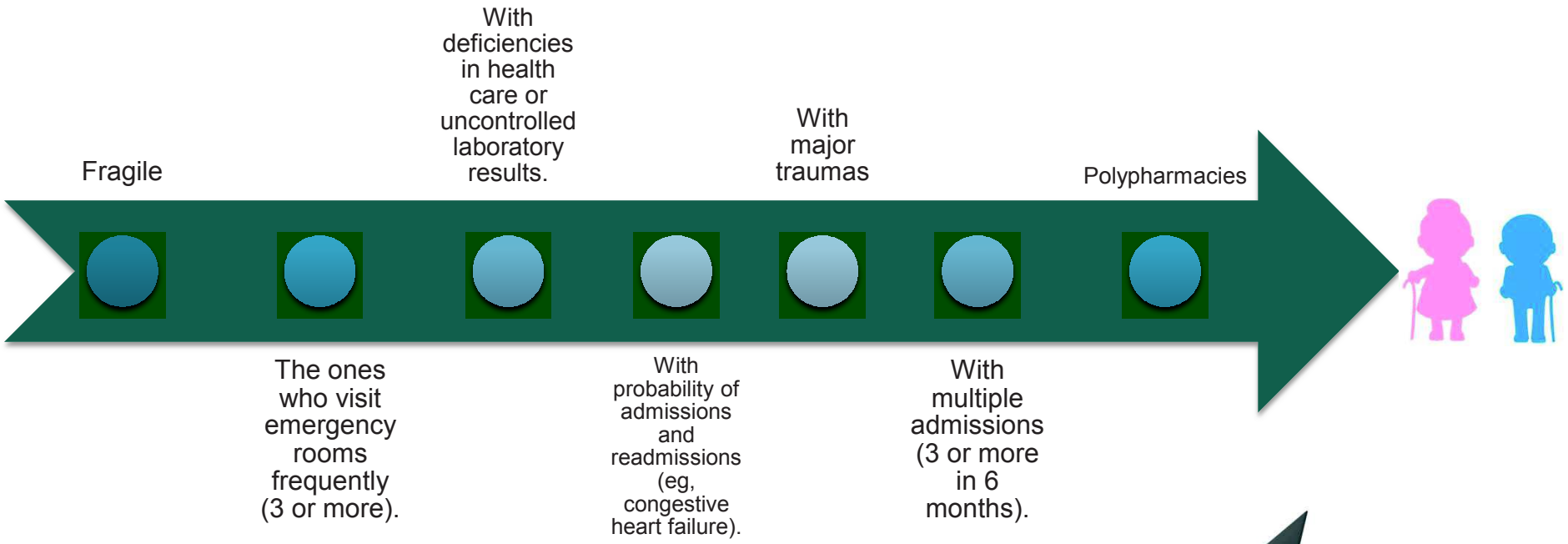
MOC 1:

Description of the Special Needs Population (SNP)

Provider Education

The most vulnerable

Identify those members with greater vulnerability.



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The most vulnerable

Members with chronic uncontrolled conditions:

- COPD
- Asthma
- CHF
- Cardiovascular Disease
- Arteriosclerosis
- HTN

Members with disabilities

Members that require complex procedures or transition of care:

- Organ transplant
- Bariatric surgery

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MOC 2:

Service Coordination

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Coordinated Care

Ensures the health needs of beneficiaries of an SNP; information is shared among the interdisciplinary staff.

Coordinates the delivery of specialized services that meet the needs of the most vulnerable population.

Performs health risk assessments, Individualized Care Plan and has an established Interdisciplinary Team.

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Care Management Program Focus

Guarantee members **access** to **resources** available in the **community**.

Ensure that members **identify** and qualify for the program using established criteria.

Provide **resources** of effective medical **benefits** while ensuring quality care.

Ensure that all program members have a **comprehensive** needs **assessment**.

Ensure that member care services are **coordinated** and given the **appropriate treatmen**t in an efficient manner.

Ensure that all active members of the program have an **individual and personalized attention plan** with targeted interventions, to meet the identified needs.

Health Risk Assessment (HRA)

HRA is performed to identify medical, psychosocial, cognitive and functional needs of people with special needs.

Initial HRA/90 days from membership to complete it. Annual HRA/starting 365 days after the initial.

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Health Risk Assessment (HRA)

HRA is done by phone or on paper.

Results → Individualized Care Plan:

* Problems, goals and interventions with an interdisciplinary team HRA refers to→ Care Management Programs

* Case Management, among others.

Care plan is shared with:

Member + interdisciplinary team (including PCP)

Individualized care plan (ICP)

ICP is developed for each SNP member by the respective interdisciplinary team, identifying the needs of the member based on the result obtained in the HRA.

ICP guarantees what needs are covered, the course of evaluation and coordination of services and the member's benefits.

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Individualized care plan (ICP)

ICP is communicated to the member or caregiver, and shared with the provider through our InnovaMD portal.

Review annually or when health status changes.

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Interdisciplinary team (ICT)

Group focused on the member, discusses the health status and interventions for the patient.

Providers responsibilities in the ICT:

1. Participate in ICP discussion.
2. Collaborate in goals setting.
3. Involve members in the management of self-management and follow up.
4. Integrate other doctors and providers.
5. Participate in ICT meetings.
6. Communicate changes to ICT components through meetings or phone calls.

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Care Transition

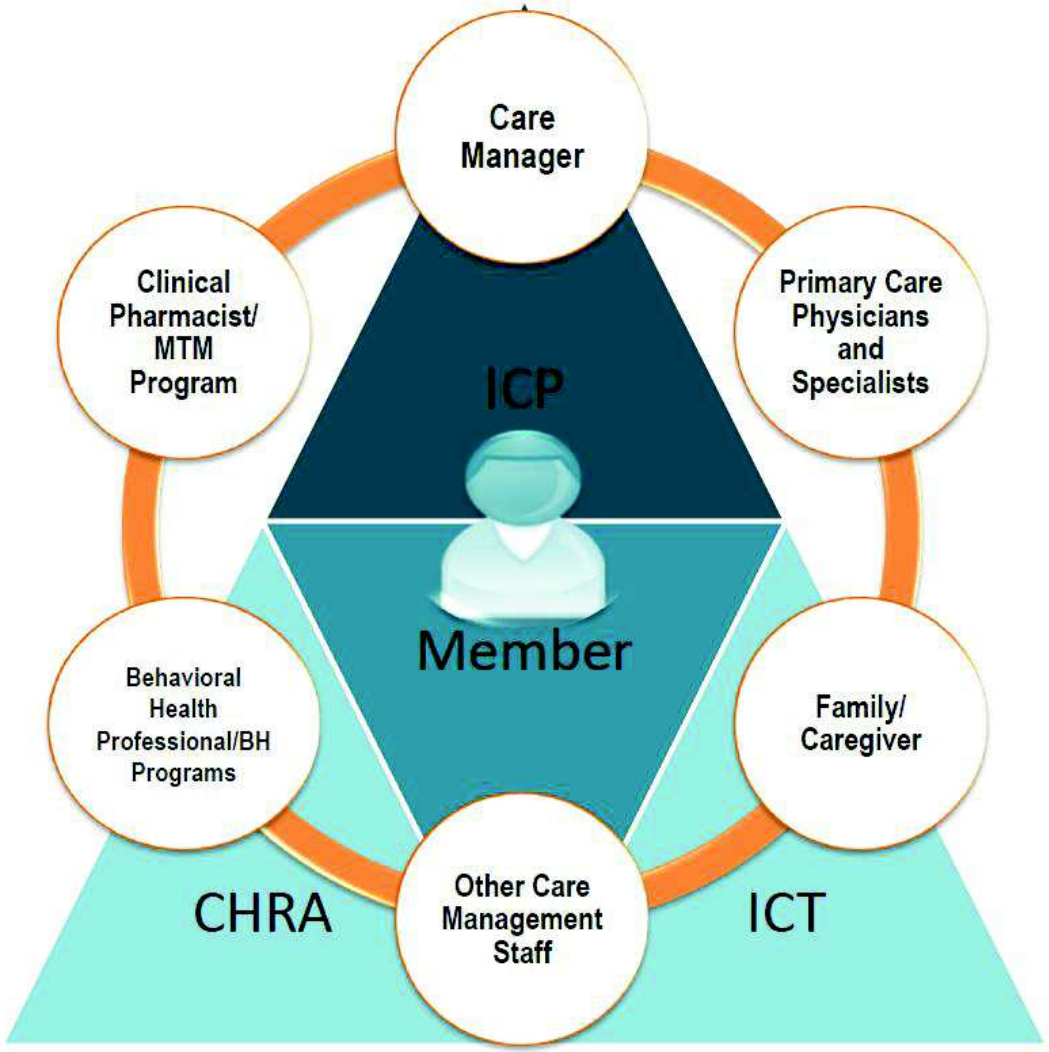
Transition processes and protocols are established to maintain continuity of care.

Different units work in collaboration with primary doctors and providers to guarantee and support the coordinated care the member deserves.

Staff available in the discharge planning unit facilitates communication between care centers, primary physician and the member or its caregiver.

Member's ICP is shared with member and primary care physician when a transition of care occurs.

Care Transition Protocols



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Provider Role in the Model of Care

- Ensures the continuous access to services, and what needs and information is shared among staff.
- Coordinates specialized services to the most vulnerable population.
- Promotes Health Risk Assessment for Individualized Care Plan.
- Active participation as part of the Interdisciplinary Team.

MOC 3:
Specialized providers network in the care plan

Provider Education

Focus

Maintain a network of specialized providers to meet the needs of our members by being the primary link in their care.

The provider network monitors:

- The use of clinical practice guidelines and protocols.
- Ensure collaboration and active communication with ICT administrators and cases.
- Assist in the preparation and updating of care plans.
- Ensure that all network providers are evaluated and qualified through a credentialing process.

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MOC 4:

Quality Measurement and Performance Improvement

Provider Education

Quality Evaluation and Improvement

The plans have a Quality Improvement Program established to monitor health outcomes and performance of the care model through:

- Data collection and follow-up of the specific SNP Five Stars Program measures (HEDIS).
- Implementation of the Annual Quality Improvement Project focuses on improving the clinical aspect or service that is relevant to the SNP population.
- Measure SNP member satisfaction.

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Quality Evaluation and Improvement

- Chronic Care Improvement Program (CCIP) for chronic disease that identifies eligible members, and intervention to improve disease management and evaluate the effectiveness of the program.
- Collection of data to evaluate if the objectives of the SNP program are met.
- An annual basis, whose results come from the performance and improvement of the SNP MOC quality. These results are notified to all interested parties, including: members, employees, providers and the general public.

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Our commitment to quality

Today we are proud to see that MMM special needs coverage will continue to improve the quality of life for thousands around the Island.

For more information:

787-993-2317 (Metro Area)

1-866-676-6060 (Toll Free)

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

Provider Education

Questions?

