



EPIC MANAGEMENT

ANNUAL COMPLIANCE TRAINING

Includes Medicare Parts C & D FWA and General Compliance, HIPAA, Code of Conduct, and Specialized Training Modules.

January
2017

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COMBATING MEDICARE PARTS C & D FRAUD, WASTE, AND ABUSE

From Medicare Learning Network® Web-Based Training

WHY DO I NEED TRAINING?

- ❖ Every year **billions** of dollars are improperly spent because of FWA. It affects everyone – **including you**. This training will help you detect, correct, and prevent FWA.
- ❖ 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.

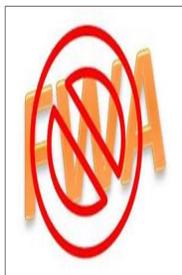
Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

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 WBT 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.

Course content

This course consists of two lessons:



What is FWA?



Your Role in the Fight Against FWA

What is FWA?

Lesson 1: Learning Objectives

This lesson describes Fraud, Waste, and Abuse (FWA) and the laws that prohibit it. 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; and
- Recognize potential consequences and penalties associated with violations.

FRAUD

- ❖ **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

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

ABUSE

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

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

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

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; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

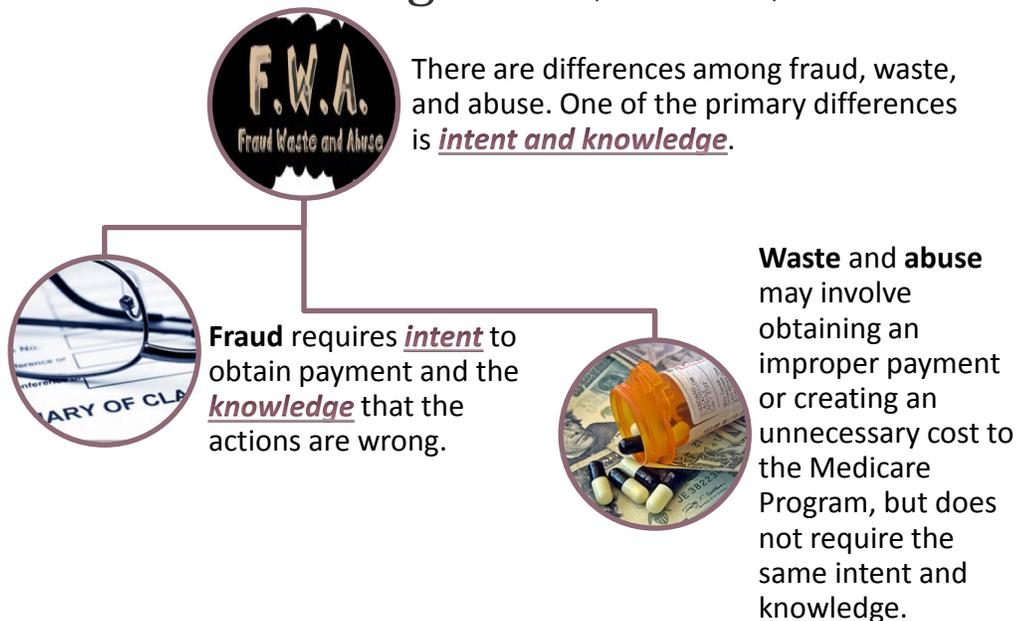
Examples of actions that may constitute Medicare waste include:

- Conducting excessive office visits or writing excessive prescriptions;
- Prescribing more medications than necessary for the treatment of a specific condition; and
- Ordering excessive laboratory tests.

Examples of actions that may constitute Medicare abuse include:

- Billing for unnecessary medical services;
- Billing for brand name drugs when generics are dispensed;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

Differences among Fraud, Waste, and Abuse



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 Statute (Physician Self-Referral Law);
- Exclusion; and
- Health Insurance Portability and Accountability Act (HIPAA).

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

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;
 - Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government;
 - Makes or uses a false record or statement supporting a false claim; or
 - Presents a false claim for payment or approval.

For more information, refer to 31 United States Code (U.S.C.) Sections 3729-3733 on the Internet.

EXAMPLE

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare & Medicaid Services (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; and
- Agreed to pay **\$22.6 million** to settle FCA allegations.

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. The Civil Monetary Penalty (CMP) may range from **\$5,500 to \$11,000** for each false claim.

Civil False Claims Act (FCA)

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 whistle blower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.

Health Care Fraud Statute

The **Health Care Fraud Statute** states that “Whoever knowingly and willfully executes, or attempts to execute, a scheme to ... defraud any health care benefit program ... shall be fined ... 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 U.S.C. Section 1346 on the Internet

EXAMPLE

A Pennsylvania pharmacist:

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

The owners of two Florida Durable Medical Equipment (DME) companies:

- Submitted **false claims** of approximately **\$4 million** to Medicare for products that were not authorized and not provided;
- Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;
- Were **sentenced to 54 months in prison**; and
- Were ordered to pay **more than \$1.9 million** in restitution.

Criminal Fraud

Persons who knowingly make a false claim may be subject to:

Criminal fines up to **\$250,000**;

- Imprisonment for up to **20 years**; or

Both.

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 U.S.C. Section 1347 on the Internet.

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 U.S.C. Section 1320A-7b (b) on the Internet.

Damages and Penalties

Violations are punishable by:

- A fine of up to **\$25,000**;
- Imprisonment for up to **5 years**; or
- **Both.**

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

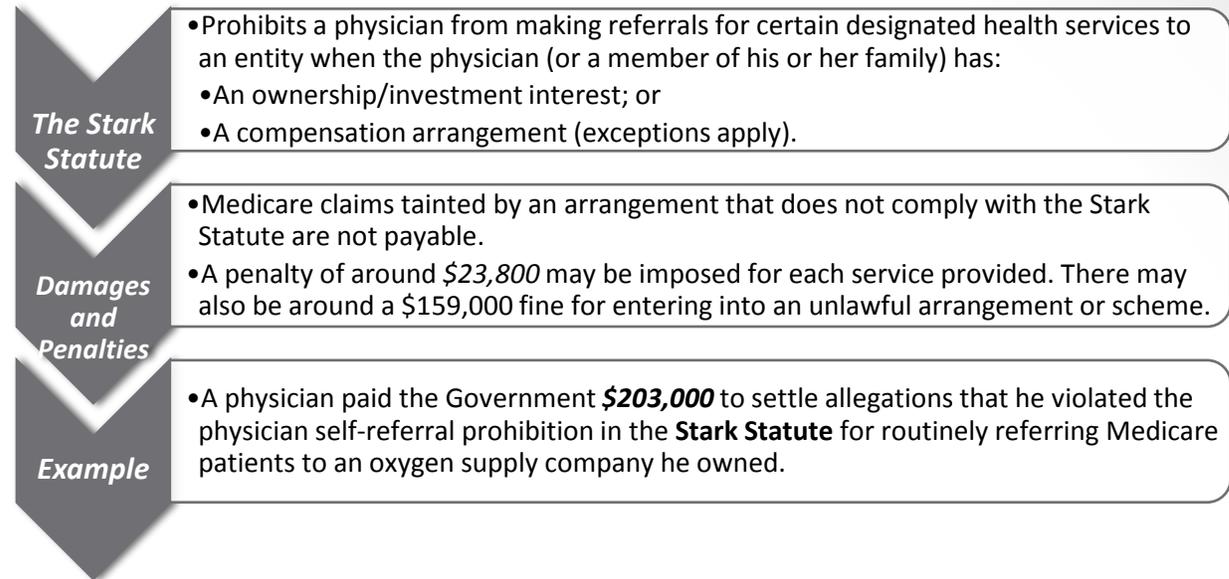
EXAMPLE

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey:

- Obtained nearly **\$2 million in payments** from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests;
- Paid doctors for referring patients;
- Pleaded guilty to violating the **Anti-Kickback Statute**; and
- Was sentenced to **46 months** in prison.

