EPIC MANAGEMENT, L.P.

2016 ANNUAL COMPLIANCE TRAINING

Training Modules

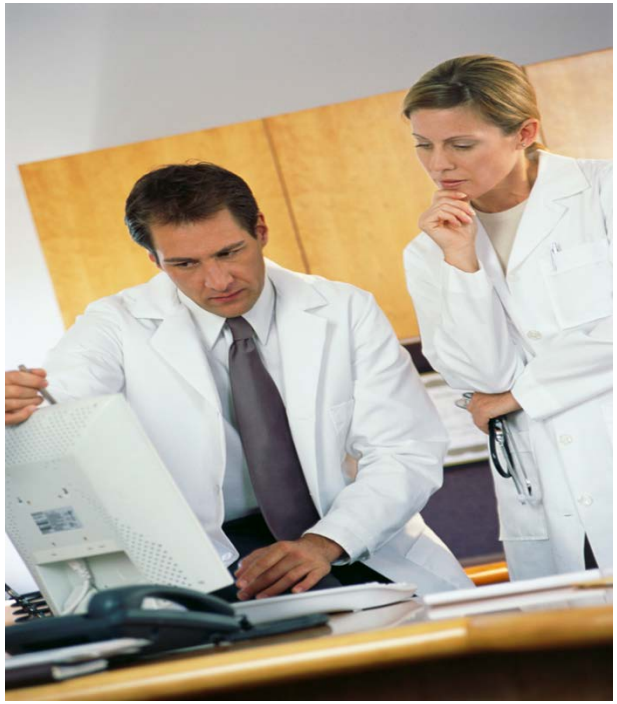
Common Terms & Abbreviations → HIPAA Privacy and Security → Medicare Fraud, Waste, and Abuse → Medicare General Compliance → Code of Conduct → Cultural and Linguistic Competency → Special Needs Plans (SNP)

Click on link to go directly to the selected training module then click on the 'home' key to return .

COMMON TERMS & ABBREVIATIONS

- **HIPAA: Health Insurance Portability & Accountability Act**
- **PHI: Protected Health Information**
- **Medicare Part C: Medicare Advantage Plan; Health plan options approved by Medicare and are run by private companies**
- **MAO / MA: Medicare Advantage Organization / Medicare Advantage**
- **FWA: Fraud, Waste, and Abuse**
- **CMS: Centers for Medicare and Medicaid Services**
- **Sponsor: Medicare Advantage Health Plan**
- **Enrollee: Medicare Advantage Beneficiary**
- **FDR: First Tier, Downstream, Related Entity**
- **C.F.R.: Code of Federal Regulations**
- **Beneficiary: The name for a person who has health care insurance through the Medicare or Medi-Cal/Medicaid program**
- **CMP: Civil Monetary Penalties**
- **Remuneration: an amount of money paid to someone for the work that person has done**
- **OIG: Office of the Inspector General**
- **U.S.C.: United States Code**
- **P.L.: Public Law**
- **IPA: Independent Practice Associations**
- **IOM: Medicare 'Internet-Only Manual'**
- **HPMS: Health Plan Management System**
- **HHS: Health and Human Services**
- **LGBT: Lesbian, gay, bisexual, and transgender**
- **Ask Me 3™: Patient education program designed to improve communication between patients and health care providers, encourage patients to become active members of their health care team, and promote improved health outcomes.**
- **SNP: Special Needs Plans**
- **MOC: Model of Care**
- **C-SNP: Chronic Conditions – Special Needs Plans**
- **D-SNP: Dual Eligible – Special Needs Plans**
- **I-SNP: Institutional – Special Needs Plans**
- **LTC: Long Term Care Facility**
- **ICF: Intermediate Care Facility**
- **ALF: Assisted Living Facility**
- **SNF / NF: Skilled Nursing Facility / Nursing Facility**

HIPAA
Do The Right Thing!



HIPAA PRIVACY RULE

- HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.
- Healthcare providers, health plans and healthcare clearinghouses – called covered entities – are required by law to follow the Rule.
- Some healthcare professionals are still unclear about what the Rule requires them to do to safeguard patient information.
- Misinterpretations affect the quality of patient care.

HIPAA REVIEW: DISCLOSURE

- **Protected Health Information (PHI) is any personal information – oral, recorded, on paper or sent electronically – about a patient's physical or mental health, healthcare services or payment.**
  - A name and address, social security number, or even physician notes are PHI.
  - PHI needs to be protected.
- **Think minimum – limit the use and disclosure of PHI, inside & outside of your facility, to the minimum – except when it comes to treatment.**
  - Healthcare providers need access to the entire record to provide quality care

HIPAA REVIEW: DISCLOSURE

- Use and disclosure of PHI is permitted for payment, claims billing, or to obtain & review services for coverage of medical necessity and the day-to-day operations necessary for healthcare delivery.
- PHI use and disclosure is permitted for incidental uses like physicians talking to patients in semi-private rooms or waiting room sign-in sheets.
- You're permitted to use or disclose a patient's PHI when that person requests or authorizes it with a few exceptions:
  - You're not permitted to use or disclose PHI when it comes to psychotherapy notes about private counseling sessions or information that can be used in litigation.
  - You're not permitted to use or disclose PHI if it could endanger the health or safety of the patient, staff or anyone else.