Provider Education

Thanks

Provider Education

MMM Holdings

Integrating Compliance within **MMM Holdings, LLC 2020**

Overview

- MMM and PMC are referred to as MA and MAPD Sponsors through our contracts with CMS to offer health and prescription drug coverage to eligible beneficiaries.
- MMM Holdings, LLC. is committed with business ethics and compliance and to follow all applicable laws, regulations and guidance that govern the Medicare and Medicaid Programs.
- MMM Holdings, LLC. must ensure that all employees, contractors, and related entities implement a Compliance and FWA training for all personnel who participate in the provision of administrative or health services to Medicare beneficiaries. Participation in these trainings is mandatory as a condition of continued employment or contract and is part of the performance evaluation of employees, contractors and delegated entities.

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Definitions

- **First Tier Entity** - any party that enters into a written agreement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the MA program or Part D program.
- **Downstream Entity** - is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit. This agreement is between the contractor or subcontactor is one level below the one that exists between an MA organization or Part D Plan Sponsor. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- **Related entity** - An entity that is related to an MAO or Part D Sponsor by common ownership or control and that performs some of the MAO or Part D plan Sponsor's management functions under contract or delegation

MMM Holdings

Compliance Department

Myra Plumey

MMM and PMC Chief Compliance Officer

The Chief Compliance Officer overall has the responsibility and accountability for compliance matters and reports directly to the Chief Executive Officer, Richard A. Shinto, M.D. and to the President, Orlando González.

MMM Holdings

MMM Holding's, LLC
Compliance Program
and
Code of Ethics and Business Conduct

MMM
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MMM Holding's Compliance Program

- A Compliance Program is a series of internal controls and measures to ensure that the Company follows applicable laws and regulations that govern federal programs, like Medicare.
- The adoption and implementation of a Compliance Program significantly reduces the risk of FWA in the healthcare setting, while providing quality services and care to patients
- Organizations contracting directly or indirectly with the federal government are obligated to
  - Report FWA
  - Demonstrate their commitment to eliminating FWA
  - Implement internal policies and procedures to identify and combat healthcare fraud.
- MMM Holding's LLC has a Compliance Program that includes the seven (7) core elements required by regulation.
- In accordance with the Compliance Program, the Company will continue conducting regular, periodic compliance audits using internal and external auditors and staff who have expertise in federal and state healthcare laws and regulations.
- It is the organization's responsibility to monitor and audit its first tier, downstream and related entities to ensure compliance with all applicable laws and regulations.
- The Compliance Department is responsible for conducting a pre-assessment prior to contract with any related entity and to conduct a full audit of all delegated functions, annually thereafter.

MMM Holdings

Code of Ethics and Business Conduct

Objectives:

- Promote the highest standards of integrity and ethics
- Establish standards and guidelines of how we conduct ourselves responsibly
- Regulate everyone's behavior
- As part of the Compliance Training, each employee will sign a Code of Conduct upon hired date and later on an annual basis

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Code of Ethics and Business Conduct

Principles:

I. We must conduct business in accordance with the law at all times.

II. We must strive to perform assigned duties using the highest ethical standards.

III. We must avoid any situation where a conflict could exist or appear to exist between our personal interests and those of the Company.

A. Conflict of Interest Policy

IV. We must protect the Members, Providers and the Company's confidential and proprietary information at all times

A. HIPAA

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Code of Ethics and Business Conduct

Principles:

V. We must ensure that the Company's data is recorded and reported accurately and honestly.

VI. We must ensure that the Company's records are retained in accordance with applicable laws and the Company's record retention policy.

A. Record Retention P&P

VII. We must use the Company's property for business purposes only.

VIII. We must share information through trainings and participate in training programs because it is our most valuable tool to develop our most important asset: our employees.

MMM Holdings

Code of Ethics and Business Conduct

Principles:

IX. We must ensure that our relationship with other team members, business partners, providers and members are built with honesty, fairness, dignity and respect at all times.

X. We must respect our relationship with the government as our client.

XI. We must immediately report any activity or conduct believed to be inconsistent with the law, regulation, Company policy, guideline or standards.

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Conflict of Interest Policy

- As addressed in the Compliance Program, directors and associates must avoid situations where their personal interests could conflict or appear to conflict with the best interests of the company.
- If you find yourself in a situation where you believe a conflict of interest exists, you are responsible for seeking guidance from the Chief Compliance Officer, Compliance Department or Legal Department.

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Conflict of Interest Policy

Examples:

- Gifts and Entertainment
  - Do not accept unusual gifts or favors from clients, competitors or other outside parties
  - Give gifts to clients of a $15 nominal value
- Supervising a family member
- Conducting business with a family member that is employed by a provider or subcontractor
- Having financial relationship with entities that currently have or in the future may have a relationship with the company

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Conflict of Interest Policy

Examples:

- Be a member of another Company's Board of Directors
- Ownership in or employment by a family member outside party that does business with or competes with the Company
- Perform duties or render services for any competitor and/or supplier without proper knowledge and approval of the Company.

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Excluded Individuals and Entities Policy

- Our organization has the responsibility to ensure that employees, contractors, providers, Board of Director members and related entities have not been convicted of a criminal offense or excluded from Medicaid, Medicare or any state or federal sponsored service program.
- For this, verification of DHHS OIG and General Services Administration (GSA) lists are done prior to employment or contracting, and at least monthly thereafter.
- MMM Holdings, LLC. shall terminate immediately the relationship with any person or entity identified in the exclusion lists.

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Receipt and Distribution of CMS, ASES and Other Entities Notifications Policy

- The Compliance Department is responsible for notifying the organization's management and related entities about any notification from CMS, ASES or other entity related to new regulations and/or changes in regulations and rules that affect the operations of the company.
- Each department and/or related entity is responsible for implementing the process notified in a timely manner and must notify the Compliance Department about actions taken.

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Medicare Improvement for Patients and Providers Act of 2008 (MIPPA)

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MIPPA

- Includes provisions prohibiting and limiting certain sales and marketing activities of Medicare Advantage plans and Prescription Drug Plans

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Marketing Rules
Do's and Don'ts

MA Plans Must Not:	Providers Cannot:
• Offer cash gifts, including charitable contributions, gift certificates or gift cards that can be readily converted to cash • Offer inducements to persuade beneficiaries to enroll • Door-to-door solicitation • Cross-sell related products such as life insurance or annuities • Provide or subsidize meals at promotional/sales events or meetings where plan benefits are being discussed or plan materials are being distributed • Hold sales and marketing activities in healthcare settings, health fairs, educational or any other related events	• Direct, urge or attempt to persuade any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor) • Collect enrollment applications • Offer inducements to persuade beneficiaries to enroll in a particular plan • Health screen "cherry picking" when distributing information to patients, as health screening is a prohibited marketing activity

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Marketing Rules
Do's and Don'ts

MA Plans Must Not:	Providers Must Not:
• Market any healthcare related products during a marketing appointment beyond the scope agreed upon by the beneficiary • Imply that a face-to-face meeting is required for a beneficiary to receive information about a Medicare Advantage Plan • Send unsolicited email • Enroll beneficiaries through outbound telemarketing • Misrepresent or use high pressure sales tactics • Engage in any activity which a Medicare Advantage Plan is prohibited from engaging in	• Offer anything of value to induce plan enrollees to select them as their provider • Expect compensation in consideration for the enrollment of a beneficiary

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Marketing Rules
Do's and *Don'ts*

MA Plans should:	MA Plans May:
• Use Marketing materials that have been reviewed and approved by CMS • Comply with the "Do not call registry;" honor "do not call" requests and abide by calling hours set forth in Federal and State Laws • Provide information in a professional manner • Ensure that sales and marketing agents have received training and testing regarding compliance with CMS rules and regulations • Use state-licensed, certified, or registered indviduals to market plans • Ensure that a marketing agent clearly identifies the types of products the sales agent will discuss prior to marketing	• Educate potential enrollees at health fairs • Schedule appointments with beneficiaries upon request • Offer gifts to potential enrollees if they attend a marketing presentation as long as the gifts are of nominal value and are provided whether or not the individual enrolls in the plan • Use direct mail (postcards, reply cards), but plans cannot include enrollment forms • Use television, radio, outdoor advertisements • Use banners, Internet, and print advertisements (newspaper, magazine, flyers, posters, brochures) • Conduct Sales presentations at sales/ marketing events • Distribute and accept enrollment applications at sales/marketing events

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Marketing Rules
Do's and *Don'ts*

Providers May:

- Provide the names of plans which they contract and/or participate in
- Provide objective information and assistance in applying for the low income subsidy
- Provide objective information on specific plan formularies, based on a particular patient's medications and healthcare needs
- Provide objective information regarding specific plans, such as covered benefits, cost sharing, and utilization management tools
- Distribute marketing materials, except for Medicare Advantage Plan enrollment application forms and sales appointment forms
- Refer patients to other sources of information and share information from CMS website
- Use comparative marketing materials comparing plan information created by a third party who doesn't provide benefits or healthcare services
- Display posters or other materials that advertise their relationship with the plans

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Report ethical, compliance, fraud, waste and abuse violations, in a confidential manner by accesing here.

www.innovacarehealth.ethicspoint.com

1-877-307-1211

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Medicare Parts C and D

General Compliance and Fraud, Waste, and Abuse Training 2020

Agenda

Medicare Parts C and D General Compliance - Training

- Introduction
- LESSON: Compliance Program Training
- Post Assessment
- Appendix A: Resources
- Appendix B: Job Aids

Combating Medicare Parts C and D Fraud, Waste, and Abuse - Training

- Introduction
- LESSON 1: What is FWA?
- LESSON 2: Your role in the fight against FWA
- Post Assessment
- Appendix A: Resources
- Appendix B: Job Aids

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ACRONYMS

The following acronyms are used throughout the course.

ACRONYM	TITLE TEXT
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FDR	First-tier, Downstream, and Related Entity
FWA	Fraud, Waste, and Abuse
HHS	U.S. Department of Health & Human Services
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	MA Prescription Drug
MLN	Medicare Learning Network®
OIG	Office of Inspector General
PDP	Prescription Drug Plan

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The Medicare Parts C and D General Compliance Training course is brought to you by the Medicare Learning Network®.

January 2019

Introduction

- This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance training requirements in the regulations and sub-regulatory guidance at:
  - 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
  - 42 CFR Section 423.504(b)(4)(vi)(C)
  - Section 50.3 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)
  - The "Downloads" section of the CMS Compliance Program Policy and Guidance webpage
- Completing this training in and of itself does not ensure a Sponsor has an "effective Compliance Program." Sponsors and their FDRs are responsible for establishing and executing an effective compliance program according to the CMS regulations and program guidelines.

Introduction

- **Why Do I Need Training?**

  Every year, **billions** of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – **including you**.
  This training helps you detect, correct, and prevent FWA. **You** are part of the solution.
  Compliance is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

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

  Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training about compliance with CMS program rules.
  You may need to complete FWA training within 90 days of your initial hire. More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website. Please contact your management team for more information.