The radiologist was among **17 people, including 15 physicians**, who have been convicted in connection with this scheme.

Stark Statute (Physician Self-Referral Law)



For more information, refer to 42 U.S.C. Section 1395nn on the Internet.

For more information, visit <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral> on the CMS website and refer to the Act, Section 1877 on the Internet.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose Civil penalties for a number of 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 it;
- Making false claims; or
- Paying to influence referrals.

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; or
- 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.

For more information, refer to the Act, Section 1128A (a) on the Internet.

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).

- You can access the LEIE at <https://exclusions.oig.hhs.gov> on the Internet.

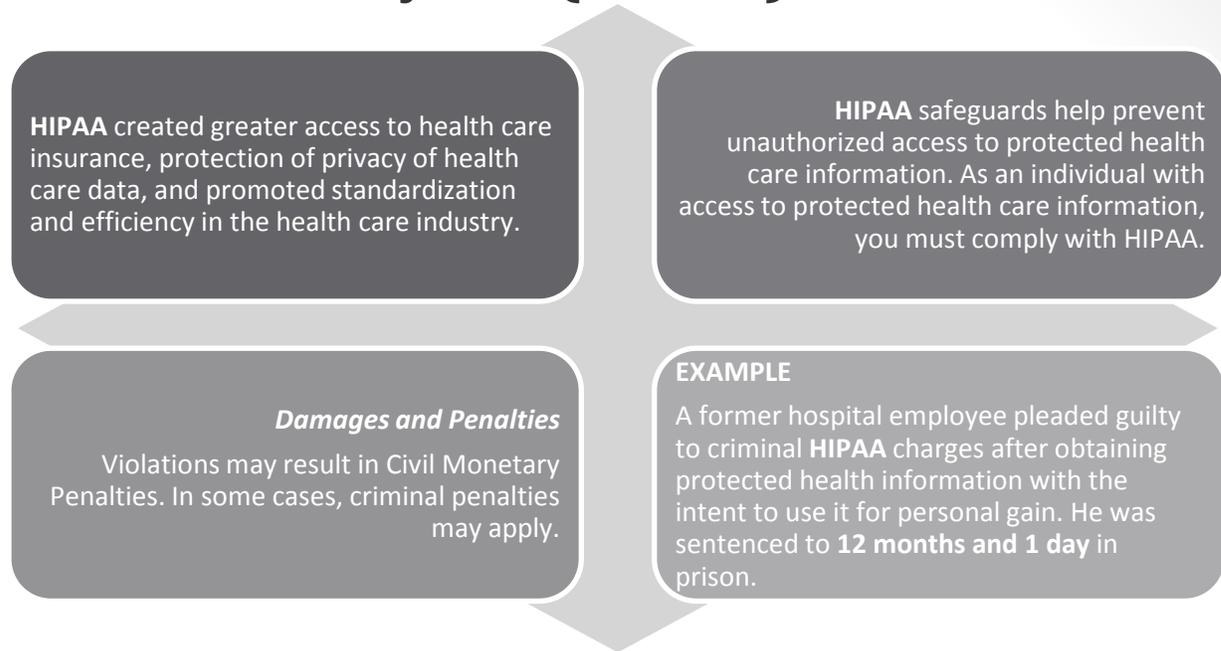
The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS at <https://www.sam.gov> on the Internet.

- If looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same.

EXAMPLE: A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The executive of the pharmaceutical firm was excluded based on the company's guilty plea. At the time the executive was excluded, he had not been convicted himself, but there was evidence he was involved in misconduct leading to the company's conviction.

For more information, refer to 42 U.S.C. Section 1320a-7 and 42 Code of Federal Regulations Section 1001.1901 on the Internet.

Health Insurance Portability and Accountability Act (HIPAA)



For more information, visit <http://www.hhs.gov/ocr/privacy> on the Internet.

Lesson 1 Summary & Review

There are differences among **FWA**. One of the primary differences is **intent** and **knowledge**. **Fraud** requires that the person have intent to obtain payment and the knowledge that their actions are wrong. **Waste and abuse** may involve obtaining an improper payment but do not require 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;
- Exclusion from participation in all Federal health care programs;
- Imprisonment; or
- Loss of provider license

Now that you have completed Lesson 1, let's do a quick knowledge check. The following questions do not contribute to your overall course score in the Post-Assessment.

Knowledge Check

Which of the following requires intent to obtain payment and the knowledge that the actions are wrong?

Select the correct answer.

- A. Fraud
- B. Abuse
- C. Waste

CORRECT ANSWER: A

Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting Fraud, Waste, and Abuse (FWA)?

Select the correct answer.

- A. Civil Monetary Penalties
- B. Deportation
- C. Exclusion from participation in all Federal health care programs

CORRECT ANSWER: B

***You completed Lesson 1: What is FWA?
Now that you have learned about FWA and the laws and regulations prohibiting it, let's look closer at your role in the fight against FWA.***

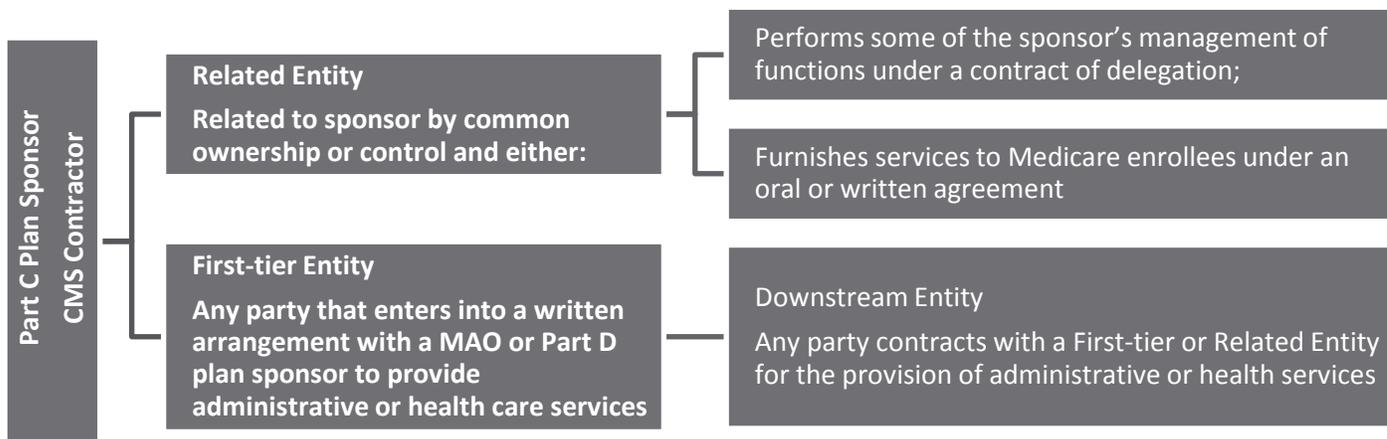
Your Role in the Fight against FWA

Lesson 2: 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. Upon completing the lesson, you should be able to correctly:

- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA.

Where Do I Fit In?



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

- **Sponsor;**
- **First-tier entity** (Examples: Pharmacy Benefit Management (PBM), hospital or health care facility, provider group, doctor office, clinical laboratory, customer service provider, claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, and contracted sales agent);
- **Downstream entity** (Examples: pharmacies, doctor office, firms providing agent/broker services, marketing firms, and call centers); or
- **Related entity** (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®).

Where Do I Fit In?

❖ 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 shows examples of functions that relate 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 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.

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 that you may be aware of.
- **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/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; and
- Verify all information provided to you.

Stay Informed about Policies & Procedures

Familiarize yourself with 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**; and
- 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.

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.

Do not be concerned about whether it is **fraud, waste, or abuse**. Just report any concerns to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department area 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.