WHEN PATIENT AUTHORIZATION ISN'T REQUIRED

- To control and prevent disease
- Report victim abuse
- Law enforcement
- Coroners, tissue / organ donations
- HIPAA review

PATIENT AGREEMENT
(NOT WRITTEN AUTHORIZATION)
REQUIRED FOR USE AND DISCLOSURE OF PHI:

- Patient directory or inform agencies during disaster relief efforts.
- To inform family, caregivers or other identified persons involved in the patient's care or payment, or notify them on patient location, general condition, or death.
- For non-responsive patients, follow your facility rules.
- Your facility rules may differ from state or federal rules.
- The key question is if it's in the best interest of the patient to disclose or use information.
- Privacy official is a resource for any issues you don't understand.

PATIENT AUTHORIZATION:

THE FOLLOWING REQUIRES A SIGNED AUTHORIZATION FORM FOR USE & DISCLOSURE OF PHI

- Psychotherapy notes about private counseling sessions
- Marketing
  - Exceptions include
    - Informing patients about services like smoking cessation classes or specialists
    - Informing on services such as discounts for prescription drugs

PATIENT AUTHORIZATION FORMS

- Authorization forms include a description of the PHI, who will use or disclose it and if disclosure will result in financial gain for the covered entity.
- Forms also include the patient's right to revoke authorization, how he or she can do so, a signature, date of signing and expiration date.
- After the expiration date, you're required to get a new authorization.
- Make sure the patient receives a copy of the form.

PATIENTS' PRIVACY RIGHTS

- The Rule gives patients the right to choose how their PHI is used.
- Facility privacy practices should be displayed at the site of service and posted on a website.
- Patients can have PHI communicated to them by alternate means and at alternative locations.
- Patients can request inspection and amendment of PHI, obtain copies and make unlimited requests.
- You have the right to ask that requests be made in writing.
- If you believe the information could cause harm to the patient, or endanger staff or anyone else, you do not have to agree.
- If you do deny access to PHI, you are required to give the patient a written explanation of the reason and a description of how to lodge complaints.

PATIENT REPRESENTATIVES

- Patients who can't exercise their rights can pre-designate or have a court appointed Patient Representative.
- A designated Personal Representative can exercise all the rights that apply to the patient and can have full medical authority to make all healthcare decisions.
- Or, a Personal Representative may only have power of attorney regarding use of artificial life support and only have the right to the PHI needed to make that decision.
- Generally parents can access and control the PHI of their minor children.
- Exceptions include when state law overrides parental control.
- Examples include HIV testing of minors without parental permission or in cases of abuse, or when parents have agreed to give up control of their minor child.

PRIVACY SOLUTIONS

- Guarding sensitive information is just as important as guarding a life.
- In many cases, patient families have had difficulties obtaining information about their loved ones due to misinterpretation of HIPAA.
- To add to the confusion, states have rules in addition to Federal privacy laws.
- State laws take precedence over HIPAA rules if they provide greater privacy protections or for the reporting of disease or injury, child abuse, birth, death or for public health surveillance, investigation or intervention.

Privacy Solutions

- Know the facts about HIPAA requirements.
- Get familiar with your state laws and your facility rules.
- Ask for help.
- Make every effort to comply.
- Do the right thing when deciding to use or disclose confidential health information.

PEOPLE ARE COUNTING ON YOU!

Click on ‘Close’ to return to main menu.
If in full-screen mode click on ‘Escape’ and then ‘Close’.

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

Web-Based Training (WBT) Course

TABLE OF CONTENTS

INTRODUCTION

The Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training course is brought to you by the Medicare Learning Network®, a registered trademark of the U.S. Department of Health & Human Services (HHS)

INTRODUCTION

This Web-Based Training (WBT) 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 within the WBT for your reference.

This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT 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.

This training module will assist Medicare Parts C and D plan Sponsors employees, governing body members, and their first-tier, downstream, and related entities (FDRs) in satisfying the annual 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-4159-F, Medicare Program Contract Year 2015 Policy and Technical Changes in the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; and
- 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 may use this module to satisfy FWA training requirements. 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.

ACRONYM	TITLE TEXT
CFR	*Code of Federal Regulations*
FDR	*First-tier, Downstream, and Related Entity*
FWA	*Fraud, Waste, and Abuse*
WBT	*Web-Based Training*

INTRODUCTION PAGE 2

INTRODUCTION

Welcome to the Medicare Learning Network® (MLN) – Your free Medicare education and information resource!

The MLN is home for education, information, and resources for the health care professional community. The MLN provides access to the Centers for Medicare & Medicaid Services (CMS) Program information you need, when you need it, so you can focus more on providing care to your patients.

Serving as the umbrella for a variety of CMS education and communication activities, the MLN offers:

1. MLN Educational Products, including MLN Matters® Articles;
2. Web-Based Training (WBT) Courses (many offer Continuing Education credits);
3. MLN Connects® National Provider Calls;
4. MLN Connects® Provider Association Partnerships;
5. MLN Connects® Provider eNews; and
6. Provider electronic mailing lists.

ACRONYM	TITLE TEXT
CMS	*Centers for Medicare & Medicaid Service*
MLN	*Medicare Learning Network®*

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.

INTRODUCTION

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.

Learn more about Medicare Part C

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

MA plans must cover all services that Medicare covers with the exception of hospice care. MA plans 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 all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Insurance companies or other companies approved by Medicare provide prescription drug coverage to individuals who live in a plan's service area.