Learn more about Medicare Part C

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

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

Learn more about Medicare Part D

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

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Lesson
Compliance Training

- **Course Objectives**
  - After completing this course, you should correctly:
    - Recognize how a compliance program operates
    - Recognize how compliance program violations should be reported

- **Introduction and Learning Objectives**
  - This lesson outlines effective compliance programs. It should take about 15 minutes to complete. After completing this lesson, you should correctly:
    - Recognize how a compliance program operates
    - Recognize how compliance program violations should be reported

- **Compliance Program Requirement**
  - The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans. An effective compliance program must:
    - Articulate and demonstrate an organization's commitment to legal and ethical conduct
    - Provide guidance on how to handle compliance questions and concerns
    - Provide guidance on how to identify and report compliance violations

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Lesson
Compliance Training

- **What Is an Effective Compliance Program?**

  – An effective compliance program fosters a culture of compliance within an organization and, at a minimum:
    - Prevents, detects, and corrects non-compliance
    - Is fully implemented and is tailored to an organization's unique operations and circumstances;
    - Has adequate resources
    - Promotes the organization's Standards of Conduct
    - Establishes clear lines of communication for reporting non-compliance

  – An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

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Lesson
Compliance Training

- **Seven Core Compliance Program Requirements**

CMS requires an effective compliance program to include seven core requirements:

1. **Written Policies, Procedures, and Standards of Conduct**
   These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.
2. **Compliance Officer, Compliance Committee, and High-Level Oversight**
   The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

   The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.
3. **Effective Training and Education**
   This covers the elements of the compliance plan as well as preventing, detecting and reporting of FWA. Tailor this training and education to the different employees and their responsibilities and job functions.
4. **Effective Lines of Communication**
   Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good- faith compliance issues reporting at Sponsor and First-Tier, Downstream, or Related Entity (FDR) levels.
5. **Well-Publicized Disciplinary Standards**
   Sponsor must enforce standards through well-publicized disciplinary guidelines.
6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**
   Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.
   NOTE: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.
7. **Procedures and System for Prompt Response to Compliance Issues**
   The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Lesson
Compliance Training

- **Compliance Training: Sponsors and Their FDRs**

  CMS expects all Sponsors will apply their training requirements and "effective lines of communication" to their FDRs. Having "effective lines of communication" means that employees of the Sponsor and the Sponsor's FDRs have several avenues to report compliance concerns.

- **Ethics: Do the Right Thing!**

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

  - Act fairly and honestly
  - Adhere to high ethical standards in all you do
  - Comply with all applicable laws, regulations, and CMS requirements
  - Report suspected violations

- **How Do You Know What Is Expected of You?**

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

  Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their operational principles and values. Organizational Standards of Conduct vary. The organization should tailor the Standards of Conduct content to their individual organization's culture and business operations. Ask management where to locate your organization's Standards of Conduct.

  Reporting Standards of Conduct violations and suspected non-compliance is **everyone's** responsibility.

  An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

Lesson
Compliance Training

What is Non-Compliance?

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

- Agent/broker misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

For more information, refer to the Compliance Program Guidelines in the "Medicare Prescription Drug Benefit Manual" and "Medicare Managed Care Manual."

Know the Consequences of Non-Compliance

Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences including:

- Contract termination
- Criminal penalties
- Exclusion from participation in all Federal health care programs
- Civil monetary penalties

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training
- Disciplinary action
- Termination

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Lesson
Compliance Program Training

- **NON-COMPLIANCE AFFECTS EVERYBODY**

  Without programs to prevent, detect, and correct non-compliance, we all risk:

  Harm to beneficiaries, such as:

  - Delayed services
  - Denial of benefits
  - Difficulty in using providers of choice
  - Other hurdles to care

  Less money for everyone, due to:

  - High insurance copayments
  - Higher premiums
  - Lower benefits for individuals and employers
  - Lower Star ratings
  - Lower profits

Don't Hesitate to Report Non-Compliance

When you report suspected non-compliance in good faith, the Sponsor can't retaliate against you.

Each Sponsor must offer reporting methods that are:

•Anonymous

•Confidential

•Non-retaliatory

- **How to Report Potential Non-Compliance**
- **Employees of a Sponsor**
  - Call the Medicare Compliance Officer
  - Make a report through your organization's website
  - Call the Compliance Hotline
- **First-Tier, Downstream, or Related Entity (FDR) Employees**
  - Talk to a Manager or Supervisor
  - Call your Ethics/Compliance Help Line
  - Report to the Sponsor
- **Beneficiaries**
  - Call the Sponsor's Compliance Hotline or Customer Service
  - Make a report through the Sponsor's website
  - Call 1-800-Medicare

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Lesson
Compliance Program Training

- **What Happens After Non-Compliance Is Detected?**

  Non-compliance must be investigated immediately and corrected promptly. Internal monitoring should ensure:

  - No recurrence of the same non-compliance
  - Ongoing compliance with CMS requirements
  - Efficient and effective internal controls
  - Protected enrollees

- **What Are Internal Monitoring and Audits?**

  Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.

  Internal auditing is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

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Lesson
Compliance Program Training

- **Lesson Summary**
  - Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.
  - To help ensure compliance, behave ethically and follow your organization's Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.
  - Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

- **Lesson Review**
  - Now that you have completed the lesson, let's do a quick knowledge check.

Compliance Is Everyone's Responsibility!

Prevent: Operate within your organization's ethical expectations to prevent non-compliance!

Detect & Report: Report detected potential non-compliance!

Correct: Correct non-compliance to protect beneficiaries and save money!

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Compliance Training Post Assessment

- **Knowledge Check - Select the Correct Answer**

1. **You discover an unattended email address or fax machine in your office receiving beneficiary appeals requests. You suspect that no one is processing the appeals. What should you do?**
   a. Contact law enforcement
   b. Nothing
   c. Contact your compliance department (via compliance hotline or other mechanism)
   d. Wait to confirm someone is processing the appeals before taking further action
   e. Contact your supervisor

2. **A sales agent, employed by the Sponsor's First-Tier, Downstream, or Related Entity (FDR), submitted an application for processing and requested two things: 1) to back-date the enrollment date by one month, and 2) to waive all monthly premiums for the beneficiary. What should you do?**
   a. Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department
   b. Make the requested changes because the sales agent determines the beneficiary's start date and monthly premiums
   c. Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions) – you will not file a report because you don't want the sales agent to retaliate against you
   d. Process the application properly (without the requested revisions) – inform your supervisor and the compliance officer about the sales agent's request
   e. Contact law enforcement and the Centers for Medicare & Medicaid Services (CMS) to report the sales agent's behavior

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Correct Answers: 1. C; 2. D; 3. B; 4. E

Compliance Training
Post Assessment

- **Knowledge Check - Select the Correct Answer *(cont.)***

3. **You work for a Sponsor. Last month, while reviewing a Centers for Medicare & Medicaid Services (CMS) monthly report, you identified multiple enrollees not enrolled in the plan, but for whom the Sponsor is paid. You spoke to your supervisor who said don't worry about it. This month, you identify the same enrollees on the report again. What should you do?**
   a. Decide not to worry about it as your supervisor instructed – you notified him/her last month and now it's his/her responsibility
   b. Although you know about the Sponsor's non-retaliation policy, you are still nervous about reporting – to be safe, you submit a report through your compliance department's anonymous tip line to avoid identification
   c. Wait until the next month to see if the same enrollees appear on the report again, figuring it may take a few months for CMS to reconcile its records – if they are, then you will say something to your supervisor again
   d. Contact law enforcement and CMS to report the discrepancy
   e. Ask your supervisor about the discrepancy again

4. **You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?**
   a. Call local law enforcement
   b. Perform another review
   c. Contact your compliance department (via compliance hotline or other mechanism)
   d. Discuss your concerns with your supervisor
   e. Follow your pharmacy's procedures

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Correct Answers: 1. C; 2. D; 3. B; 4. E

Compliance Training: Post-Assessment

Select the correct answer.

1. Compliance is the responsibility of the Compliance Officer, Compliance Committee, and Upper Management only.
    - ○ A. True
    - ○ B. False
2. Ways to report a compliance issue include:
    - ○ A. Telephone hotlines
    - ○ B. Report on the Sponsor's website
    - ○ C. In-person reporting to the compliance department/supervisor
    - ○ D. All of the above
3. What is the policy of non-retaliation?
    - ○ A. Allows the Sponsor to discipline employees who violate the Code of Conduct
    - ○ B. Prohibits management and supervisor from harassing employees for misconduct
    - ○ C. Protects employees who, in good faith, report suspected non-compliance
    - ○ D. Prevents fights between employees
4. These are examples of issues that can be reported to a Compliance Department: suspected fraud, waste, and abuse (FWA); potential health privacy violation, and unethical behavior/employee misconduct.
    - ○ A. True
    - ○ B. False
5. Once a corrective action plan begins addressing non-compliance or fraud, waste, and abuse (FWA) committed by a Sponsor's employee or first-tier, downstream, or related entity's (FDR's) employee, ongoing monitoring of the corrective actions is not necessary.
    - ○ A. True
    - ○ B. False

Compliance Training: Post-Assessment

Select the correct answer. *(cont.)*

6. Medicare Parts C and D plan Sponsors are not required to have a compliance program.
   - ○ A. True
   - ○ B. False
7. At a minimum, an effective compliance program includes four core requirements.
   - ○ A. True
   - ○ B. False
8. Standards of Conduct are the same for every Medicare Parts C and D Sponsor.
   - ○ A. True
   - ○ B. False
9. Correcting non-compliance _____.
   - ○ A. Protects enrollees, avoids recurrence of the same non-compliance, and promotes efficiency
   - ○ B. Ensures bonuses for all employees
   - ○ C. Both A. and B.
10. What are some of the consequences for non-compliance, fraudulent, or unethical behavior?
   - ○ A. Disciplinary action
   - ○ B. Termination of employment
   - ○ C. Exclusion from participating in all Federal health care programs
   - ○ D. All of the above

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Appendix A: Resources

- **Disclaimers**

  This course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided for your reference.

  This course was prepared as a service to the public and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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- **Glossary**

  For glossary terms, visit the Centers for Medicare and Medicaid Services Glossary.

Appendix B: Job Aids

Job Aid A: Seven Core Compliance Program Requirements

The Centers for Medicare & Medicaid Services (CMS) requires that an effective compliance program must include seven core requirements:

1. **Written Policies, Procedures, and Standards of Conduct**

   These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

2. **Compliance Officer, Compliance Committee, and High-Level Oversight**

   The Sponsor must designate a compliance officer and a compliance committee to be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

   The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

3. **Effective Training and Education**

   This covers the elements of the compliance plan as well as prevention detection and reporting of fraud, waste, and abuse (FWA). This training and education should be tailored to the different responsibilities and job functions of employees.

4. **Effective Lines of Communication**

   Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good- faith reporting of compliance issues at Sponsor and First-Tier, Downstream, or Related Entity (FDR) levels.

5. **Well-Publicized Disciplinary Standards**

   Sponsor must enforce standards through well-publicized disciplinary guidelines.