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, 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**, you should include:

- ✓ Contact information for the source of the information, suspects, and witnesses;
- ✓ Details of the alleged FWA;
- ✓ Identification of the specific Medicare rules allegedly violated; and
- ✓ 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: https://forms.oig.hhs.gov/hotlineoperations	For Medicare Parts C and D: National Benefit Integrity Medicare Drug Integrity Contractor (NBI 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): https://www.stopmedicarefraud.gov	

Correction

Once **fraud, waste, or abuse** has been detected, it must be promptly corrected. Correcting the problem saves the Government money and ensures you are in compliance with CMS requirements.

Develop a plan to correct the issue. Consult your organization's compliance officer to find out the process for the corrective action plan development. 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 specifications;
- 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; and
- Once started, continuously monitor corrective actions to ensure they are effective.

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;
or

Terminating an employee or provider.

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 issues that may be potential FWA. 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 delivery of 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?

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

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 that brand drugs be dispensed?
- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

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 and then marking up the prices and sending to other smaller wholesalers or pharmacies?

Potential Manufacturer Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a Federal health care program?

Potential Sponsor Issues

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

Lesson 2 Summary & Review

- ❖ As a person who provides health or administrative services to a Medicare Parts C or D enrollee, you play a vital role in **preventing 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 be able to accept anonymous reports and cannot retaliate against you for reporting.
- ❖ Promptly correct identified FWA with an effective corrective action plan.

Now that you have completed Lesson 2, let's do a quick knowledge check. The following questions do not contribute to your overall course score in the Post-Assessment.

Knowledge Check

A person comes to your pharmacy to drop 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?

Select the correct answer.

- 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

CORRECT ANSWER: C

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 verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the Sponsor’s process and to adjust/add risk diagnosis codes for certain individuals. What should you do?

Select the correct answer.

- A. Do what your immediate supervisor asked you to do and adjust/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 ANSWER: B

You are in charge of payment of 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 that Doe Diagnostics’ claims far exceed any other provider that you reviewed. What should you do?

Select the correct answer.

- 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

CORRECT ANSWER: B

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

Select the correct answer.

- 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 ANSWER: E

You completed Lesson 2: Your Role in the Fight Against FWA

MEDICARE PARTS C AND D GENERAL COMPLIANCE TRAINING

From Medicare Learning Network® Web-Based Training

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, your every action potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Compliance Program Training Course Objectives

This lesson outlines effective compliance programs.

When you complete this course, you should be able to correctly:



Recognize how a compliance program operates; and



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 should:



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; and
- ❖ 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.

For more information, refer to:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi) on the Internet;
- 42 CFR Section 423.504(b)(4)(vi) on the Internet;
- "Medicare Managed Care Manual," Chapter 21 on the CMS website; and
- "Medicare Prescription Drug Benefit Manual," Chapter 9 on the CMS website.

Seven Core Compliance Program Requirements

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 that will 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 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.

Compliance Training

Sponsors and their FDRs

CMS expects that 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!



How Do You Know What is Expected of You?

Beyond following the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation? Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates. Contents will vary, as Standards of Conduct should be tailored to each individual organization's culture and business operations. If you are not aware of your organization's standards of conduct, ask your management where they can be located.

Everyone has a responsibility to report violations of Standards of Conduct and suspected non-compliance.

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

What is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS has identified the following Medicare Parts C & 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; and
- Quality of care.

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; or
- 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; or
- Termination.

For more information, refer to the Compliance Program Guidelines in the “Medicare Prescription Drug Benefit Manual” and “Medicare Managed Care Manual” on the CMS website.

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

How to Report Potential Non-Compliance

Employees of a Sponsor

- Call the Medicare Compliance Officer;
- Make a report through your organization's website; or
- Call the Compliance Hotline.

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

- Talk to a Manager or Supervisor;
- Call your Ethics/Compliance Help Line; or
- Report to the Sponsor.

Beneficiaries

- Call the Sponsor's Compliance Hotline or Customer Service;
- Make a report through the Sponsor's website; or
- Call 1-800-Medicare.

Don't Hesitate to Report Non-Compliance

- There can be **no retaliation** against you for reporting suspected non-compliance in good faith.
- Each Sponsor must offer reporting methods that are:
 - Anonymous;
 - Confidential; and
 - Non-retaliatory.

What Happens After Non-Compliance is Detected?



However, internal monitoring should continue to ensure:

- There is no recurrence of the same non-compliance;
- Ongoing compliance with CMS requirements;
- Efficient and effective internal controls; and
- Enrollees are protected.

What are Internal Monitoring and Audits?

- Internal monitoring activities are regular reviews that confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Internal auditing is a formal review of compliance with a particular set of standards (for example, policies and procedures, laws, and regulations) used as base measures.

Lesson Summary and Review

- 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.

Compliance Is Everyone's Responsibility!

- **Prevent:** Operate within your organization's ethical expectations to prevent non-compliance!
- **Detect & Report:** If you detect potential non-compliance, report it!
- **Correct:** Correct non-compliance to protect beneficiaries and save money!

Now that you have completed the Compliance Program Training lesson, let's do a quick knowledge check. The following questions do not contribute to your overall course score in the Post-Assessment.

Knowledge Check

You discover an unattended email address or fax machine in your office that receives beneficiary appeals requests. You suspect that no one is processing the appeals. What should you do?

Select the correct answer.

- 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

CORRECT ANSWER: C

A sales agent, employed by the Sponsor's First-Tier or Downstream entity, 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?

Select the correct answer.

- 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

CORRECT ANSWER: D

You work for a Sponsor. Last month, while reviewing a monthly report from the Centers for Medicare & Medicaid Services (CMS), you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan. You spoke to your supervisor who said not to worry about it. This month, you have identified the same enrollees on the report again. What should you do?

Select the correct answer.

- A. Decide not to worry about it as your supervisor instructed – you notified him last month and now it's his responsibility
- B. Although you have seen notices 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 so you cannot be identified
- 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

CORRECT ANSWER: B

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

Select the correct answer.

- 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 ANSWER: E

End of Medicare General Compliance training section

HIPAA PRIVACY AND SECURITY

Rules & Compliance

Do the right thing!



Objectives

- Describe requirements of Omnibus Rule
- Explain Privacy and Security Rules
- Explain Breach Notification and Enforcement Rules

KNOW THE RULES!



HIPAA Privacy Rule

Restricts use and disclosure of PHI in all forms



Oral



Recorded



Paper



Electronic

Protects all information that can be used to connect to the patient



Name



Address



Physician's notes



Billing information

Minimum Necessary Rule

Use least amount of PHI needed to get job done



Use and Disclosure

- PHI can't be used or disclosed to anyone unless permitted or required by Privacy Rule
- Covered entities use PHI when information is:
 - Shared
 - Examined
 - Applied
 - Analyzed
- Anyone outside the covered entity discloses PHI when information is:
 - Released
 - Transferred
 - Accessed

You are Permitted to Use and Disclose PHI

- For treatment, payment and healthcare operations
- With authorization/agreement from the patient
- For disclosure to the patient
- For incidental uses, such as
 - Physicians talking to patients in semi-private rooms
 - Sign-in sheets

Use and Disclosure of PHI is Required

- When requested or authorized by the patient
- When required by Department of Health and Human Services (HHS)



PHI Disclosure

- Patients **cannot** restrict disclosure of PHI for treatment
 - Healthcare providers need access so they can deliver quality care
- Patients **can** restrict disclosure to health plans or business associates if disclosure
 - Is for payment
 - Is for healthcare operations
 - Is for treatment for which the individual has paid out-of-pocket in full

PHI Authorization

Is *not* needed to

- Maintain facility's patient directory
- Inform family and other persons involved in patient care

Is need for

- Use and disclosure of psychotherapy notes
- Marketing and fundraising

Patient requests for PHI access may be denied

- ❖ For example, psychotherapy notes from private counseling sessions

Signed Patient Authorization

PHI can be shared **without** permission or authorization

- In interest of public health and during disaster relief
- To control and prevent disease
- To report victim abuse
- To monitor the safety of FDA-regulated products
- For health oversight activities to ensure quality of care
- For certain law enforcement purposes, to comply with HIPAA investigations