ACRONYM	TITLE TEXT
MA	*Medicare Advantage*

FWA TRAINING REQUIREMENTS EXCEPTION

There is one exception to the FWA training and education requirement. FDRs will have met the FWA training and education requirements if they have met the FWA certification requirement through:

- Accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; or
- Enrollment in Medicare Part A (hospital) or B (medical) Program.

If you are unsure if this exception applies to you, please contact your management team for more information.

INTRODUCTION PAGE 6

COURSE CONTENT

The WBT course consists of two lessons:

1. What Is FWA?
2. Your Role in the Fight Against FWA

Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You may use this WBT course to satisfy the FWA requirements.

THE FOLLOWING APPLIES TO THE MLN® LEARNING WEBSITE ONLY:

You do not have to complete this course in one session; however, you must complete at least one lesson before exiting this course. Do not click the "X" button in the upper right-hand corner of the window as this will cause you to exit the WBT course without properly saving your progress. You can complete the entire course in about 30 minutes.

Successfully completing the course requires completing all lessons and course evaluation, and scoring 70 percent or higher on the Post-Assessment. After successfully completing the Post-Assessment, you'll get instructions to complete the course evaluation and print your certificate. If you do not successfully complete the course, you will be given the opportunity to review the course material and retake the Post-Assessment

COURSE OBJECTIVES

When you complete this course, 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;
- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA.

LESSON 1:
WHAT IS FWA?

Lesson 1: 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; and
- Recognize potential consequences and penalties associated with violations.

ACRONYM	TITLE TEXT
FWA	*Fraud, Waste, and Abuse*

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.

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

WASTE AND ABUSE

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 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.

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

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 screens 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.

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.

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

ACRONYM	TITLE TEXT
FCA	*False Claims Act*

CIVIL FALSE CLAIMS ACT (FCA)

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.

CIVIL FCA (CONTINUED)

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.

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.

HEALTH CARE FRAUD STATUTE

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 Internet.

ANTI-KICKBACK STATUTE

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)

Stark Statute (Physician Self-Referral Law)

The Stark Statute 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; or
- A compensation arrangement (exceptions apply).

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

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of up to $15,000 may be imposed for each service provided. There may also be up to a $100,000 fine for entering into an unlawful arrangement or scheme.

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.

STARK STATUTE
(PHYSICIAN SELF-REFERRAL LAW)

EXAMPLE

A physician paid the Government $203,000 to settle allegations that he violated the physician self-referral prohibition in the Stark Statute for routinely referring Medicare patients to an oxygen supply company he owned.

CIVIL MONETARY PENALTIES 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.

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

Damages and Penalties

The penalties range from $10,000 to $50,000 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.

ACRONYM	TITLE TEXT
OIG	*Office of Inspector General*

CIVIL MONETARY PENALTIES LAW

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.

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.

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

ACRONYM	TITLE TEXT
EPLS	*Excluded Parties List System*
LEIE	*List of Excluded Individuals and Entities*

EXCLUSION

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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards help prevent 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 http://www.hhs.gov/ocr/privacy on the Internet.

Damages and Penalties

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

ACRONYM	TITLE TEXT
HIPAA	*Health Insurance Portability and Accountability Act*

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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.

LESSON 1 SUMMARY

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.

LESSON 1 REVIEW

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

KNOWLEDGE CHECK

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

LESSON 1

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.

LESSON 2:
YOUR ROLE IN THE FIGHT AGAINST FWA

Lesson 2: 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; and
- Recognize how to correct FWA.

ACRONYM	TITLE TEXT
FWA	*Fraud, Waste, and Abuse*

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? (CONTINUED)

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.

WHERE DO I FIT IN? (CONTINUED)

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 AND 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.

ACRONYM	TITLE TEXT
FDRs	*First-Tier, Downstream, or Related Entities*

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.

ACRONYM	TITLE TEXT
CMS	*Centers for Medicare & Medicaid Services*

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?

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

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 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)?

ACRONYM	TITLE TEXT
PBMs	*Pharmacy Benefit Managers*

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 and 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 provide samples, knowing that the samples will be billed to a Federal health care program?

KEY INDICATORS: 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

- 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.

LESSON 2 REVIEW

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

KNOWLEDGE CHECK

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

KNOWLEDGE CHECK

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

KNOWLEDGE CHECK

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

POST-ASSESSMENT

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

Now that you have learned how to fight FWA, you will take a post-assessment at the end of this training to see how much you've learned!

APPENDIX A: RESOURCES

Disclaimers

This Web-Based Training (WBT) 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 within the document for your reference.

This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT 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.

The Medicare Learning Network® (MLN)

ACRONYM	TITLE TEXT
MLN	*Medicare Learning Network®*
WBT	*Web-Based Training*

GLOSSARY

For the Centers for Medicare & Medicaid Services (CMS) Glossary, visit https://www.cms.gov/apps/glossary on the CMS website.