6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**

   Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

   NOTE: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

7. **Procedures and System for Prompt Response to Compliance Issues**

   The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Appendix B: Job Aids

Job Aid B: Resources

- Compliance Education Materials: Compliance 101
- Health Care Fraud Prevention and Enforcement Action Team
- Provider Compliance Training
- Office of Inspector General's (OIG's) Provider Self-Disclosure
- Protocol
- Part C and Part D Compliance and Audits - Overview
- Physician Self-Referral
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians
- Safe Harbor Regulations

HYPERLINK URL	LINKED TEXT/IMAGE
https://oig.hhs.gov/compliance/101	Compliance Education Materials: Compliance 101
https://oig.hhs.gov/compliance/provider-compliance-training	Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp	Office of Inspector General's (OIG's) Provider Self-Disclosure Protocol
https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance- and-audits	Part C and Part D Compliance and Audits - Overview
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral	Physician Self-Referral
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html	Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians
https://oig.hhs.gov/compliance/safe-harbor-regulations	Safe Harbor Regulations

Link to Source Documents

HYPERLINK URL	LINKED TEXT/IMAGE
https://www.ecfr.gov/cgi-bin/text-idx?SID=c66a16ad53319afd0580db00f12c5572&mc=true&node=pt42.3.422&rgn=div5#se42.3.422_1503	42 Code of Federal Regulations (CFR) Section 422.503
https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5cff780d3df38cc4183f2802223859ba&mc=true&r=PART&n=pt42.3.423	42 CFR Section 423.504
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf	Chapter 9 of the Medicare Prescription Drug Benefit Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Chapter 21 of the Medicare Managed Care Manual
https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html	CMS Compliance Program Policy and Guidance webpage
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf	Medicare Parts C and D Compliance Trainings and Answers to Common Questions
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf	Medicare Prescription Drug Benefit Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Medicare Managed Care Manual
https://www.cms.gov/apps/glossary	Centers for Medicare and Medicaid Services Glossary

The Combating Medicare Parts C and D Fraud, Waste, and Abuse Training course is brought to you by the Medicare Learning Network®.

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ACRONYMS

The following acronyms are used throughout the course.

ACRONYM	TITLE TEXT
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
EPLS	Excluded Parties List System
FCA	False Claims Act
FDRs	First-tier, Downstream, and Related Entities
FWA	Fraud, Waste, and Abuse
HIPAA	Health Insurance Portability and Accountability Act
LEIE	List of Excluded Individuals and Entities
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network®
NPI	National Provider Identifier
OIG	Office of Inspector General
PBM	Pharmacy Benefits Manager
WBT	Web-Based Training

Introduction

- This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:
  - 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
  - 42 CFR Section 423.504(b)(4)(vi)(C)
  - CMS-4182-F, Medicare Program Contract Year 2019 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
  - Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the "Medicare Prescription Drug Benefit Manual" and Chapter 21 of the "Medicare Managed Care Manual")
- Sponsors and their FDRs are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

Introduction

- **Why Do I Need Training?**
  Every year **billions** of dollars are improperly spent because of FWA. It affects everyone – **including you**.
  This training helps you detect, correct, and prevent FWA. **You** are part of the solution.
  Combating FWA is **everyone's** responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

- **Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees**
  Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training for preventing, detecting, and correcting FWA.
  FWA training must occur within 90 days of initial hire and at least annually thereafter.
  More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website.

Learn more about Medicare Part C

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

Learn more about Medicare Part D

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

Introduction

- **Course Objectives**
  - When you complete this course, you should correctly:
    - Recognize FWA in the Medicare Program
    - Identify the major laws and regulations pertaining to FWA
    - Recognize potential consequences and penalties associated with violations
    - Identify methods of preventing FWA
    - Identify how to report FWA
    - Recognize how to correct FWA

Lesson 1 - What is FWA?

- **Introduction and Learning Objectives**
  - This lesson describes Fraud, Waste, and Abuse (FWA) and the laws that prohibit it. It should take about 10 minutes to complete. Upon completing the lesson, you should be able to correctly:
    - Recognize FWA in the Medicare Program
    - Identify the major laws and regulations pertaining to FWA
    - Recognize potential consequences and penalties associated with violations

Lesson 1 - What is 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. The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000

- **Waste** includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such a overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

- **Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is not legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the "Medicare Managed Care Manual" and Chapter 9 of the "Prescription Drug Benefit Manual" on the Centers for Medicare & Medicaid Services (CMS) website.

Lesson 1 - What is FWA?

- **Examples of FWA**
  - Examples of actions that may constitute Medicare **fraud** include:
    - Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments that the patient failed to keep
    - Billing for non-existent prescriptions
    - Knowingly altering claim forms, medical records, or receipts to receive a higher payment
  - Examples of actions that may constitute Medicare **waste** include:
    - Conducting excessive office visits or writing excessive prescriptions
    - Prescribing more medications than necessary for the treatment of a specific condition
    - Ordering excessive laboratory tests
  - Examples of actions that may constitute Medicare **abuse** include:
    - Unknowingly billing for unnecessary medical services
    - Unknowingly billing for brand name drugs when generics are dispensed
    - Unknowingly excessively charging for services or supplies
    - Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Lesson 1 - What is FWA?

- **Differences Among Fraud, Waste, and Abuse**
  - There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge that the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program, but does not require the same intent and knowledge.

- **Understanding FWA**
  - To detect FWA, you need to know the **law.**
  - The following pages provide high-level information about the following laws:
    - Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
    - Anti-Kickback Statute
    - Stark Law (Physician Self-Referral Law)
    - Exclusion from all Federal health care programs
    - Health Insurance Portability and Accountability Act (HIPAA)
  - For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

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Lesson 1- What is FWA?

- **Civil False Claims Act (FCA)**
  - The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:
    - Conspires to violate the FCA
    - Carries out other acts to obtain property from the Government by misrepresentation
    - Conceals or improperly avoids or decreases an obligation to pay the Government
    - Makes or uses a false record or statement supporting a false claim
    - Presents a false claim for payment or approval
  - For more information, refer to 31 United States Code (USC) Sections 3729-3733 .

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty.

EXAMPLES

- A Medicare Part C plan in Florida:
  - Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS
  - Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported
  - Failed to report the unsupported diagnosis codes to Medicare
  - Agreed to pay $22.6 million to settle FCA allegations
- The owner-operator of a medical clinic in California:
  - Used marketers to recruit individuals for medically unnecessary office visits
  - Promised free, medically unnecessary equipment or free food to entice individuals
  - Charged Medicare more than $1.7 million for the scheme
  - Was sentenced to 37 months in prison

Whistleblowers: A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent of the money collected.

Lesson 1 - What is FWA?

- **Health Care Fraud Statute**
  - The Health Care Fraud Statute states, "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both."
  - Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 USC Sections 1346-1347.

- **Criminal Health Care Fraud**
  - Persons who knowingly make a false claim may be subject to:
    - Criminal fines up to $250,000
    - Imprisonment for up to 20 years
  - If the violations resulted in death, the individual may be imprisoned for any term of years or for life.
  - For more information, refer to 18 USC Section 1347 .

EXAMPLE

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

- The owners of multiple Durable Medical Equipment (DME) companies in New York:
  - Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors
  - Provided no DME to any beneficiaries as claimed
  - Submitted almost $1 million in false claims to the nonprofit; $300,000 was paid
  - Pleaded guilty to one count of conspiracy to commit health care fraud

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Lesson 1 - What is FWA?

- **Anti-Kickback Statute**
  - The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare Program).
  - For more information, refer to 42 USC Section 1320a-7b(b).

Damages and Penalties

Violations are punishable by:

- A fine up to $25,000
- Imprisonment up to 5 years

For more information, refer to the Social Security Act (the Act), Section 1128B(b) .

EXAMPLE

- From 2012 through 2015, a physician operating a pain management practice in Rhode Island:
  - Conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl
  - Reported patients had breakthrough cancer pain to secure insurance payments
  - Received $188,000 in speaker fee kickbacks from the drug manufacturer
  - Admitted the kickback scheme cost Medicare and other payers more than $750,000
- The physician must pay more than $750,000 restitution and is awaiting sentencing

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Lesson 1- What is FWA?

- **Stark Law (Physician Self-Referral Law)**
  - The Stark Law prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:
    - An ownership/investment interest
    - A compensation arrangement
  - Exceptions may apply.
  - For more information, refer to 42 USC Section 1395nn.

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Law are not payable. A penalty of around **$24,250** may be imposed for each service provided. There may also be around a **$161,000** fine for entering into an unlawful arrangement or scheme.

For more information, visit the Physician Self-Referral webpage and refer to the Act, Section 1877.

EXAMPLE

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

Lesson 1 - What is FWA?

- **Civil Monetary Penalties (CMP) Law**
  - The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:
    - Arranging for services or items from an excluded individual or entity
    - Providing services or items while excluded
    - Failing to grant OIG timely access to records
    - Knowing of an overpayment and failing to report and return an overpayment
    - Making false claims
    - Paying to influence referrals
  - For more information, refer to 42, USC 1320a-7a and the Act, Section 1128A(a) .

Damages and Penalties

The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item
- Of remuneration offered, paid, solicited, or received

EXAMPLE

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

Lesson 1 - What is FWA?

- **Exclusion**
  - No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).
  - The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.
  - When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 USC Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901 .

EXAMPLE

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

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Lesson 1- What is FWA?

- **Health Insurance Portability and Accountability Act (HIPAA)**
  - HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
  - HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.
  - For more information, visit HIPAA webpage.

Damages and Penalties

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

EXAMPLE

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

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Lesson 1- What is FWA?

- **Lesson Summary**
  - There are differences among fraud, waste, and abuse (FWA). One of the primary differences is **intent** and **knowledge**. Fraud requires the person have intent to obtain payment and the knowledge his or her actions are wrong. Waste and abuse may involve obtaining an improper payment but not the same intent and knowledge.
  - Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:
    - Civil Monetary Penalties
    - Civil prosecution
    - Criminal conviction, fines, or both
    - Exclusion from all Federal health care program participation
    - Imprisonment
    - Loss of professional license

- **Lesson Review**
  - Now that you have completed Lesson 1, let's do a quick knowledge check.

Lesson 1 - What is FWA?

- **Knowledge Check - Select the Correct Answer**

1. **Which of the following requires intent to obtain payment and the knowledge that the actions are wrong?**
   a. Fraud
   b. Abuse
   c. Waste

2. **Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting Fraud, Waste, and Abuse (FWA)?**
   a. Civil Monetary Penalties
   b. Deportation
   c. Exclusion from participation in all Federal health care programs

Correct Answers: 1. A; 2. B

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Lesson 2 - Your Role in the Fight Against FWA

- **Introduction and Learning Objectives**
  - This lesson explains the role you can play in fighting against Fraud, Waste, and Abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. It should take about 10 minutes to complete. Upon completing the lesson, you should be able to correctly:
    - Identify methods of preventing FWA
    - Identify how to report FWA
    - Recognize how to correct FWA

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Lesson 2 - Your Role in the Fight Against FWA

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

Lesson 2 - Your Role in the Fight Against FWA

- **Where Do I Fit In? *(cont.)***
  - **I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.**
    - The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.
    - Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.
  - **I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.**
    - The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flowchart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.
    - Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

Lesson 2 - Your Role in the Fight Against FWA

- **What Are Your Responsibilities?**
  - You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare non-compliance.
    - **FIRST**, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
    - **SECOND**, you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations of which you may be aware.
    - **THIRD**, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.
- **How Do You Prevent FWA?**
  - Look for suspicious activity
  - Conduct yourself in an ethical manner
  - Ensure accurate and timely data and billing
  - Ensure coordination with other payers
  - Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS's guidance
  - Verify all received information
- **Stay Informed About Policies and Procedures**
  - Know your entity's policies and procedures.
  - Every Sponsor and First-Tier, Downstream, or Related Entity (FDR) must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.
  - Standards of Conduct should describe the Sponsor's expectations that:
    - All employees conduct themselves in an ethical manner
    - Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA
    - Reported issues will be addressed and corrected
  - Standards of Conduct communicate to employees and FDRs that compliance is everyone's responsibility, from the top of the organization to the bottom.