Patients Have the Right to:

- ✓ Receive Notice of Privacy Practices
- ✓ Have PHI communicated by alternate means
- ✓ Designate third party as recipient of ePHI
- ✓ Inspect, correct and request an amendment of PHI
- ✓ View or request copies of PHI
- ✓ Request history of non-routine disclosures
- ✓ Request history of disclosures related to treatment, payment or healthcare operations
- ✓ Receive information on how they can contact the facility's Privacy Officer or HHS

Personal Representative

- **Is a designated or appointed person if the patient is**
 - Incapable of exercising their rights
 - For example,
 - A minor (with some exceptions)
 - A legally blind person

Normally all rights exercised by the patient apply to the personal representative, including inspecting patient's PHI

Administrative Safeguards

- Responsible parties include executive teams, managers and HIPAA Security officials
- Rules on workplace security include who can and cannot access ePHI
- Systems are created to detect, correct and prevent security breaches
 - Outline how to respond to security breaches
 - Protection during emergencies and natural disasters
 - Audits and evaluations make sure you're in compliance
- Never share your password with anyone
 - Individuals are subject to same enforcement penalties as providers



Physical Safeguards

- Protect physical things
 - Computer systems
 - High tech equipment
 - Facility where information is stored
- Examples include
 - Users IDs, security guards, sign-in sheets and ID badges
 - Facility access controls protect areas where ePHI is housed
 - Device and media controls protect hardware or software



Technical Safeguards

- Access controls - ensure only authorized personnel can access ePHI
- Authentication controls - verify who's logging onto facility's system
- Monitoring systems - track who's logging in successfully and who's failing
- Digital signatures - ensure stored PHI is not tampered with or destroyed
- Integrity controls or virus protection - protects ePHI from alteration or destruction
- Encryption programs - protect ePHI transmitted over open networks
- Instant reporting systems alarms - alert authorities to suspicious behavior

What is a Breach?

- Under the Omnibus Rule - **all impermissible** acquisition, access, use or disclosure of PHI is presumed to be a breach
- Covered entities and business associates must:
 - Demonstrate low probability that PHI has been compromised
 - Determine low probability through a risk assessment

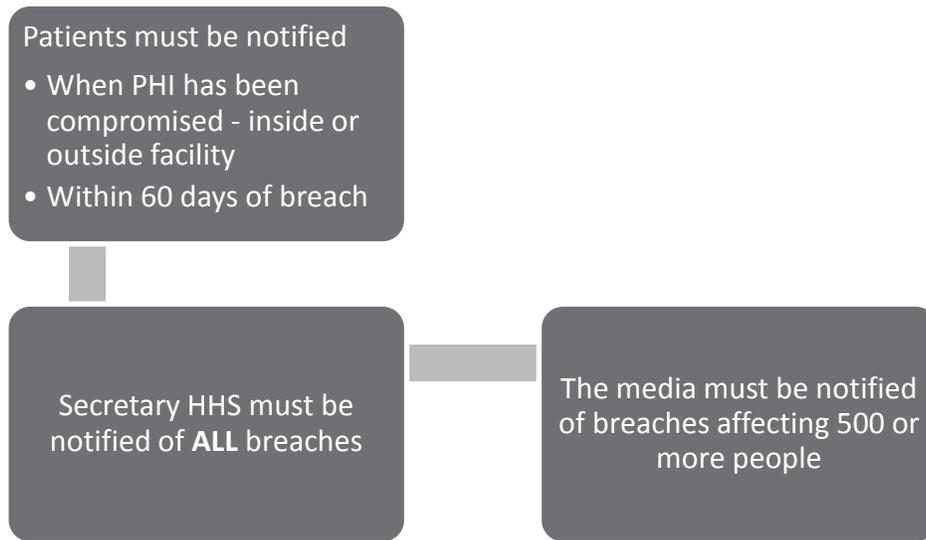


When Should a Breach be Reported?

Employers must consider:

- Did the information include patient identifiers?
- Who may have had unauthorized access to the exposed data?
- Was data inappropriately viewed?
- Was the risk resolved quickly?

Breach Notification



Enforcement

- Significant penalties for violations and non-compliance
- Penalties apply to covered entities, business associates, subcontractors, and individuals

Civil Violations

- ❖ Civil Monetary Penalties – Based on tiered civil penalty structure and the nature/extent of the violation and the resulting harm
- ❖ \$100 - \$50,000 / violation
- ❖ \$25,000 - \$1.5 million annual maximum for repeat violations

Criminal Penalties

- ❖ Handled by the Department of Justice (DOJ) for investigation
- ❖ Criminal violations have different levels of severity
- ❖ “Knowingly” obtain/disclose PHI = fines up to \$50,000 and imprisonment up to 1 year
- ❖ Offense committed under false pretense = \$100,000 fine, with up to 5 years in prison
- ❖ Offense committed with intent to sell, transfer or use PHI for commercial advantage, personal gain or malicious harm = fines of \$250,000 and imprisonment up to 10 years

Audits

- ❖ Can help facilities stay compliant
- ❖ Businesses, subcontractors and covered entities can all be audited

Summary

- HIPAA Omnibus Rule helps us protect
 - Patient personal information
 - Everyone's right to privacy and security
- Do your part to comply and understand HIPAA Omnibus Rule, which includes
 - HIPAA Privacy
 - Security and Breach Notification
 - Enforcement Rules

**PROTECT YOUR PATIENTS' PHI AND ENCOURAGE OTHERS
TO DO THE SAME**

End of HIPAA training section

OUR PRINCIPLES OF ETHICS & INTEGRITY - CODE OF CONDUCT



What are a Compliance Plan and Code of Conduct?

The Compliance Plan and Code of Conduct are formal statements of EPIC's standards and rules of ethical business conduct.

We need a Compliance Program for the following reasons:

- To provide a formal statement of EPIC's standards and rules of ethical conduct to all EPIC employees and business partners.
- To inform employees about existing and future laws and EPIC policies.
- To investigate reports of unethical or unlawful behavior and stop such behavior after it is discovered.
- To protect EPIC from legal action should a breach of ethical conduct occur.

The Code of Conduct is a key part of EPIC's Compliance Program. There are nine areas of conduct covered in the code:

1. Ethical Responsibilities
2. Compliance with Laws and Regulations
3. Fraud and Abuse
4. Patient's Rights
5. Anti-Trust
6. Safety, Health and Environment
7. Confidentiality and Business Information
8. Employee's Rights and Obligations
9. Financial Accounting and Records



Who to contact

The Compliance Program applies to everyone. No person’s job or position at EPIC is more important than preserving EPIC’s reputation for integrity. Acting with integrity begins with understanding and abiding by the laws, regulations, Company policies, and contractual obligations that apply to our roles and activities.

Reporting Misconduct

If you encounter what you believe to be a potential Code or policy violation, speak up. Speaking up is not only the right thing to do, it’s required by Company policy. EPIC, CMS, and your health plans provide many ways to report concerns. All reports will be reviewed and, if necessary, investigated.

You always have the option of reporting anonymously, and, regardless of how you report, you are protected from retaliation whenever you speak up in good faith.

First contact for workplace issues	<i>Your Manager or Supervisor</i>
Contact for policy guidance and interpretation, workplace issues, compensation and employee benefit concerns.	<u>Human Resources</u> Internal ext. 43520 External 909-335-4195
Contact for questions or advice on: <ul style="list-style-type: none"> • The Code of Conduct • Corporate Compliance Plan • Reporting violations or suspected violations of FWA, compliance, or unethical behavior 	<u>Compliance and Ethics</u> Corporate Compliance Officer Internal ext. 43621 External 909-786-0821 Compliance Team Member Internal ext. 43622 External 909-786-0822 Compliance Hotline 909-335-4153
Contact to report unsafe conditions and workplace hazards.	<u>Safety, Health, and Environment</u> Director of Risk Management and Safety Internal ext. 43518 Risk Management & Safety Manager Internal ext. 43619

Ethical Responsibilities

ETHICAL PERFORMANCE

As an employee of EPIC, you have an obligation to:

- Be honest in all your dealing with clients, patients, vendors, and third parties.
- You must know and comply with applicable laws and all policies and procedures.