ACRONYM	TITLE TEXT
CMS	*Centers for Medicare & Medicaid Services*

APPENDIX B: JOB AIDS

Job Aid A: Applicable Laws for Reference

Law	Available At
Anti-Kickback Statute 42 U.S.C. Section 1320A-7b(b)	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
Civil False Claims Act 31 U.S.C. Sections 3729–3733	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title31/pdf/USCODE-2013-title31-subtitleIII-chap37-subchapIII.pdf
Civil Monetary Penalties Law 42 U.S.C. Section 1320a-7a	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7a.pdf
Criminal False Claims Act 18 U.S.C. Section 287	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title18/pdf/USCODE-2013-title18-partI-chap15-sec287.pdf
Exclusion 42 U.S.C. Section 1320a-7	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7.pdf
Health Care Fraud Statute 18 U.S.C. Section 1347	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title18/pdf/USCODE-2013-title18-partI-chap63-sec1347.pdf
Physician Self-Referral Law 42 U.S.C. Section 1395nn	http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXVIII-partE-sec1395nn.pdf

APPENDIX B: JOB AIDS (CONTINUED)

Job Aid B: Resources

Resource	Website
Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training	https://oig.hhs.gov/compliance/provider-compliance-training
OIG's Provider Self-Disclosure Protocol	https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf
Physician Self-Referral	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral
A Roadmap for New Physicians: Avoiding Medicare Fraud and Abuse	https://oig.hhs.gov/compliance/physician-education
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations

APPENDIX B: JOB AIDS (CONTINUED)

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: 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

URL	Text/Image
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts	MLN Educational Products
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles	MLN Matters® Articles
https://learner.mlnlms.com	WBT Courses
https://www.cms.gov/Outreach-and-Education/Outreach/NPC	MLN Connects® National Provider Calls
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-Partnership	MLN Connects® Provider Association Partnerships
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg	MLN Connects® Provider eNews
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf	Provider electronic mailing lists
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Medicare Managed Care Manual
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Prescription Drug Benefit Manual
http://www.gpo.gov/fdsys/pkg/USCODE-2013-title31/pdf/USCODE-2013-title31-subtitleIII-chap37-subchapIII.pdf	31 United States Code (U.S.C.) Sections 3729-3733
http://www.gpo.gov/fdsys/pkg/USCODE-2013-title18/pdf/USCODE-2013-title18-partI-chap63-sec1346.pdf	18 U.S.C. Section 1346
http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap63-sec1347.pdf	18 U.S.C. Section 1347

URL	Text/Image
http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7b.pdf	42 U.S.C. Section 1320A-7b(b)
https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm	Social Security Act (the Act), Section 1128B(b)
http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXVIII-partE-sec1395nn.pdf	42 U.S.C. Section 1395nn
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral
https://www.ssa.gov/OP_Home/ssact/title18/1877.htm	the Act, Section 1877
http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm	the Act, Section 1128A(a)
https://exclusions.oig.hhs.gov	https://exclusions.oig.hhs.gov
https://www.sam.gov	https://www.sam.gov
http://www.gpo.gov/fdsys/pkg/USCODE-2013-title42/pdf/USCODE-2013-title42-chap7-subchapXI-partA-sec1320a-7.pdf	42 U.S.C. Section 1320a-7
http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol5/pdf/CFR-2014-title42-vol5-sec1001-1901.pdf	42 Code of Federal Regulations Section 1001.1901

Click on ‘Close’ to return to main menu.
If in full-screen mode click on ‘Escape’ and then ‘Close’.

Medicare Parts C and D General Compliance Training

Web-Based Training Course

TABLE OF CONTENTS

INTRODUCTION

The Medicare Parts C and D General Compliance Training course is brought to you by the Medicare Learning Network®, a registered trademark of the U.S. Department of Health & Human Services (HHS)

INTRODUCTION

This Web-Based Training (WBT) 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 within the WBT for your reference.
This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT 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.
Completing this training module satisfies the Medicare Parts C and D plan Sponsors 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);
- 42 CFR Section 423.504(b)(4)(vi);
- 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"); and
- June 17, 2015, Health Plan Management System (HPMS) memo: Update – Reducing the Burden of the Compliance Program Training Requirements. (Keep up-to-date with the most recent memos on the CMS Compliance Program Policy and Guidance website.)

While Sponsors are required to complete this training or use this module's downloaded content to satisfy compliance training requirements, completing this training in and of itself does not ensure that a Sponsor has an "effective Compliance Program." Sponsors are responsible for establishing and executing an effective compliance program according to the Centers for Medicare & Medicaid Services (CMS) regulations and program guidelines.

ACRONYM	TITLE TEXT
CFR	*Code of Federal Regulations*
WBT	*Web-Based Training*

INTRODUCTION

Welcome to the Medicare Learning Network® (MLN) – Your free Medicare education and information resource!

The MLN is home for education, information, and resources for the health care professional community. The MLN provides access to the Centers for Medicare & Medicaid Services (CMS) Program information you need, when you need it, so you can focus more on providing care to your patients.

Serving as the umbrella for a variety of CMS education and communication activities, the MLN offers:

1. MLN Educational Products, including MLN Matters® Articles;
2. Web-Based Training (WBT) Courses (many offer Continuing Education credits);
3. MLN Connects® National Provider Calls;
4. MLN Connects® Provider Association Partnerships;
5. MLN Connects® Provider eNews; and
6. Provider electronic mailing lists.

ACRONYM	TITLE TEXT
CMS	*Centers for Medicare & Medicaid Services*
MLN	*Medicare Learning Network®*

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.