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Lesson 2 - Your Role in the Fight Against FWA

- **Report FWA**
  - Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.
  - Report any potential FWA concerns you have to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.
Review your organization's materials for the ways to report FWA.

When in doubt, call your Compliance Department or FWA Hotline.

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Lesson 2 - Your Role in the Fight Against FWA

- **Reporting FWA Outside Your Organization**
  - If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice (DOJ), or CMS.
  - Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government- directed investigation and civil or administrative litigation.

- **Details to Include When Reporting FWA**
  - When reporting suspected FWA, include:
    - Contact information for the information source, suspects, and witnesses
    - Alleged FWA details
    - Alleged Medicare rules violated
    - The suspect's history of compliance, education, training, and communication with your organization or other entities

WHERE TO REPORT FWA

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.gov
- Online: Forms.OIG.hhs.gov/hotlineoperations/index.aspx

For Medicare Parts C and D:

- Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal health care programs:

- CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Medicare beneficiary website: Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

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Lesson 2 - Your Role in the Fight Against FWA

- **Correction**
  - Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS requirements.
  - Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances. In general:
    - Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance.
    - Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions.
    - Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action.
    - Monitor corrective actions continuously to ensure effectiveness.

Corrective Action Examples

Corrective actions may include:

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

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Lesson 2 - Your Role in the Fight Against FWA

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

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

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

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Lesson 2 - Your Role in the Fight Against FWA

- **Key Indicators: Potential Pharmacy Issues**
  - Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
  - Are the dispensed drugs expired, fake, diluted, or illegal?
  - Are generic drugs provided when the prescription requires dispensing brand drugs?
  - Are PBMs billed for unfilled or never picked up prescriptions?
  - Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
  - Do you see prescriptions being altered (changing quantities or Dispense As Written)?

- **Key Indicators: Potential Wholesaler Issues**
  - Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
  - Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics, then marking up the prices, and sending to other smaller wholesalers or pharmacies?

- **Key Indicators: Potential Manufacturer Issues**
  - Does the manufacturer promote off-label drug usage?
  - Does the manufacturer knowingly provide samples to entities that bill Federal health care programs for them?

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

Lesson 2 - Your Role in the Fight Against FWA

- **Lesson 2 Summary**
  - As a person providing health or administrative services to a Medicare Parts C or D enrollee, you play a vital role in preventing fraud, waste, and abuse (FWA). Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
  - Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.
  - Promptly correct identified FWA with an effective corrective action plan

- **Lesson 2 Review**
  - Now that you have completed Lesson 2, let's do a quick knowledge check.

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Lesson 2 - Your Role in the Fight Against FWA

- **Knowledge Check - Select the Correct Answer**

1. **A person drops off a prescription for a beneficiary who is a "regular" customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery. What is your next step?**
   a. Fill the prescription for 160
   b. Fill the prescription for 60
   c. Call the prescriber to verify the quantity
   d. Call the Sponsor's compliance department
   e. Call law enforcement

2. **Your job is to submit a risk diagnosis to the Centers for Medicare & Medicaid Services (CMS) for the purpose of payment. As part of this job, you use a process to verify the data is accurate. Your immediate supervisor tells you to ignore the Sponsor's process and to adjust or add risk diagnosis codes for certain individuals. What should you do?**
   a. Do what your immediate supervisor asked you to do and adjust or add risk diagnosis codes
   b. Report the incident to the compliance department (via compliance hotline or other mechanism)
   c. Discuss your concerns with your immediate supervisor
   d. Call law enforcement

Correct Answers: 1. C; 2. B; 3. B; 4. E

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Lesson 2 - Your Role in the Fight Against FWA

- **Knowledge Check - Select the Correct Answer**

3. **You are in charge of paying claims submitted by providers. You notice a certain diagnostic provider ("Doe Diagnostics") requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize Doe Diagnostics' claims far exceed any other provider that you reviewed. What should you do?**
   a. Call Doe Diagnostics and request additional information for the claims
   b. Consult with your immediate supervisor for next steps or contact the compliance department (via compliance hotline, Special Investigations Unit [SIU], or other mechanism)
   c. Reject the claims
   d. Pay the claims

4. **You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?**
   a. Call local law enforcement
   b. Perform another review
   c. Contact your compliance department (via compliance hotline or other mechanism)
   d. Discuss your concerns with your supervisor
   e. Follow your pharmacy's procedures

Correct Answers: 1. C; 2. B; 3. B; 4. E

FWA Training: Post-Assessment

Select the correct answer.

1. Once a corrective action plan is started, the corrective actions must be monitored annually to ensure they are effective.
    - ○ A. True
    - ○ B. False
2. Ways to report potential fraud, waste, and abuse (FWA) include:
    - ○ A. Telephone hotlines
    - ○ B. Mail drops
    - ○ C. In-person reporting to the compliance department/supervisor
    - ○ D. Special Investigations Units (SIUs)
    - ○ E. All of the above
3. Any person who knowingly submits false claims to the Government is liable for five times the Government's damages caused by the violator plus a penalty.
    - ○ A. True
    - ○ B. False
4. These are examples of issues that can be reported to a Compliance Department: suspected fraud, waste, and abuse (FWA); potential health privacy violation, and unethical behavior/employee misconduct.
    - ○ A. True
    - ○ B. False

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FWA Training: Post-Assessment

Select the correct answer. ***(cont.)***

5. Bribes or kickbacks of any kind for services that are paid under a Federal health care program (which includes Medicare) constitute fraud by the person making as well as the person receiving them.

- ○ A. True
- ○ B. False

6. Waste includes any misuse of resources, such as the overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.

- ○ A. True
- ○ B. False

7. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

- ○ A. True
- ○ B. False

8. Some of the laws governing Medicare Parts C and D fraud, waste, and abuse (FWA) include the Health Insurance Portability and Accountability Act (HIPAA), the False Claims Act, the Anti-Kickback Statute, and the Health Care Fraud Statute.

- ○ A. True
- ○ B. False

FWA Training: Post-Assessment

Select the correct answer. ***(cont.)***

9. You can help prevent fraud, waste, and abuse (FWA) by doing all of the following:
    - Look for suspicious activity
    - Conduct yourself in an ethical manner
    - Ensure accurate and timely data and billing
    - Ensure you coordinate with other payers
    - Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance
    - Verify all information provided to you
    - A. True
    - B. False

10. What are some of the penalties for violating fraud, waste, and abuse (FWA) laws?
    - A. Civil Monetary Penalties
    - B. Imprisonment
    - C. Exclusion from participation in all Federal health care programs
    - D. All of the above

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Appendix A: Resources

- **Disclaimers**

  This course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided for your reference.

  This course was prepared as a service to the public and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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- **Glossary**

  For glossary terms, visit the Centers for Medicare and Medicaid Services Glossary.

Appendix B: Job Aids

Job Aid A: Applicable Laws for Reference

- Anti-Kickback Statute 42 USC Section 1320A-7b(b)
- Civil False Claims Act 31 USC Sections 3729–3733
- Civil Monetary Penalties Law 42 USC Section 1320a-7a
- Criminal False Claims Act 18 USC Section 287
- Exclusion 42 USC Section 1320a-7
- Health Care Fraud Statute 18 USC Section 1347
- Physician Self-Referral Law 42 USC Section 1395nn

HYPERLINK URL	KINKED TEXT/IMAGE
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pd	42 USC Section 1320A-7b(b)
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf	31 USC Sections 3729–3733
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf	42 USC Section 1320a-7a
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap15-sec287.pdf	18 USC Section 287
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf	42 USC Section 1320a-7
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf	18 USC Section 1347
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf	42 USC Section 1395nn

Appendix B: Job Aids

Job Aid B: Resources

- Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
- OIG's Provider Self-Disclosure Protocol
- Physician Self-Referral
- Avoiding Medicare Fraud and Abuse: A Roadmap for New Physicians
- Safe Harbor Regulations

HYPERLINK URL	LINKED TEXT/IMAGE
https://oig.hhs.gov/compliance/provider-compliance-training	Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training
https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf	OIG's Provider Self-Disclosure Protocol
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral	Physician Self-Referral
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html	Avoiding Medicare Fraud and Abuse: A Roadmap for New Physicians
https://oig.hhs.gov/compliance/safe-harbor-regulations	Safe Harbor Regulations

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Appendix B: Job Aids

Job Aid C: Where to Report Fraud, Waste, and Abuse (FWA)

- HHS Office of Inspector General:
  Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
  Fax: 1-800-223-8164
  Email: HHSTips@oig.hhs.gov
  Online: Forms.OIG.hhs.gov/hotlineoperations/index.aspx
- For Medicare Parts C and D:
  Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)
- For all other Federal health care programs:
  CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048
- HHS and U.S. Department of Justice (DOJ): Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

HYPERLINK URL	LINKED TEXT/IMAGE
mailto:hhstips@oig.hhs/gov	HHSTips@oig.hhs.gov
https://forms.oig.hhs.gov/hotlineoperations/index.aspx	Forms.OIG.hhs.gov/hotlineoperations/index.aspx
https://www.medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html	Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

Links to Source Documents

HYPERLINK URL	LINKED TEXT/IMAGE
https://www.ecfr.gov/cgi-bin/text-idx?SID=c66a16ad53319afd0580db00f12c5572&mc=true&node=pt42.3.422&rgn=div5#se42.3.422_1503	42 Code of Federal Regulations (CFR) Section 422.503
https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=c66a16ad53319afd0580db00f12c5572&mc=true&r=PART&n=pt42.3.423#se42.3.423_1504	42 CFR Section 423.504
https://www.gpo.gov/fdsys/pkg/FR-2014-05-23/pdf/2014-11734.pdf	CMS-4159-F, Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf	Chapter 9 of the Medicare Prescription Drug Benefit Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Chapter 21 of the Medicare Managed Care Manual
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf	Medicare Parts C and D compliance trainings and answers to common questions
http://www.gpo.gov/fdsys/pkg/USCODE-2013-title31/pdf/USCODE-2013-title31-_subtitleIII-chap37-subchapIII.pdf	31 USC Sections 3729-3733

Links to Source Documents

HYPERLINK URL	LINKED TEXT/IMAGE
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1346.pdf	18 USC Sections 1346–1347
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf	18 USC Section 1347
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pdf	42 USC Section 1320a-7b(b)
https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm	Social Security Act (the Act), Section 1128B(b)
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf	42 USC Section 1395nn
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral	Physician Self-Referral webpage
https://www.ssa.gov/OP_Home/ssact/title18/1877.htm	the Act, Section 1877
https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf	42 USC 1320a-7a
http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm	the Act, Section 1128A(a)
https://exclusions.oig.hhs.gov	LEIE
https://www.sam.gov	EPLS

Links to Source Documents

HYPERLINK URL	LINKED TEXT/IMAGE
http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/pdf/CFR-2014-title42-vol5-sec1001-1901.pd	42 Code of Federal Regulations Section 1001.1901
http://www.hhs.gov/hipaa	HIPAA webpage
mailto:hhstips@oig.hhs/gov	HHSTips@oig.hhs.gov
https://forms.oig.hhs.gov/hotlineoperations/index.aspx	Forms.OIG.hhs.gov/hotlineoperations/index.aspx
https://www.medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html	Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html
https://www.cms.gov/apps/glossary	Centers for Medicare and Medicaid Services Glossary

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Vital Plan
Compliance and Integrity Programs

Compliance Program and Code of Conduct

Compliance is EVERYONE'S responsibility!