Claims of ignorance, good intentions, or using poor judgement will not be accepted as an excuse for noncompliance.

ETHICAL LEADERSHIP

Leadership requires setting a personal example of high ethical standards in the performance of your job. It is up to you as management, to set the tone for EPIC.

You must:

- Take responsibility for the actions of your employees.
- Be accountable for making sure that your employees understand and apply the ethical standards set forth in the Code of Conduct.

Compliance with Laws and Regulations

We will comply with all laws and regulations that apply to EPIC's operations, business and dealings.

- We must comply with both the spirit and letter of all laws that apply to EPIC operations, business, and dealings.
- We must disclose any situation that may be, or that gives the appearance of, a conflict of interest to the appropriate regulatory or funding agencies.
- We are expected to have a practical working knowledge of the laws and regulations that affect our job responsibilities.

We must cooperate with the government officials who are responsible for administering and enforcing these laws and for monitoring and regulating EPIC's activities.



Fraud and Abuse

We will maintain honest and accurate records concerning the provision of health care services, and never offer, pay or receive any money, gifts or services in return for the referral of patients or to induce the purchase of items or services. Employees must not make false statements or misrepresentations at any time.

We will not engage in any of the activities which are prohibited by law.



Patients' Rights

Patients must receive quality care delivered in a considerate, respectful, and cost-effective manner. Patients have the right to make their own health care decisions after disclosure of all relevant information.

We must protect a patient's personal privacy and preserve the confidentiality of a patient's medical treatment program, including the patient's medical records / electronic medical records.

Anti-Trust

We will avoid activities that reduce or eliminate competition, control prices, allocate markets or exclude competitors.

- The purpose of antitrust and trade regulation laws is to protect EPIC and other companies from unfair trade practices, promote competition, and preserve the free enterprise system.
- When attending trade shows, professional meetings and other gatherings, we will avoid subjects that affect competition.



Safety, Health, & Environment

We will maintain a safe and healthy working environment.

- We have a responsibility to follow safe operating procedures, to safeguard our health as well as that of our co-workers and patients, and to maintain a safe and healthful workplace.
- Our policy is to comply with the federal, state, and local agencies' laws and regulations affecting safety, health, and environmental protection.
- If you do not know the correct procedure for handling or disposing of any material, promptly ask your supervisor or another EPIC resource such as your safety officer for assistance.



Confidentiality and Business Information

We will protect confidential and proprietary information including patient information.



Do you have my test results?

Never disclose confidential patient information to any unauthorized person. Common curiosity makes us wonder about people we know who become patients. **It is never ethical or proper to look in a patient's confidential record unless it is required as part of your job.**

❖ **We must safeguard EPIC's confidential information and trade secrets.**

Examples of confidential and trade secret information includes:

- Financial data
- Planned new projects or information about areas where EPIC intends to expand
- Employee information, wage and salary data
- Capital investment plans and projected earnings
- Changes in management or policies of EPIC



Discuss restricted, or exclusive, information with others only on a need-to-know basis. Be cautious about accidentally discussing confidential information or trade secrets in social conversations or in normal business relations.



Employee's Rights and Obligations

We will maintain a working environment free from harassment, abuse of any kind and unlawful discrimination. We expect supervisors, co-workers, vendors and medical staff to treat one another with dignity, respect and courtesy.



EPIC is an equal opportunity employer. We prohibit discrimination in any work-related decision.



We are committed to providing an efficient and productive working environment. Any involvement with illegal and/or mood altering drugs or consumption of alcohol in the work place by employees is prohibited and may result in corrective action, up to and including dismissal.



We strictly prohibit and do not tolerate any form of harassment, including sexual harassment.

Financial Accounting & Records

WE WILL MAINTAIN HONEST AND ACCURATE FINANCIAL RECORDS.

- EPIC relies on its business records for making business decisions; for billing the government, third-party payors, customers, and patients; for paying its vendors and for making representations to the government and others.
- We must record all entries in EPIC's books and records accurately, honestly and fairly so that these entries reflect the true nature and purpose of the transactions that are being recorded.
- No compromise of the integrity of financial records or financial statements and no "off the books" transactions will be permitted.
- Financial reports must fairly and consistently reflect performance and accurately disclose the results of operations. They must also comply with Generally Accepted Accounting Principles, regulations of the Centers for Medicare and Medicaid (CMS) and other applicable rules.
- Accuracy of EPIC's books and records begins with each employee. Whether the record is time cards, expense reports, general accounting records, purchasing records, or billing/coding entries, you have a personal responsibility to ensure that every document and entry is complete and accurate.

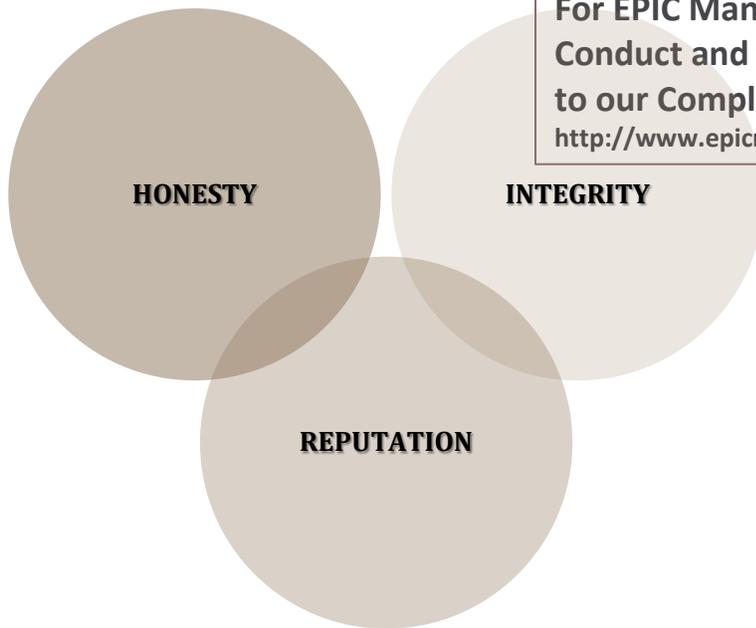


Conclusion

This Code sets forth EPIC guidelines and expectations about proper job-related conduct. However, this Code cannot anticipate every situation that you as an employee may encounter.

You should consult with your supervisor for guidance if this Code does not provide adequate direction or if you are being pressured to compromise your behavior, whether by another employee, a physician, a supplier, a competitor or a patient. If you are unable to resolve your concerns with your supervisor, you should contact the Compliance Officer. Any questions about interpretations of the law or the legality of a particular course of conduct should be discussed with the Compliance Officer who may in turn consult with legal counsel.

No employee's concern is too small or unimportant if he or she thinks it implicates policies concerning proper conduct. An employee will find that by seeking guidance a resolution can be found which will both meet the employee's concerns and be consistent with this Code.



Code of Conduct

For EPIC Management's complete Code of Conduct and those of contracted Health Plans go to our Compliance Toolbox at <http://www.epicmanagementlp.com/compliance.aspx>

End of Code Of Conduct Training Section

SPECIAL NEEDS PLAN (SNP)

MODEL OF CARE – BASICS

Training Goals & Overview

- ❖ Describe the importance and goals of the SNP program
- ❖ Describe the three types of SNPs
- ❖ Define SNPs role and responsibilities

Special Needs Plans or “SNPs” provide important programs to help health plan members get the care and services they need.

What’s a SNP?