ACRONYM	TITLE TEXT
FWA	*Fraud, Waste, and Abuse*

INTRODUCTION PAGE 4

INTRODUCTION

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

Certain training requirements apply to people involved in performing or delivering the Medicare Parts C and D benefits. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this WBT course as "Sponsors") and the entities with which they contract to provide administrative or health care services for enrollees on behalf of the sponsor (referred to as "FDRs") must receive training about compliance with CMS program rules.

You may also be required to complete FWA training within 90 days of your initial hire. Please contact your management team for more information.

Learn more about Medicare Part C

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

MA plans must cover all services that Medicare covers with the exception of hospice care. MA plans 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 all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Insurance companies or other companies approved by Medicare provide prescription drug coverage to individuals who live in a plan's service area.

ACRONYM	TITLE TEXT
MA	*Medicare Advantage*

COURSE CONTENT

This WBT course consists of general compliance program training, a post-assessment, and a course evaluation.

Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You may use this WBT course to satisfy the FWA requirements.

.

THE FOLLOWING APPLIES TO THE MLN® LEARNING WEBSITE ONLY:

You do not have to complete this course in one session; however, you must complete at least one lesson before exiting this course. Do not click the "X" button in the upper right-hand corner of the window as this will cause you to exit the WBT course without properly saving your progress. You can complete the entire course in about 30 minutes.

Successfully completing the course requires completing all lessons and course evaluation, and scoring 70 percent or higher on the Post-Assessment. After successfully completing the Post-Assessment, you'll get instructions to complete the course evaluation and print your certificate. If you do not successfully complete the course, you will be given the opportunity to review the course material and retake the Post-Assessment

COURSE OBJECTIVES

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.

LESSON:
COMPLIANCE PROGRAM TRAINING

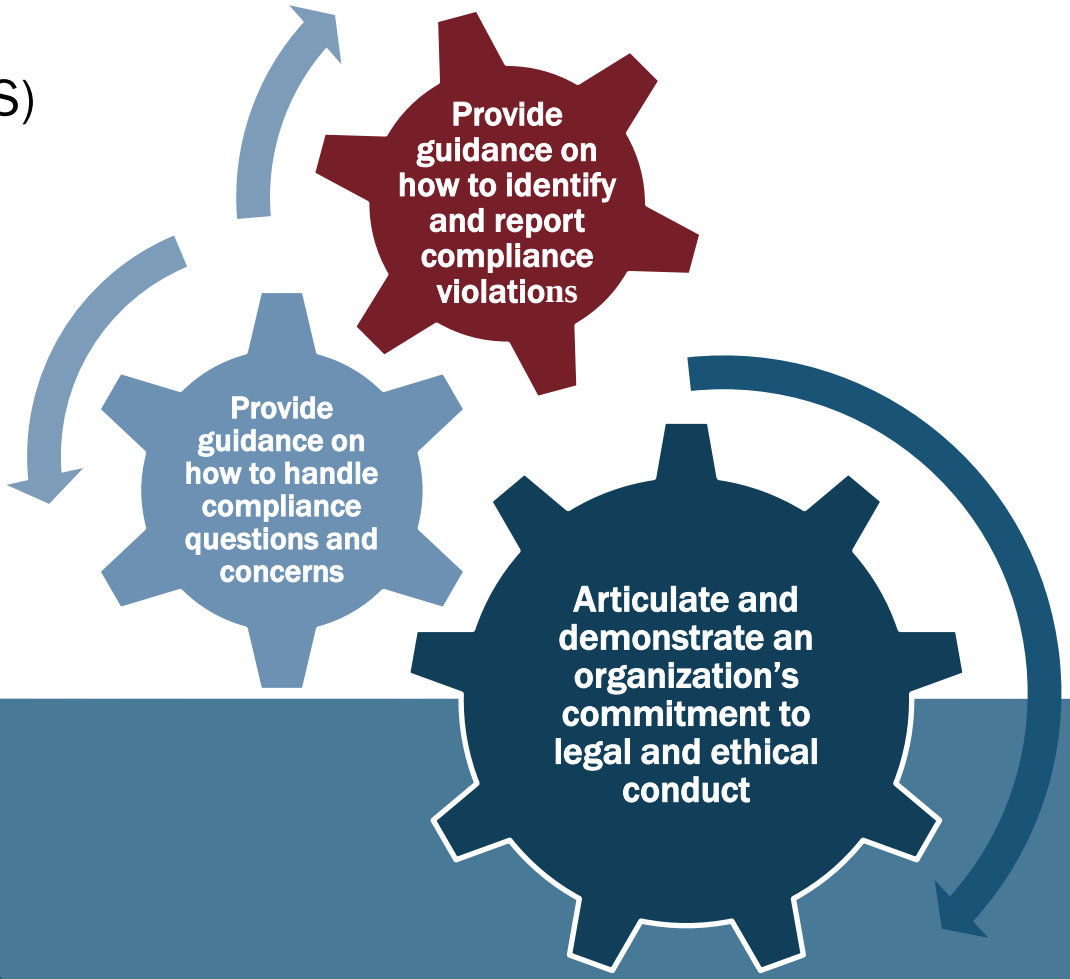
Introduction and Learning Objectives

This lesson outlines effective compliance programs. It should take about 15 minutes to complete. Upon completing the lesson, 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.*

ACRONYM	TITLE TEXT
FWA	*Fraud, Waste, and Abuse*

SEVEN CORE COMPLIANCE PROGRAM REQUIREMENTS (CONTINUED)

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.