As an Individual or Entity that provides services to Beneficiaries of Medicaid under the Government Health Plan.

Every action has a direct potential to affect our Beneficiaries.

General Vision

- The Puerto Rico Health Insurance Administration (PRHIA), as well as the Medicare and Medicaid Service Centers (CMS), require annual trainings of compliance, privacy and fraud, waste and abuse ("FWA") for the organizations that provide health services.

- MMM Multihealth is committed with Ethics, Corporate Compliance, and with all the laws, regulations and guides that govern the requirements of the Medicaid Program.

Compliance Officer- Medicaid
Liza Rivera - Ortiz

Compliance Officer Roles and Responsibilities:

- Be aware of regulatory changes and / or contractual amendments, keeping the operational areas updated;
- Maintain a continuous and effective communication with the regulatory entities;
- Evaluate performance of operations and require corrective and disciplinary actions if necessary;
- Keep MMM-MH's top management informed about all aspects and regulatory requirements;
- Identify, correct and monitor the aspects that may represent a level of corporate risk, which have been identified internally or externally;
- Provide an environment of "open doors" for easy access for employees, where they can refer and attend to regulatory aspects, without fear of retaliation;
- Support compliance efforts established through the company.

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Employees, Contractors and Sub-Contractors Responsibilities

First

- Comply with all requirements, statutes and regulations of PRHIA and Medicaid, policies and corporate procedures and the Ethic and Conduct Code.

Second

- Report any violations to the management and Compliance Officer.

Third

- Comply with all operational, regulatory and compliance trainings.

What is a Compliance Program?

- A Compliance Program is a set of internal controls and measures to ensure the entities follow the applicable rules and regulations that govern the federal programs, such as Medicare and Medicaid.
- The adoption of a Compliance Program reduces significantly the risk of fraud, waste and abuse, while it guarantees access to patient care and quality of services.

7 Elements of an Effective Compliance Program

1. **Written Policies, Procedures and Standard of Conduct**: develop and keep written policies and procedures.
2. **Compliance Officer, Compliance Committee and communication with High level Management**: designation of an Officer and a Committee that have the responsibility and authority of operating and monitoring the Compliance Program.
3. **Effective Training and Education** : development and implementation of trainings and effective continuing education.
4. **Effective Audit System, Continuous Monitoring and Notification of Compliance Risks**: Use of risk evaluation techniques and audits to monitor compliance and help reduce identified situations in the areas.

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7 Elements of an Effective Compliance Program

5. **Discipline Mechanisms Properly Published**: policies to establish disciplinary actions and strengthen standards consistently.
6. **Effective Lines of Communication**: Among the Compliance Officer, employees and the organizations management, as well as with contractors, subcontractors and related entities.
   - Their should be a system to respond to questions about regulations, reports or situations with a potential of non-compliance.
   - Every person should have the tools to report suspected breaches of confidentiality.
7. **Procedures to respond in a fast and timely manner to situations of compliance**: policies of response and immediate corrective actions to prevent and avoid similar situations in the future.

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What is Non-compliance?

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

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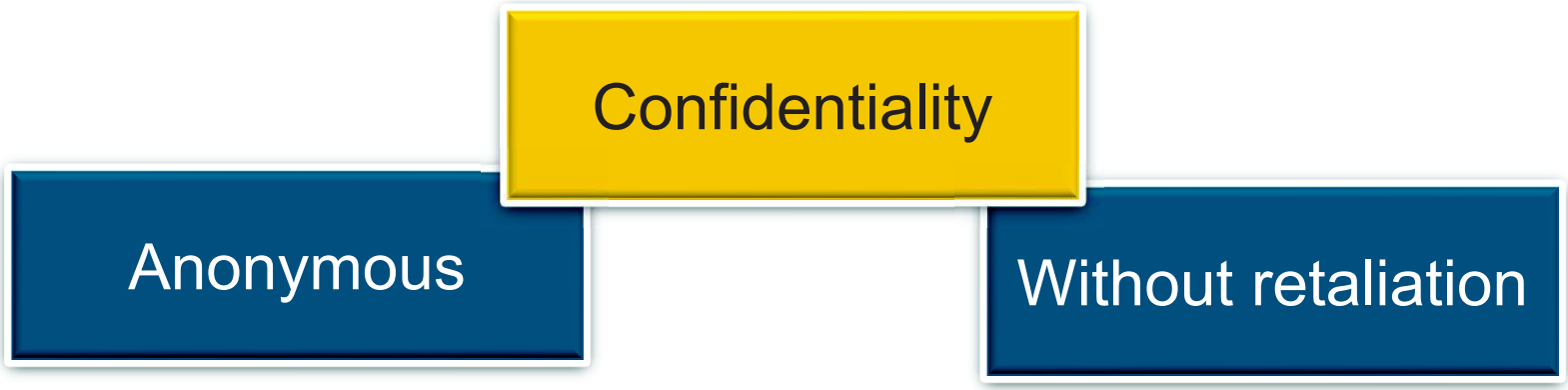
No Retaliation Policy

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

MMM Multihealthoffers methods to report, these are:



How can I report Possible Non-Compliance?

Provider, Beneficiary or Delegated Entities

Call the help line of Ethics Point

1-844-256-3953

Employees

- Contact your supervisor or manager
- Report through the Ethics Point service line **1-844-256-3953**

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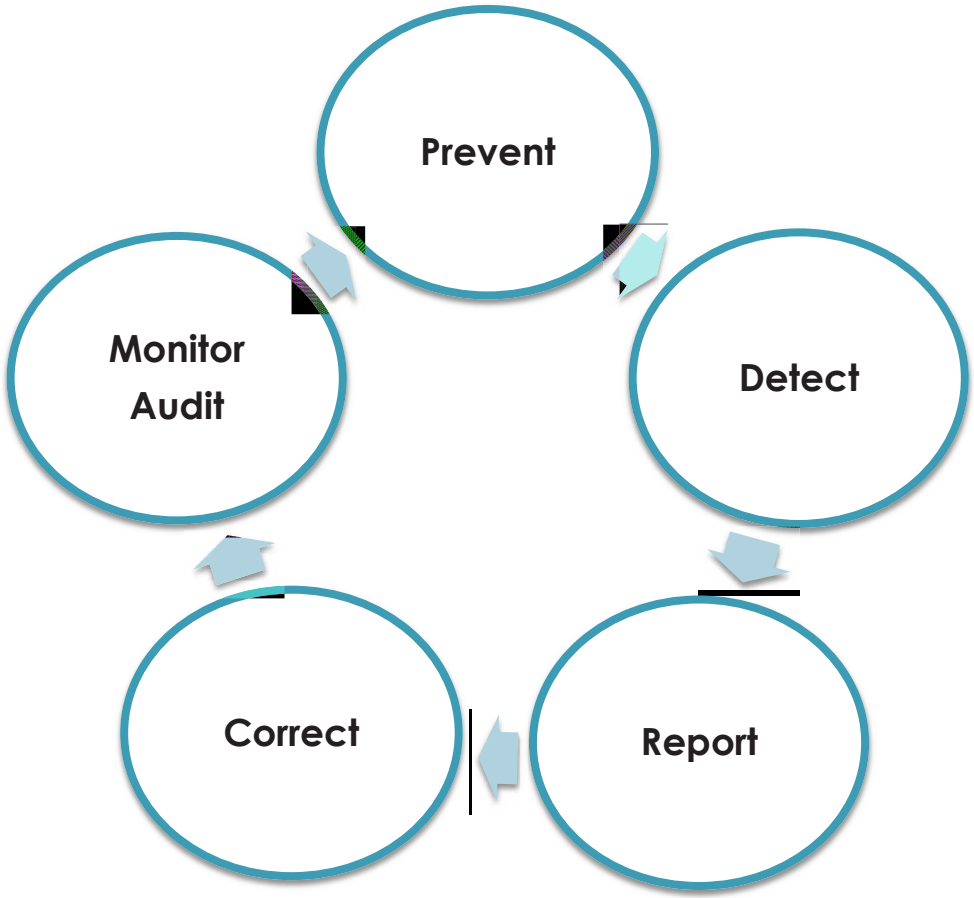
How to prevent Non-Compliance recurrence?

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



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Ethic – Do what is correct!

Corporate Code of Ethic and Conduct

Objectives:

- Promote the highest Standards of Ethic and Integrity.
- Establish Guidelines and Standards about how to behave responsibly.
- Regulate EVERYONE'S behavior.

Corporate Code of Ethic and Conduct

Principles:

I. We must do business in accordance with the law at any moment.

II. We must strive to realize the assigned tasks using the highest ethic standards.

III. We must avoid any situation where a conflict may occur or apparently exists between our personal interests and the company interests.

    a. Conflict of Interest Policy

IV. We must protect confidential information from Affiliates, Providers and of the company at every moment.

    a. HIPAA

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Corporate Code of Ethic and Conduct

Principles (cont.):

V. We must assure that company's' data is compiled and reported correctly and honestly.

VI. We must assure that company's files are saved accordingly with the applicable laws and the company's Retention of Files Policy.

A.Retention of Files Policy

VII. We must use the company's property for business purpose only.

VIII. We must share information through trainings and participate of training programs, because it's our most valuable tool to develop our most important resource, our employees.

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Corporate Code of Ethic and Conduct

Principles (cont.):

IX. We must assure that our relations with others members of the Team, Business partners, Providers and Affiliates, are performed with honesty, justice, dignity and respect at every moment.

X. We must respect our relation with the Government as our client.

XI. We must report immediately any activity or conduct that we believe is inconsistent with the policies, guides or standards.

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Conflict of Interest Policy

- As established in the Compliance Program, employees and management should avoid those situations where their personal interests can cause conflict or appear conflict with the interests of the company.