In 2003, Congress created a new type of Medicare Advantage (MA) program called the ‘Special Needs Plan’.

It is administered by the Centers for Medicare and Medicaid (CMS). A SNP is a MA coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special need individuals.

Goals of Special Needs Plans (SNPs)

- ✓ Improve access to medical, mental health, and social services
- ✓ Improve Coordination of Care
 - ✓ Through an identified care coordinator to work with the provider network to improve transitions of care and utilization of services
- ✓ Improve patient health outcomes

In this training, you’ll learn more about SNPs and how these plans support special needs members.

*Did you know?***Not all Medicare Advantage Plans offer SNPs**

Special Needs Plan Types

C-SNP Chronic Care

- Designed for Medicare members with specific severe or disabling chronic conditions.
- Focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum.
- CMS has approved 15 SNP-specific chronic conditions

D-SNP Dual Eligible

- D-SNP enrolls people who are entitled to both Medicare and Medi-Cal/Medicaid
- It coordinates care so members can access the full range of services available from Medicare and Medi-Cal/Medicaid.

I-SNP Institutional

- Designed for eligible individuals who, for 90 days or longer, require or are expected to need the level of service provided in a LTC SNF/NF, a SNF/NF, an ICF for the intellectually disabled, or an inpatient psychiatric facility.
- For an I-SNP to enroll MA eligible individuals living in the community, but requiring an institutional level of care (LOC), the following two conditions must be met:
 - A determination of institutional LOC that is based on the use of a state assessment tool.
 - The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective I-SNP) with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity.

SNPs - Model of Care

Model of Care

As provided under section 1859(f) (7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). Per CMS, the MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.

A Medicare Advantage Organization (MAO) must develop separate MOCs to meet the needs of the patients for each SNP type it offers.

CMS revised the MOC elements in 2014 to:

- Integrate the related elements
- Clarify and enhance the focus on care needs and activities
- Highlight the importance of care coordination
- Address care transitions as well as other aspects of care coordination

Model of care re-organization

Previous MOC Elements

- Description of SNP-specific target population
- Measurable goals
- Staff structure and Care Management goals
- Interdisciplinary Care Team
- Provider Network: specialized expertise and use of clinical practice guidelines & protocols
- MOC training for personnel and provider network
- Health Risk Assessment
- Individualized Care Plan
- Integrated Communication Network
- Care Management for most vulnerable subpopulations
- Performance and health outcomes measurement

Revised MOC Elements

As of August 2014

- ✓ **Description of SNP Population (General Population)**
- ✓ **Care Coordination**
- ✓ **SNP Provider Network**
- ✓ **Quality Measurement & Performance Improvement**

These revised four elements capture all the information collected in the previous elements and continue to ensure that the MOC is the vital quality improvement tool and integral component for ensuring all SNP beneficiaries' needs are identified and addressed.

Model of Care Elements

<https://www.cms.gov/Regulations-and-uidance/Guidance/Manuals/Downloads/mc86c05.pdf>
20.2.1 – Model of Care Elements

SNP POPULATION

- MOC must provide an overview that fully addresses the full continuum of care of current and potential SNP beneficiaries.
- Description of the SNP population:
 - Focuses on the target population in the SNP
 - Includes overall general targeted population as well as most vulnerable beneficiaries
 - Targets the unique health needs of all beneficiaries including the most vulnerable

CARE COORDINATION

- Care coordination maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes.
- Care Coordination:
 - Ensures SNP beneficiaries' healthcare needs, and information is shared across healthcare staff and facilities over time
 - Coordinates the delivery of services and meets the needs of the most vulnerable population
 - Health Risk Assessment Tool (HRAT), Individualized Care Plan (ICP), and Interdisciplinary Care Team (ICT)

SNP PROVIDER NETWORK

- A network of healthcare providers who are contracted to provide health care services to SNP beneficiaries.
- SNP Provider Network:
 - Has specialized clinical expertise
 - Use of clinical practice guidelines & care transitions protocols
 - **Initial and annual MOC training for the provider network, as well as out-of-network providers**

MOC QUALITY MEASUREMENT & PERFORMANCE IMPROVEMENT

- Quality measurement & Performance Improvement:
 - Quality Performance Improvement Plan
 - Measureable goals & health outcomes
 - Measuring SNP member satisfaction
 - Supporting ongoing improvement of the MOC
 - Communicating quality improvement performance results

SNP - Model of Care

REMINDERS:

- Not all Medicare Advantage Plans offer SNPs
- Medicare Advantage Organizations (MAO) do not have to sponsor all 3 SNP types
- CMS has approved 15 SNP-specific chronic conditions (C-SNP)
 - MAOs may apply to offer a C-SNP that targets any one of the following:
 - A single CMS-approved chronic condition (refer to list “15 SNP-Specific Chronic Conditions”)
 - A CMS-approved group of commonly co-morbid and clinically-linked conditions, or
 - An MAO-customized group of multiple chronic conditions
 - CMS-approved list and conditions can be found at <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/C-SNPs.html>

For EPIC Management MEDICAL PARTNERS – Plans offering one or more types of SNPs

Scan Health Plan sponsors all three types of SNPs

- C-SNPs: Heart First; VillageHealth; SCAN Balance
- D-SNPs: Connections & Connections at Home
- I-SNPs: Healthy at Home

Health Net sponsors two types of SNPs

- C-SNPs: Jade SNPs – AZ, OR, CA (Kern, LA, Orange Counties only)
- D-SNPs: AZ, OR, CA - Amber I (Kern, LA, Orange, Riverside, San Bernardino); Amber II (Kern, LA, Orange, Riverside, San Bernardino, San Francisco, San Diego, Fresno, Tulare); Amber II Premier (Fresno)

Central Health Medicare Plan sponsors all three types of SNPs

- C-SNPs: Central Health Focus Plan (LA, Orange*, San Bernardino* Counties)
- D-SNPs: Central Health Medi-Medi Plan (LA, San Bernardino* Counties)
- I-SNPs: Central Health Advance Plan (LA County)

How Do We Help Patients with Special Needs?



It is often difficult to understand the health care system. Patients with multiple health issues or low income can find it even more difficult and challenging to access proper health care services through most providers. Often times this prevents them from getting the care they need in a timely manner.

CMS created a Medicare Advantage (MA) program, the Special Needs Plan (SNP), to help these patients get the quality care they need. Our MA Health Plans, that have developed SNP MOCs, work with SNP patients, provider networks, and teams of clinical/non-clinical personnel to ensure appropriate & timely healthcare services are provided.

Example of a SNP-MOC & Roles

Developed by:
SCAN Health Plan – 2016
Special Needs Plan (SNP) Model of Care - Basics

<u>MOC</u>	<u>Health Plan Roles</u>	<u>Our Roles</u>
	<ul style="list-style-type: none"> Care Managers Care Navigators Primary Care Physician Pharmacist Complex Care Managers Geriatrician Nutritionist Care Transition Coach Behavioral Health Specialist Member Services Rep PAL (Personal Assistance Line) Delegation Oversight Health Care Informatics 	<p><u>All of you</u>, whether clinical or non-clinical staff (including all the “behind-the-scenes” staff, like Compliance, Provider Services, & Finance), have an important role in providing quality care to keep our patients <i>healthy and independent!</i></p> <p>It is our responsibility to understand the goals and scope of each SNP program and how we coordinate care and communicate with our SNP patients.</p>

<https://www.scanhealthplan.com/providers/clinical-guidelines-and-practice-tools/snp-model-of-care-training>

Summary

The SNP Model of Care: Helping Make a Difference

You now have a better understanding of what a SNP is, why it is important, and how you can continue serving all our patients – including those with special needs.