ACRONYM	TITLE TEXT
FDR	*First-Tier, Downstream, or Related Entity*

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!

1. Act Fairly and Honestly

3. Comply with all applicable laws, regulations, and CMS requirements; and

As a part of the Medicare program, you must conduct yourself in an ethical and legal manner.

It's about doing the right thing!

2. Adhere to high ethical standards in all you do

4. Report suspected violations

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 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; 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.

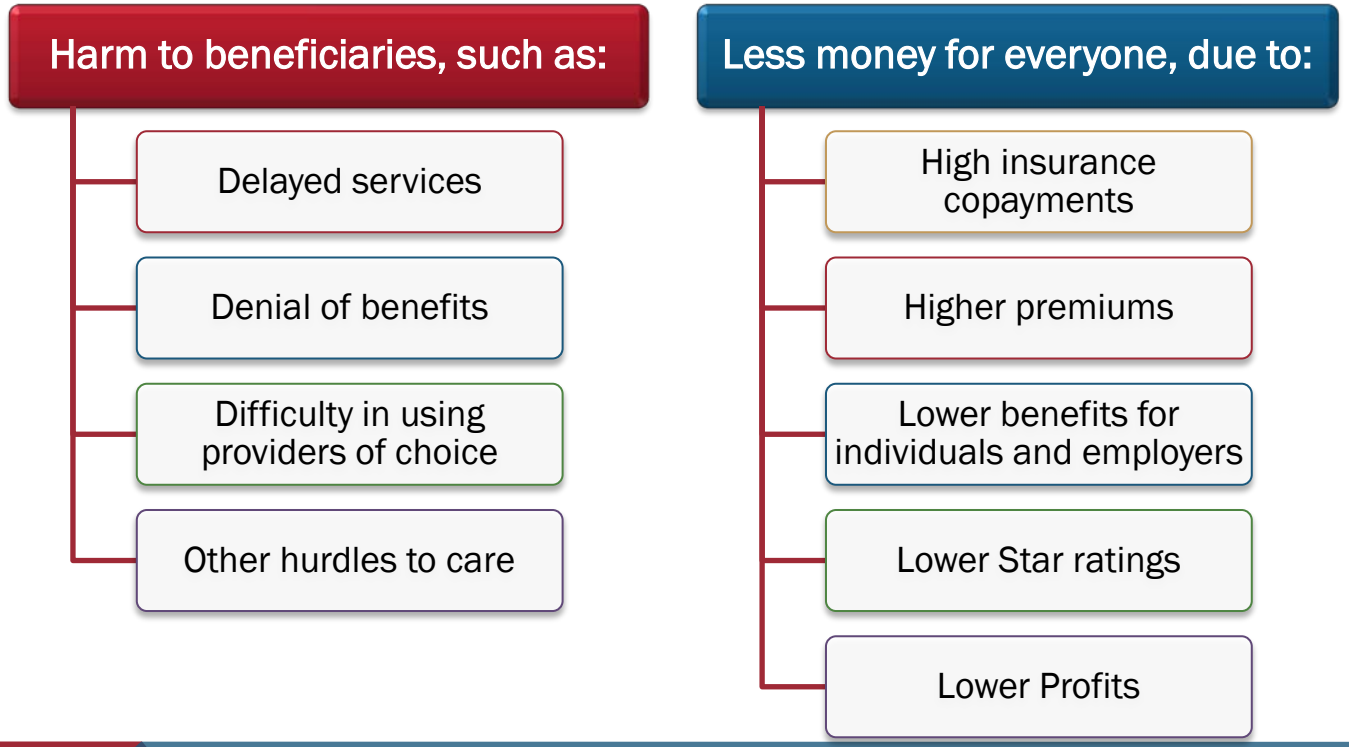
Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- 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:



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

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!

LESSON REVIEW

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

KNOWLEDGE CHECK

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

KNOWLEDGE CHECK

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

ACRONYM	TITLE TEXT
CMS	*Centers for Medicare & Medicaid Services*

KNOWLEDGE CHECK

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

POST-ASSESSMENT

You've completed the lesson!

Now that you have learned about compliance programs, you will take a post-assessment at the end of this training to see how much you've learned!

APPENDIX A: RESOURCES

RESOURCES PAGE 1 OF 1

Disclaimers

This Web-Based Training (WBT) 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 within the document for your reference.

This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT 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.

The Medicare Learning Network® (MLN)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Glossary

For the Centers for Medicare & Medicaid Services (CMS) Glossary, visit https://www.cms.gov/apps/glossary on the CMS website.

APPENDIX B: JOB AIDS

Job Aid A: 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.

APPENDIX B: JOB AIDS

Job Aid A: Seven Core Compliance Program Requirements (continued)

CMS requires that an effective compliance program must include seven core requirements:

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.