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

Conflict of Interest Policy

Examples:

- Presents and Entertainment;
  - Cannot accept gifts or unusual favors from clients, competition o suppliers;
  - Gifts to clients-nominal value of $15

- Supervise a family member;
- Do business with a family member employed by a Provider or Supplier;
- Financial relations with entities that actually have or that in the future may have relation with the company;
- Be member of the Board of Directors of another company;
- Perform any function or offer services for the competition or suppliers, without the consent of the company.

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Integrity Program

Fraude, Waste and Abuse (FWA)

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

- It is estimated that at least 3% - or more than $100 billon a year, is lost due to fraud.

- You are part of the solution.

- You should be alert to any activity that may appear suspicious.

Who can commit Fraud?

Fraud in health services can be committed at different levels, including but not limiting to;

- A Provider or Employee of a contracted entity;
- A Beneficiary;
- A Medicaid Employee, among others.

How can I prevent FWA?

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

Definitions

Fraud

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

Waste

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

Abuse

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

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Differences between Fraud, Waste and Abuse

The main difference is the intention and knowledge.

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

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

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Applicable Laws and Regulations

- The False Claims Act prohibits that any person:
  - Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.
  - Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government.
  - Conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government.

- Penalties:

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

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Applicable Laws and Regulations

Anti-Kickback Statute

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

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

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

Whistleblower Protections

The Federal False Claims Act includes a qui tam provision that allows people who are not affiliated with the government, to file actions on behalf of the Government.

The provision also protects employees who file FCA qui tam cases from discharge, demotion, suspension, threats, harassment and discrimination in the terms and conditions of employment.

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Applicable Laws and Regulations

Penalties for violation of the Anti-Kickback Statute

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

Penalties for violation of the Anti-Kickback Statute

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

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Applicable Laws and Regulations

• Penalties Under the Stark Law

The penalties for violating the "Stark" law include:

Up to $ 23,863 of fine for each service provided.

Recovery of claims.

The possibility of exclusion from federal health programs.

• Exclusion Provisions

- Federal health care programs should not be billed for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity.

42 U.S.C. § 1395 (e) (1)

42 C.F.R. § 1001.1901

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List of Excluded Individuals and Entities (LEIE)

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

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

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Each Employee, depending on their role within the company, must be able to recognize warning signs of potential fraud or abuse. Below are some examples and indicators of possible fraud or abuse.

Examples of potential FWA

Upcoding

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

Unbundling

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

Eligibility Fraud

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

Falsification of Credentials of healthcare Providers

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

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Examples of potential FWA

False Representation

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

Non-Medically Necessary Services

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

Fraud and Abuse of Beneficiaries

Beneficiaries may abuse the system through improper use of services, such as the sale of prescription drugs or medical equipment. Other forms of fraud may include share Medicaid card or number with an ineligible person for that person to receive health services to which he or she is not entitled.

Billing for Services or items not furnished

Either through the use of genuine patient information, sometimes obtained through identity theft, to fabricate claims for procedures or services that were not performed.

Incorrect Coding

Incorrect coding of non-covered services, such as medically necessary covered services, in order to obtain payments

This has been widely seen in cosmetic surgery schemes, in which cosmetic procedures not covered such as rhinoplasty, are billed as repair of septum deviation.

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FWA Key Indicators:

- A medical order, progress note, preauthorization request, result, or other document that appears to be altered or falsified.
- The services are not supported by Beneficiary's medical history.
- A Provider that bills services much more than other Providers of the same specialty and/or region.
- A Provider who prescribes mainly controlled medications.
- A Beneficiary with various narcotic orders, high doses and different prescribers.
- Medical records have no evidence of the results of billed studies.
- A Provider with a pattern of misuse of modifiers.

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Measures to Prevent FWA

Provider Enrollment and Contractual Requirements:

- Processes have been established to validate that Contracted Providers comply with State requirements, licensure, disclosures of interest in property and criminal convictions, among others.

Education of Beneficiaries and Providers:

- MMM Multihealth must ensure that Beneficiaries, Providers and their employees are effectively educated about fraud and abuse, and how and where to report it.

Mechanisms to Report Suspected Fraudulent Activity :

- MMM Multihealth has several mechanisms to report suspicious situations confidentially "hotline", "Ethics Point", email and postal mail. MMM Multihealth prohibit retaliation against any Employee who, in good faith, refers a possible FWA case.

Exclusion Screening:

- MMM Multihealth has implemented policies and procedures to review the lists of individuals or entities excluded by OIG before hiring a Provider, Employee or Contractor, and then monthly.

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What can Beneficiaries do to prevent FWA?

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

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Don’t forget!

Consequences of commiting FWA:

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

Report FWA

You do not have to determine whether the situation is fraud, waste or abuse. Report any concerns to the organization's Compliance Department.

The Compliance Department will investigate and make the appropriate determination.

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How to Report?

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

Each employee has the right, obligation and responsibility to report suspicions FWA and possible violations.

Privacy and Security
HIPAA

Health Insurance Portability and Accountability Act

HIPAA Law

- HIPAA is a federal ordinance that all health insurances and healthcare providers must comply with to protect the privacy and security of each and everyone's healthcare information.

- HIPAA is regulated by:
  - The Office of Civil Rights of the Department of Health and Human Services.

What is HIPAA?

- It's acronym means:

Health

Insurance

Portability and

Accountability

Act of 1996

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HIPAA

Health Insurance Portability and Accountability Act of 1996

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

The section of Privacy consists of **establishing safeguards to** prevent not authorized access to protected health information.

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

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HIPAA

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

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Entities Covered by HIPAA:

- Healthcare Insurances;
- "Healthcare Clearinghouses"
- Healthcare Providers.

Standard of Minimum Required:

- PHI information (quantity) to be disclosed should be the necessary to satisfy a particular purpose or to perform a specific function.

PHI- Protected Health Information

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

PHI should only be listened by people authorized to hear the disclosed information.

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

PII – *Personally Identifiable Information* – Personally identifiable information also should be protected and limited only with authorized persons.

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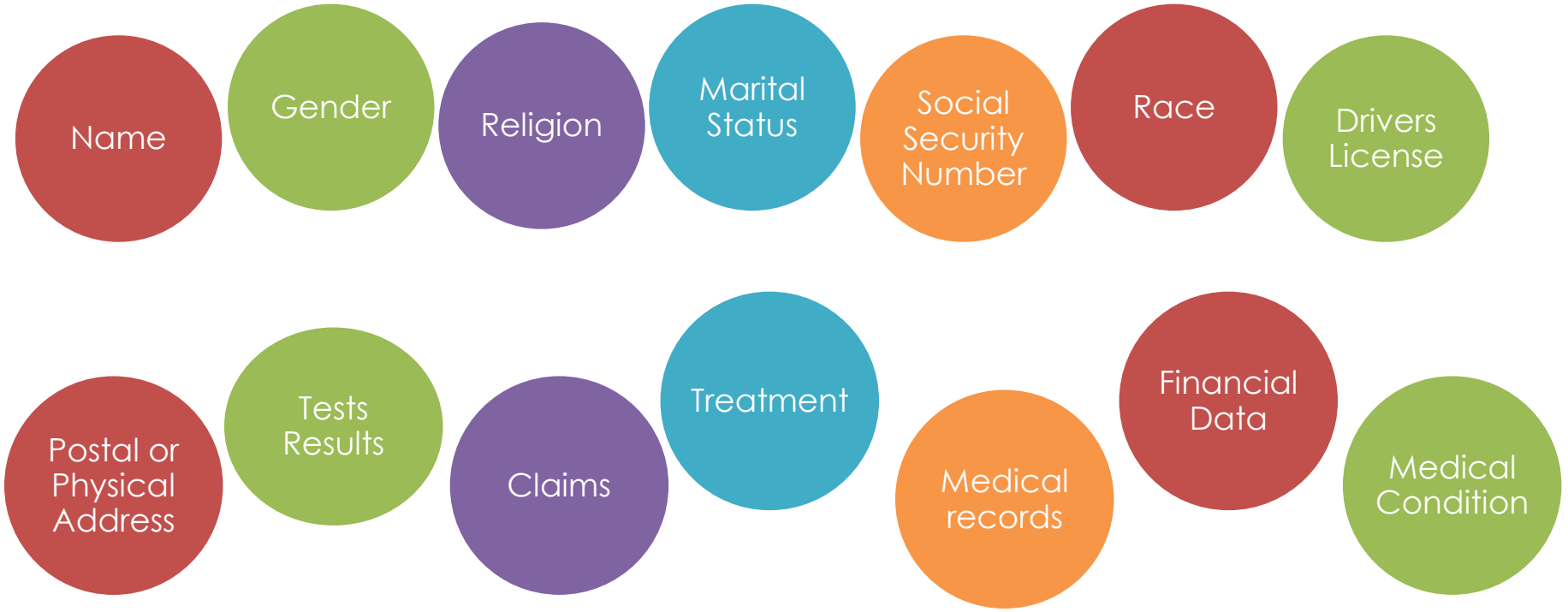
What does HIPAA protect?

Examples of Protected Health Information (PHI)



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PHI Authorization of Disclousure

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

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

Any other use requires authorization

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

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

- The parents or legal tutors of the not emancipated minors have the right to have disclosed protected health information (PHI) of such minors.
- The parent or tutor will be the personal representative of the minor, without the necessity of requiring a PHI authorization to disclose his/her information.

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

- If the minor is emancipated: (because of marriage, because his/her parents or a court emancipated him/her) then, the minor can choose who divulge his/her PHI information.
- When the law allows it, the parents or legal tutors will not be able to obtain PHI from the non emancipated minor when:
  - the medical service does not require consent of the parents or tutors
  - the minor and a court or another authorized person by law consent to such medical service.
- The parent or legal tutor can consent to a confidentiality agreement between a health care provider and the minor over a medical service.

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Privacy and Security

Privacy Practice Notification

- Document that explains the rights that individuals have and the responsibilities of covered entities related to PHI.

Security Measures in MMM Multihealth:

- Clean Desk Policy;
- Passwords / control of access to the systems and facilities (unique user identification);
- Entrance access and inventory of user identifications;
- Incident Reports;
- Audits;
- Control of email, printers and fax;
- File storage;
- Monitor visits access;
- Policies and procedures.

Keep in mind…

- The storage, transmission and inappropriate handling of PHI may cause theft or loss of the information and access to not authorized individuals (breach).
- If you come in knowledge about not authorized access to PHI, you must communicate immediately with the Privacy Officer and/or the Compliance Office.
- To comply with the law, any access not authorized to PHI should be notified to the affected, PRHIA and the Civil Rights Office within the required timeframe.
- Every Beneficiary has the right to present a complaint about non-compliance with the HIPAA law if he/she feels that his/her information has not been handled appropriately.
- The grievance can be settled in the health plan, in the Office of Civil Rights of the Human and Health Services Department or the Patient's Attorney's Office.