REFERENCES

Centers for Medicare & Medicaid Services (CMS)

Special Needs Plans

<http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans>

End of SNP MOC Training Section

CONNECTING WITH YOUR PATIENTS CULTURAL & LINGUISTIC COMPETENCY

Developed By: Industry Collaboration Effort (ICE)

Training Goals

- Define culture and cultural competence
- Explain the three benefits of clear communication
- Explore and understand LGBT (lesbian, gay, bisexual, and transgender) communities
- Address health care for refugees and immigrants
- Reflect on strategies when working with seniors and people with disabilities

Defining Culture and Cultural Competence

Adapted from <http://minorityhealth.hhs.gov>

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.

Cultural competence is the capability of effectively dealing with people from different cultures.

HOW DOES CULTURE IMPACT THE CARE THAT IS GIVEN TO MY PATIENTS?

➤ ***Culture informs:***

- concepts of health, healing
- how illness, disease, and their causes are perceived
- the behaviors of patients who are seeking health care
- attitudes toward health care providers

➤ ***Culture defines health care expectations:***

- who provides treatment
- what is considered a health problem
- what type of treatment
- where care is sought
- how symptoms are expressed
- how rights and protections are understood

CULTURE IMPACTS EVERY HEALTH CARE ENCOUNTER

Because **health care is a cultural construct** based in beliefs about the nature of disease and the human body, **cultural issues are actually central in the delivery of health services.**

Clear Communication

THE FOUNDATION OF CULTURALLY COMPETENT CARE

Did you know?

- 20% of people living in the U.S. speak a language other than English at home
- 1 out of 2 adult patients has a hard time understanding basic health information
- Average physician interrupts a patient within the first 20 seconds



Cultural Influences

How do cultural influences affect patient care & communication?



Acculturation

- Process of adopting cultural behaviors common in the host country
- May lead to changes in diet, physical activity level & environmental exposures



Botanical Treatments & Healers

- Health practices and beliefs that can be significantly different from American medicine
- Patients' health beliefs can have an impact on clinical care



Decision Making

- Know who the decision maker is
- For example, in other cultures, even if the decision making is family focused, the husband, eldest son, daughter, or the oldest male in the family (incl. extended family) may have the final say



Language Skills & Preferences

- Low health literacy
- Cultural barriers
- Limited English Proficiency (LEP)



Privacy

- Privacy and modesty is about respect in many cultures
- In western medicine privacy is drapes, closed doors and knocking before entering
- Do not be afraid to ask your patients about their privacy or modesty concerns before performing the exam

Clear Communication

Here's What we wish our healthcare team knew...

1. I tell you I forgot my glasses because I am ashamed to admit I don't read very well
2. I don't know what to ask and am hesitant to ask you
3. When I leave your office I often don't know what I should do next
4. I put medication into my ear instead of my mouth to treat an ear infection
5. I am confused about risk and information given in numbers like % or ratios – how do I decide what I should do
6. *My English is pretty good but at times I need an interpreter*
7. When I don't seem to understand, talking louder in English intimidate me
8. If I look confused or upset I may have misinterpreted your nonverbal cues
9. I am not able to make important decisions by myself
10. I am more comfortable with a female doctor
11. It's important for me to have a relationship with my doctor
12. I use botanicals and home remedies but don't think to tell you

Here's what your team can do...

1. Use a variety of instruction methods
2. Encourage questions & use Ask Me 3™
3. Use teach back
4. Use specific, plain language on prescriptions
5. Use qualitative plain language to describe risks and benefits, avoid using just numbers
6. *Office staff should confirm interpreter needs during scheduling*
7. Match the volume and speed of the patient's speech
8. Mirror body language, position, eye contact
9. Confirm decision making preferences
10. Office staff should confirm preferences during scheduling
11. Spend a few minutes building rapport
12. Ask about the use of home remedies & healers

Ask the patient if you are unsure

INTERPRETER TIPS



- Inform the interpreter of specific patient needs
- Hold a brief introductory discussion
 - Your name, organization and nature of the call/visit
 - Reassure the patient about confidentiality



- Allow enough time for the interpreted sessions
- Avoid interrupting during interpretation



- Speak in the first person
- Speak in a normal voice, try not to speak fast or too loudly
- Speak in short sentences



- Avoid acronyms, medical jargon and technical terms
- Face and talk to the patient directly
- Be aware of body language in the cultural context

Cultural Competence & the LGBT* Communities

*(lesbian, gay, bisexual, and transgender)

Some LGBT Terminology

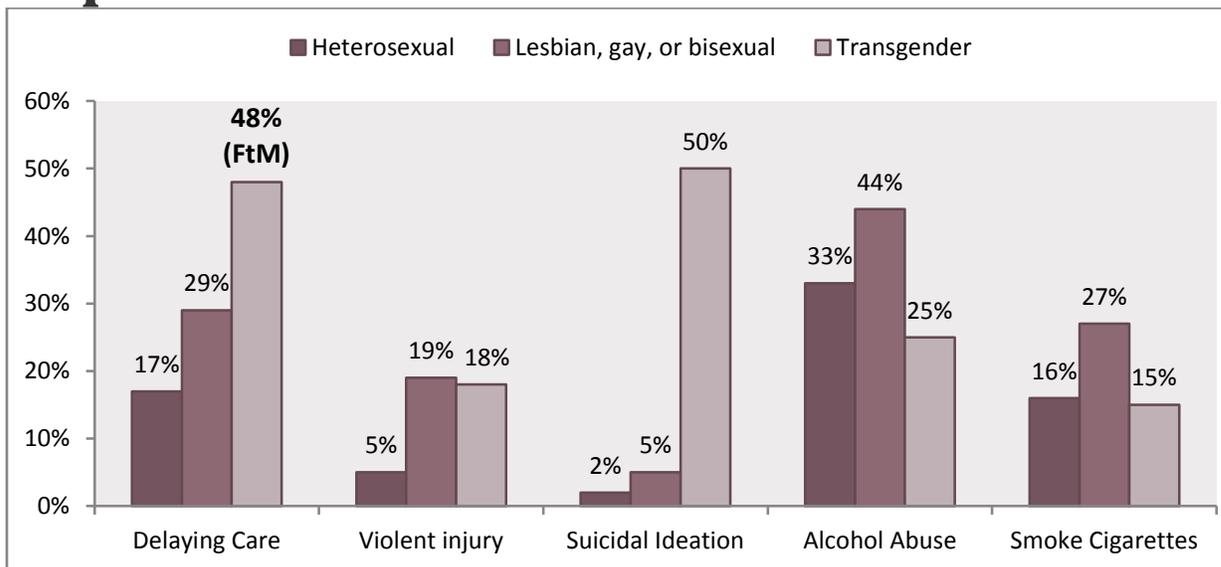
Orientation

- **Sexual orientation:** a person's emotional, sexual, and/or relational attraction to others. Usually classified as heterosexual, bisexual, and homosexual (i.e., lesbian and gay)
 - Describes how people locate themselves on the spectrum of attraction and identity
 - It is distinct from gender identity or gender expression
 - Transgender people exhibit the full range of sexual orientations
- **Bisexual:** one whose sexual or romantic attractions and behaviors are directed at both sexes to a significant degree.
- **MSM:** men who have sex with men (identify as gay)
- **WSW:** women who have sex with women (identify as lesbian)

Gender Identity

- **Transgender:** describes people whose gender identity and/or expression is different from that typically associated with their assigned sex at birth.
- **Genderqueer:** describes people who see themselves as outside the usual binary man/woman definitions
 - Having elements of many genders, being androgynous or having no gender.
 - Also **Gender Non-Conforming (GNC)**
- **Bigender:** describes people whose gender identity encompasses both male and female genders. Some may feel that one identity is stronger, but both are present.
- **MtF:** male-to-female; assigned male sex at birth but identifies & lives as female (aka: trans woman). Still needs to have prostate exams according to standard guidelines.
- **FtM:** female-to-male; assigned the female sex at birth but identifies & lives as male (aka: trans man or trans male). Still needs to have breast exams & Pap tests per standard guidelines.
- **Transsexual:** medical term for people who have used surgery or hormones to modify their bodies. Some trans people find this term offensive.