ACRONYM	TITLE TEXT
FDR	*First-Tier, Downstream, or Related Entity*

APPENDIX B: JOB AIDS

Job Aid B: Resources

Resource	Website
Compliance Education Materials: Compliance 101	https://oig.hhs.gov/compliance/101
Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training	https://oig.hhs.gov/compliance/provider-compliance-training
OIG's Provider Self-Disclosure Protocol	https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf
Part C and Part D Compliance and Audits – Overview	https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits
Physician Self-Referral	https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral
A Roadmap for New Physicians: Avoiding Medicare Fraud and Abuse	https://oig.hhs.gov/compliance/physician-education
Safe Harbor Regulations	https://oig.hhs.gov/compliance/safe-harbor-regulations

WEBSITES

URL	TEXT/IMAGE
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts	MLN Educational Products
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles	MLN Matters® Articles
https://learner.mlnlms.com	WBT Courses
https://www.cms.gov/Outreach-and-Education/Outreach/NPC	MLN Connects® National Provider Calls
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-Partnership	MLN Connects® Provider Association Partnerships
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg	MLN Connects® Provider eNews
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243324.html	Provider Electronic Mailing Lists

WEBSITES

URL	TEXT/IMAGE
https://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol3/pdf/CFR-2014-title42-vol3-sec422-503.pdf	42 Code of Federal Regulations (CFR Section 422.503(b)(4)(vi)
https://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol3/pdf/CFR-2014-title42-vol3-sec423-504.pdf	42 CFR Section 423.504(b)(4)(vi)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Medicare Managed Care Manual, Chapter 21
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf	Medicare Prescription Drug Benefit Manual, Chapter 9
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf	“Medicare Prescription Drug Benefit Manual” and “Medicare Managed Care Manual” (pg. 105)

Click on ‘Close’ to return to main menu.
If in full-screen mode click on ‘Escape’ and then ‘Close’.

EPIC MANAGEMENT, L.P.

OUR PRINCIPLES OF ETHICS & INTEGRITY

CODE OF CONDUCT

WHAT IS 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.

WHAT IS A COMPLIANCE PLAN AND CODE OF CONDUCT?

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 ABOUT THE CODE OF CONDUCT

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.

Your Manager	First contact for workplace issues
Human Resources Internal ext. 4720 External 909-335-4195	Contact for policy guidance and interpretation, workplace issues, compensation and employee benefit concerns.
Compliance and Ethics Corporate Compliance Officer Internal ext. 4821 External 909-786-0821 Compliance Team Member Internal ext. 4822 External 909-786-0822 Compliance Hotline 909-335-4153	Contact for questions or advice on: • The Code of Conduct • Corporate Compliance Plan • Reporting violations or suspected violations of compliance or unethical behavior
Safety, Health, and Environment Director of Risk Management and Safety Internal ext. 4718	Contact to report unsafe conditions and workplace hazards.

ETHICAL RESPONSIBILITIES

ETHICAL PERFOMANCE

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.

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.

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

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 are expected to have a practical working knowledge of the laws and regulations that affect our job responsibilities.
- If a representative of any government agency contacts you, you should immediately consult with your supervisor for guidance to insure that the government agency receives full cooperation.

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

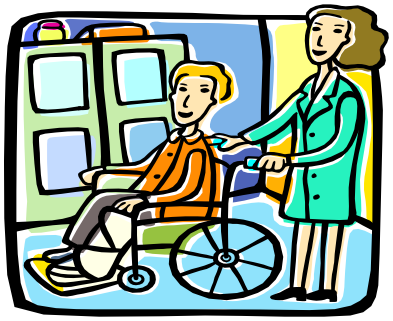
FRAUD AND ABUSE

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 following activities, all of which are prohibited by law:

- Billing for supplies or services not delivered;
- Misrepresenting or duplicate billing of services actually rendered;
- Falsely certifying that services were medically necessary;
- Seeking to collect amounts exceeding the co-payment and deductible from a Medicare or Medi-Cal beneficiary who has assigned benefits; or
- Soliciting, offering or receiving a kickback, bribe or rebate in exchange for patient referrals.

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 at all times treat patients with dignity and respect.
- Treatment of patients shall be consistent with appropriate informed consent as determined by California law
- 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
- HIPAA regulations mandate how and when we may disclose protected health information. These regulations also describe how a patient may request to limit the amount and the method that protected health information is disclosed.

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.
- We will negotiate and enter into contracts with competitors, potential competitors, contractors or suppliers on a competitive basis based upon factors like price, quality and service.
- We will not share with competitors any pricing information not normally available to the public.
- 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.
- The United States has federal, state and local agencies to ensure that everyone complies with laws and regulations affecting safety, health and environmental protection. It is our policy to comply with the standards and regulations of these agencies.
- 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.

- 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. Confidential and trade secret information includes any information that is not generally disclosed to the public.

Examples of confidential and trade secret information include:

- 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 accidently 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 on the basis of race, creed, gender, age, disability status, national origin, medical condition, or any other illegal basis.
- We strictly prohibit harassment, including sexual harassment. Sexual harassment includes sexual advances, requests for sexual favors, or any sexually offensive verbal, visual or physical conduct, or when such conduct creates an intimidating, hostile or offensive work environment. Any form of harassment will not be tolerated.
- We are committed to providing an efficient and productive working environment. We must perform our job duties safely, competently and efficiently in a manner that protects EPIC's interests and those of their co-workers. 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.

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 are 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.

CONCLUSION (CONTINUED)

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. 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. All reports will be reviewed and, if necessary, investigated.