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Keep in mind…

Santions and violations to the established HIPAA law can result in but not limiting to;

- Fines
- Jail

Contact Information:

GHP Compliance Program
Shahayra Aguilu Benitez-MBA
Compliance Manager-Medicaid
Cel.787-402-9737
Tel. 787-622-3000 Ext. 3505
Email: shahayra.aguilu@mmmhc.com

Liza Rivera-Ortiz
Compliance Officer - Medicaid
MMM Multihealth
P.O. Box 71114
San Juan, PR 00936-8014
Tel. 787-622-3000, Ext. 2233
Cel. 787-918-7332
Email: liza.rivera@mmmhc.com

How to report non compliance and FWA incidents?

- Internet – though the webpage "Ethics Point" : www.psg.ethicspoint.com
- Telephone: "Ethics Point":

1-844-256-3953

- Referrals through email: GHP_SIU@mmmhc.com

Thank you!

Corporate Training of Regulations Applicable to the Healthcare Industry

November 2019 Revision

Agenda

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

1. Cultural Competence Plan
2. Previous Will for Medical Treatment in Case of Suffering a Terminal Health Condition or Persistent Vegetative State (Law 160 of November 17, 2001), better known as "Advance Directives"
3. Patients Rights and Responsibilities(Law 194 of August 25, 2000, as amended)
4. Protocol for the prevention and identification of potential cases of financial exploitation of elderly or disabled adults

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Cultural Competence Plan

What is Cultural Competency?

A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and the sensitivity to know how these differences influence relationships with Enrollees. It is the ability to understand, interact and collaborate well with different people.

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Cultural Competence Plan

- Employees and associates of the Plan must provide service to all beneficiaries of any culture, race, ethnicity, gender identity, gender expression, real or perceived sexual orientation (lesbian, gay, bisexual, transgender better known as LGBTT + population),and religion; in order to recognize the values, respect, protect and preserve the dignity of each individual.
- The purpose is to ensure that the diverse needs of the beneficiaries are considered.

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Cultural Competence Plan Objectives

- Identify beneficiaries who have cultural limitations or language barriers.
- Ensure that all available resources meet communication requirements regarding language barriers.
- Ensure that health providers understand and recognize needs according to cultural differences.
- Ensure that all employees and associates are trained to assess cultural, religious and language differences.

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Cultural Competence Plan Objectives

- Increase communication with beneficiaries who have cultural competences or language barriers.
- Utilize culturally sensitive and appropriate educational materials for each type of cultural limitations including race, religion, LGBT(Lesbian, Gay, Bisexual and Transgender) communities, ethnicity or language.
- Decrease discrepancies in medical care received.
- Increase the understanding of our employees, contractors, health providers, about cultural and religious differences.

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Cultural Competence Plan Components

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

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Cultural Competence Plan Components

- Language or interpreter services
  - Providers help identify beneficiaries with possible linguistic barriers.
  - In coordination with the Beneficiary Services Department, they receive free interpreter services to access the covered services.
  - Interpreter services include interpretation for beneficiaries with limitations in the Spanish language or auditory impairments.
  - Contractors who provide service to our beneficiaries must comply with the approved cultural competency plan.
  - Written materials are available in both Spanish and English.

Cultural Competence Plan Components

- Religious beliefs
  - Ensure that all employees respect the beneficiaries according to their religious beliefs.
  - Providers must comply with the religious beliefs of the beneficiaries when providing medical treatment services.

Cultural Competence Plan Components

- LGTT+ Population Anti-discrimination
  - A Providers Guide is available for sensitive and adequate management when providing health services to LGBTT + enrollees that is distributed to all providers.
  - The Provider is responsible for training its staff on sensitivity to the LGBTT + population.
  - The approval and dispatch of medications, as well as medical services, should not be restricted by the enrollee sex.

Cultural Competence Plan components

- Provider Education
  - Provider must be educated according to the cultural competencies plan.
- Electronic media
  - Beneficiaries have access to the TTY / TDD line for audio-impaired services
  - Services to the beneficiary will provide the necessary follow-up services in addition to the call.

Cultural Competence Plan Components

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

Vieques and Culebra Beneficiaries

- A policy is established to require the providers to give priority to the beneficiaries resident of Vieques and Culebra, so that they are taken care of within a reasonable time after arriving at the office.
- This preferential treatment is necessary due to the location of these municipal islands, considering the longer travel time necessary for their residents to obtain medical attention.

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Advance Directives
(Law 160 of November 17, 2001)

Definition

- **Advance Directive:** A written instruction, such as a living will or durable power of attorney, granting responsibility over an individual's health care, as defined in 42 CFR 489.100, and as recognized under Puerto Rico law under Act 160 of November 17, 2001, as amended, relating to the provision of health care when the individual is incapacitated.

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Advance Directives Law

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

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Advance Directives Law

- The responsibility of notifying his/her doctor and /or the health institution about the existence of an advance directive and providing them a copy of such document relapses on the declarant.
- The advanced directive must be signed in front of a Public Notary and two witnesses that are 21 years or older.
- The enrollee can also sign the advanced directive in presence of a physician and two witnesses who are 21 years or older.
- The enrollee can modify the advance directives document, in part or totally; in any moment.
- The revocation of the document can only be requested by written.

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Limitations

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

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

What does the law establish?

Law 194 from August 25, 2000

- Created to establish the Patient Rights and Responsibility Act.
- Provide the patients rights and responsibilities and medical-hospitalary utilizers in Puerto Rico, including providers of these services and their health insurances.
- Define terms; establish dispute settlement procedures, impose penalties; and for other related purposes.
- Custodian, guardian, spouse, relatives, legal representative, attorney-in-fact, or any other person appointed by the courts or by the patient, may exercise these rights if the patient lacks the capacity to make decisions, is declared incapable by law or is a minor.

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Patient Rights

- Obtain information of the Government Health Plan (GHP) about coordinated care, facilities, health professionals, services and service access.
- Receive healthcare services of the most highest quality.
- Be treated with respect, equality and consideration before dignity and privacy.
- Obtain information about option treatment alternatives.
- Participate in decisions about healthcare, including the right to refuse treatment.
- Receive emergency services 24 hours a day, seven days a week.

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Patient Rights

- Continuity of services.
- Request and receive copy of your health care records.
- Confidentiality of your information and healthcare records.
- Settle a complaint, grievance or appeal freely and not affecting adversely the way you are treated.
- Be able to exercise your rights without retaliation.
- Receive information about Advanced Directives and Medical Treatment.

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Patient Responsibilities

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

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Patient Responsibilities

- Communicate your health treatment Advanced Directives.
- Maintain appropriate behavior that does not impair, hinder or prevent other patients receiving the necessary medical care.
- Provide the information required by your plan.
- Notify about any possibly fraudulent activity or inappropriate action related to health services, providers or facilities.

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Penalties and Patients' Advocate Office Role

- Any insurer, health care plan, health professional or health-care provider or person or entity that fails to fulfill any of the responsibilities or obligations imposed by this Act, will incur in an administrative fault and will be punished with penalty of a fine not less than five hundred (500) dollars nor more than five thousand (5,000) dollars for each incident or violation of law.
- The Office of the Patient Advocate (OPP) was created in 2001 to guarantee compliance with the rights and responsibilities of the patient. It is empowered by Act No. 77-2013 and Act No. 170-1988, as amended, to investigate and address any complaint related to the violation of the legal provisions set forth in Act No. 194-2000, as amended, known as "Patient Rights and Responsibilities Charter".

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OPP Contact Information:

Oficina del Procurador del Paciente
Mailing Address: PO Box 11247 San Juan , Puerto Rico 00910-2347

Physical Address: Mercantil Plaza Building, floor 9 Hato Rey, Puerto Rico.

Telephones: 787-977-1100 (Urban) 1-800-981-0031 (Island) ;
To request a grievance: 787-977-1100
Fax: 787-977-0915
info@opp.pr.gov
www.opp.pr.gov

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

What is financial exploitation

Financial *exploitation* is a type of abuse against the elderly or disabled adults carried out by family members, friends, neighbors, and caretakers, among others.

Act Number 121-1986 defines financial exploitation as the improper use of the funds of a competent elderly or disabled adult, of his / her property or resources by another individual, including, but not limited to, fraud, misrepresentation, embezzlement, conspiracy, forgery of documents, falsification of records, coercion, transfer of property through fraud, or denial of access to assets.

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Financial Exploitation - Reasons

Key factors that make exploitation more likely to happen:

- The adult children's financial situation
- Use and abuse of controlled substances by close family members
- Trusting in and providing information related to finances to strangers/others
- Cognitive decline (caused by age or illness)
- Changes in the usual management of bank accounts
- Disputes among adult children for the parents' financial resources

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Signs of Potential Exploitation

Among the signs of financial exploitation of the elderly are:

- Sudden and significant reduction of the balances in checking and savings accounts
- Canceling certificates of deposit before their date of maturity
- Payments made to third party bills via direct debit
- The person looks neglected or unkempt despite adequate income
- Signature forgery
- Unpaid bills
- Termination of vital utilities such as electricity, water, and telephone
- Appearance of property liens or foreclosure notices
- Withdrawal of large sums of cash from bank accounts or changes in spending habits
- Loan applications or signatures on loan applications
- Purchase of vehicles or real estate property without the victim's consent
- Sale of vehicles or of real estate property
- Purchase or cancellation of insurance policies

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Factors that increase the risk of exploitation

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

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How to avoid financial exploitation

Information that our members should know:

- Carefully pick and choose the person with whom you will share your financial information
- Protect your checkbook, credit cards, savings, financial statements, and any other sensitive document: keep them in a safe place
- Do not give out your Social Security number or your debit card's secret or personal identification number (PIN) to anyone, especially over the phone

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Penalties

Law Number 146-2012, sets the following penalties:

- When the sum of the funds, assets, personal or real estate property involved in a case of financial exploitation of an elderly or disabled person adds up to $2,500.00, the offender will incur in a misdemeanor. In those cases where the sums are larger than the abovementioned, he/she will incur in a felony.

- In all cases, the Court will impose a restitution penalty in addition to the set penalty.

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Applicable Laws

The following laws protect the elderly against financial exploitation:

- Act Number 121-1986, as amended, known as the *Bill of Rights of the Elderly*.
- Act Number 206-2008, which orders the Commissioner of Financial Institutions, the Corporation for the Supervision and Insurance of Cooperatives of Puerto Rico and the Office of the Commissioner of Insurance to Implement Those Regulations Necessary, in order to require any financial institution, cooperatives or insurance in Puerto Rico to establish a protocol for the prevention and detection of possible cases of financial exploitation to persons of elderly or adults with disabilities. These institutions are required to notify any situations in which financial exploitation is suspected.
- Act Number 146-2012, as amended, know as the *Puerto Rico Criminal Code*, in its Articles 127-C y D Financial Exploitation of Elderly Persons, sets forth, among other things, the modes and penalties for people who commit this crime.

Contacts

Every MMM employee has the responsibility to refer any potential financial exploitation situation to:

Medicaid Compliance Department
Liza Rivera-Ortiz, Compliance Officer
Medicaid
MMM Holdings, LLC
P.O. Box 71114
San Juan, PR 00936-8014
Phone: 787-622-3000, Ext. 2233
Mobile: 787-918-7332
E-mail: liza.rivera@mmmhc.com

Online, via the Ethics Point webpage:
www.psg.ethicspoint.com
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