Health Disparities of LGBT Populations



Cultural Competence & the LGBT Communities

Here's what we wish our healthcare team knew...

1. We come to you with an extra layer of anxiety
 - Verbally or physically abused
 - Rejected by families
 - Discriminated against within the health care setting
2. We've experienced harshness such as with rough blood draws, rude "orders," or ridicule
3. That heteronormative assumptions and attitudes dissuade our future care-seeking
 - Discrimination in healthcare may delay or defer treatment
4. We feel our HIPAA rights to privacy are not honored
 - Amazingly, some personnel...
 - Openly discuss our sexual orientation or gender identity with coworkers
 - Don't realize or care that we can see or hear them making fun of us with coworkers
5. Check your surprise, embarrassment, or confusion
 - Many do not disclose our sexual orientation or gender identity because we don't feel comfortable or we fear receiving substandard care
 - Your "gaydar" might be off when determining whether we might be LGBT – most of us don't fit the stereotypes
6. Transgender patients have specific health concerns
 - 19% have been refused treatment
 - May experience more trauma during removal of clothing or pelvic examinations
 - Not all transgender people want to use hormones or surgery to align with their confirmed gender

Recognize that "coming out" to you does not mean we are "coming on" to you

Cultural Competence & the LGBT Communities

Here's what your team can do...

1. A little warmth can make all the difference!
 - Signage or intake form verbiage that is safe, judgment-free, and non-discriminatory
 - Policies indicating non-discrimination for sexual and gender identity displayed in common areas
2. Listen to how patients refer to themselves and loved ones (pronouns, names)
 - Use the same language they use
 - If you're unsure, ask questions
3. Anticipate that all patients are not heterosexual
 - Use "partner" instead of "spouse" or "boy/girlfriend"
 - Replace marital status with relationship status on forms
4. Protect the patient's rights
 - Sharing personal health information, including sexual orientation or gender identity, is a violation of HIPAA
 - Confirm that the patient's rights are protected under HIPAA Privacy Rule
5. Identify your own LGBT perceptions and biases as a first step in providing the best quality care
 - Practice some helpful phrases:
 - "Do you have sex with men, women, or both?"
 - "What pronoun do you prefer I use when referring to you?"
 - "I'm glad you shared that with me. I know that might have been difficult to tell me. Is there anything else in connection with your health care that I should know about?"
6. The topic of body modification activities should be approached with care
 - Do not let curiosity lead you to examine body parts that are not involved with the medical issue at hand

Cultural Competence: Refugees and Immigrants

Health Care for Refugees & Immigrants

Refugees and Immigrants may:

- not be familiar with the U.S. health care system.
- experience illness related to life changes.
- practice spiritual and botanic healing or treatments before seeking U.S. medical advice

Benefits of Open Communication for Recent Arrivals

- Builds trust
- Results in fuller disclosure of patient knowledge and behavior

❖ *Addressing the U.S. Healthcare System*

Here's what we wish our health care team knew...

- My expectations do not align with U.S. managed care
- I'm bewildered by requirement to visit multiple doctors
- I wonder why I have diagnostic testing before a prescription is written

Here's what your team can do...

- Inform patients they may need follow up care
- Explain why a patient may need to be seen by another doctor
- Emphasize the importance of medication adherence

❖ *Common Office Expectations*

Here's what we wish our health care team knew...

- I have different expectations about time
- I prefer to have someone of the same gender
- I'm going to bring friends or family. They want to help make decisions

Here's what your team can do...

- Upon arrival, inform patient about the wait time
- Accommodate a doctor or interpreter of same gender
- Confirm decision makers at each visit

❖ *How to Address Confidentiality*

Here's what we wish our health care team knew...

- I've had different experiences in refugee camps
- My experiences have caused me to be suspicious
- I fear my health information will be released to the community

Here's what your team can do...

- Explain confidentiality
- Ensure that staff adhere to your policies
- Make HIPAA forms easy to understand, in preferred languages

Cultural Competence: Seniors & People with Disabilities

Working with Seniors and Persons with Disabilities

Adapted from US Dept. of Health and Human Services, 2007



COGNITIVE IMPAIRMENT & MENTAL HEALTH

Here's what we wish our health care team knew...

- Patients with dementia may need a caregiver
- Older adults suffer more losses
 - May be less willing to discuss feelings
 - High suicide rates for 65+

Here's what your team can do...

- Communicate with patient & caregiver
- Assess for depression, dementia/cognitive ability

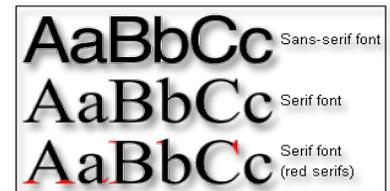
VISUAL IMPAIRMENT

Problems:

- Reading, depth perception, contrast, glare, loss of independence
 - Macular degeneration; Diabetic Retinopathy; Cataract; Glaucoma

Solutions:

- Decrease glare
- Bright indirect lighting
- Bright, contrasting colors
- **LARGE**, non-serif fonts



HEARING IMPAIRMENT

Here's what we wish our health care team knew...

- Presbycusis: gradual, bilateral, high-frequency hearing loss
 - Consonant sounds are high frequency
 - Word distinction difficult
 - Speaking louder does NOT help

Here's what your team can do...

- Face patient at all times
- Speak slowly and enunciate clearly; **do not** use contractions; rephrase if necessary
- Do not cover your mouth
- Reduce background noise (i.e., TV, hallway noise)
 - Audible solutions – offer listening devices

PHYSICAL IMPAIRMENT

Here's what we wish our health care team knew...

- Pain & reduced mobility is common due to :
 - Osteoarthritis / osteoporosis
 - Changes in feet, ligaments and cushioning
 - Stroke

Here's what your team can do...

- Keep hallways clear
- Lower exam tables, add grab bars/railings
- Use exam rooms nearest waiting area
- Offer assistance – transfers, opening sample bottles, etc.
- Recommend in home accessibility assessment

DISEASE / MULTIPLE MEDICATIONS

Here's what we wish our health care team knew...

- Neuro-cognitive processing ability impaired
 - Pain / stroke / hypertension, diabetes / UTI, pneumonia
- Meds: can affect cognition
 - Pain medication; Anti-depressants; Interactions

Here's what your team can do...

- Be aware; slow down, speak clearly use plain language; recommend assistive listening devices
- Obtain thorough health history

CAREGIVER BURDEN / BURNOUT

Here's what we wish our health care team knew...

- 12 % of active caregivers may have their own limitations
- 16% of working seniors are also caregivers
- Caregivers report more stress, higher likelihood of depression

Here's what your team can do...

- Ask about caregiver responsibilities and stress levels
- Offer caregiver support services

Summary



Remember

- ✓ Cultural competence is the capability of effectively dealing with people from different cultures
 - ✓ Clear communication allows physicians and patients to overcome the obstacles in cultural differences
- ✓ Do not discriminate against LGBT patients – this can cause the patient to delay or defer treatment
 - ✓ LGBT patient’s rights are protected under HIPAA Privacy Rule and Section 1557 of the Patient Protection and Affordable Care Act
- ✓ Refugees and immigrants may practice spiritual and botanic healing or treatments before utilizing western medicine.
- ✓ Seniors and people with disabilities might be dealing with one or more of the following:
 - ✓ Cognitive impairment / mental health issues
 - ✓ Visual, hearing, &/or physical impairments
 - ✓ Chronic medical conditions and multiple medications
 - ✓ Caregiver burden / burnout

TREAT ALL PATIENTS WITH COURTESY AND RESPECT



***For references and additional tools go to our Compliance Toolbox at
<http://www.epicmanagementlp.com/compliance.aspx>***

Phone: 909.786.0822

Internal Extension: 43622

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Questions? Contact:

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End of Cultural Competency Training Section

THE END! YOU’VE COMPLETED THE COURSE MATERIAL! GREAT JOB!