Code of Conduct

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

ADDITIONAL SOURCES FOR EPIC EMPLOYEES

Employee Handbook

Fraud and Abuse:

Administrative Policy & Procedure Manual
- Management Information Systems
- Physician Section & Patient Financial Services
- Discount and Co-payment Guidelines

Patients' Rights:

Patient's Bill of Rights

Notice of Privacy Practices

Administrative Policy & Procedure Manual
- Quality Management
- Physician's Section
- Medical Records
- Compliance & Privacy

Non-Disclosure Acknowledgement

Anti-Trust:

Administrative Policy & Procedure Manual
- Legal Guidelines and Responsibilities

Safety, Health and Environment:

Administrative Policy & Procedure Manual
- Emergency/Safety/OSHA
- Infection Control
- Radiology
- Laboratory

Organized Plans of Operation Manual

Confidentiality and Business Information:

Administrative Policy & Procedure Manual
- Medical Records

Non-Disclosure Acknowledgement

Employee's Rights and Obligations:

Equal Employment Opportunity Commission

Administrative Policy & Procedure Manual
- Human Resources

Non-Disclosure Acknowledgement

Financial Accounting and Records:

Administrative Policy & Procedure Manual
- Human Resources

Click on 'Close' to return to main menu.
If in full-screen mode click on 'Escape' and then 'Close'.

CONNECTING WITH YOUR PATIENTS

Cultural & Linguistic Competency

DEVELOPED BY:

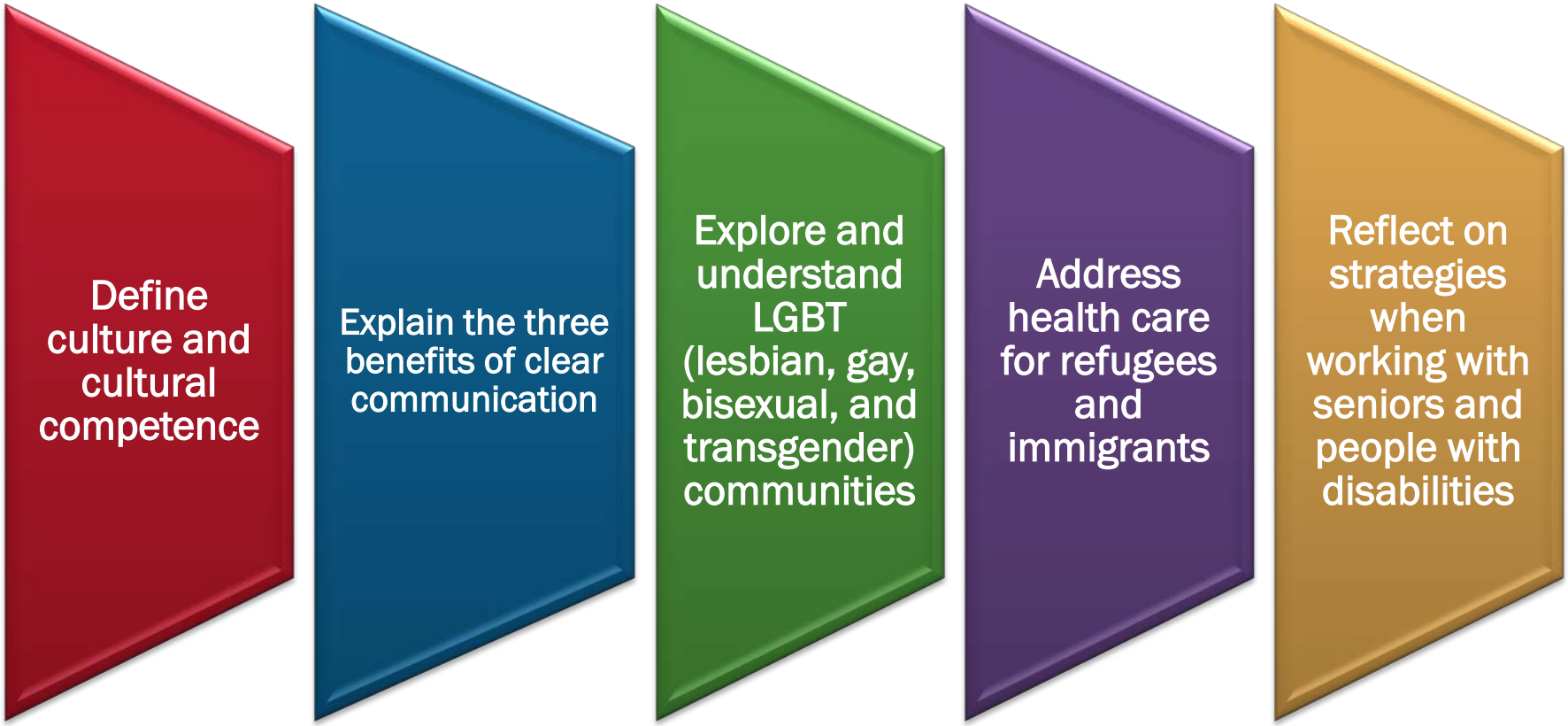
INDUSTRY COLLABORATION EFFORT (ICE)

CULTURAL AND LINGUISTIC SERVICES MAIN TEAM

CULTURAL COMPETENCY TRAINING WORKGROUP

APPROVED ON JANUARY 18, 2013 BY ICE LEADERSHIP

TRAINING GOALS



DEFINING CULTURE AND CULTURAL COMPETENCE

- 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.

Adapted from http://minorityhealth.hhs.gov

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 IMPACTS EVERY HEALTH CARE ENCOUNTER

- 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

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.

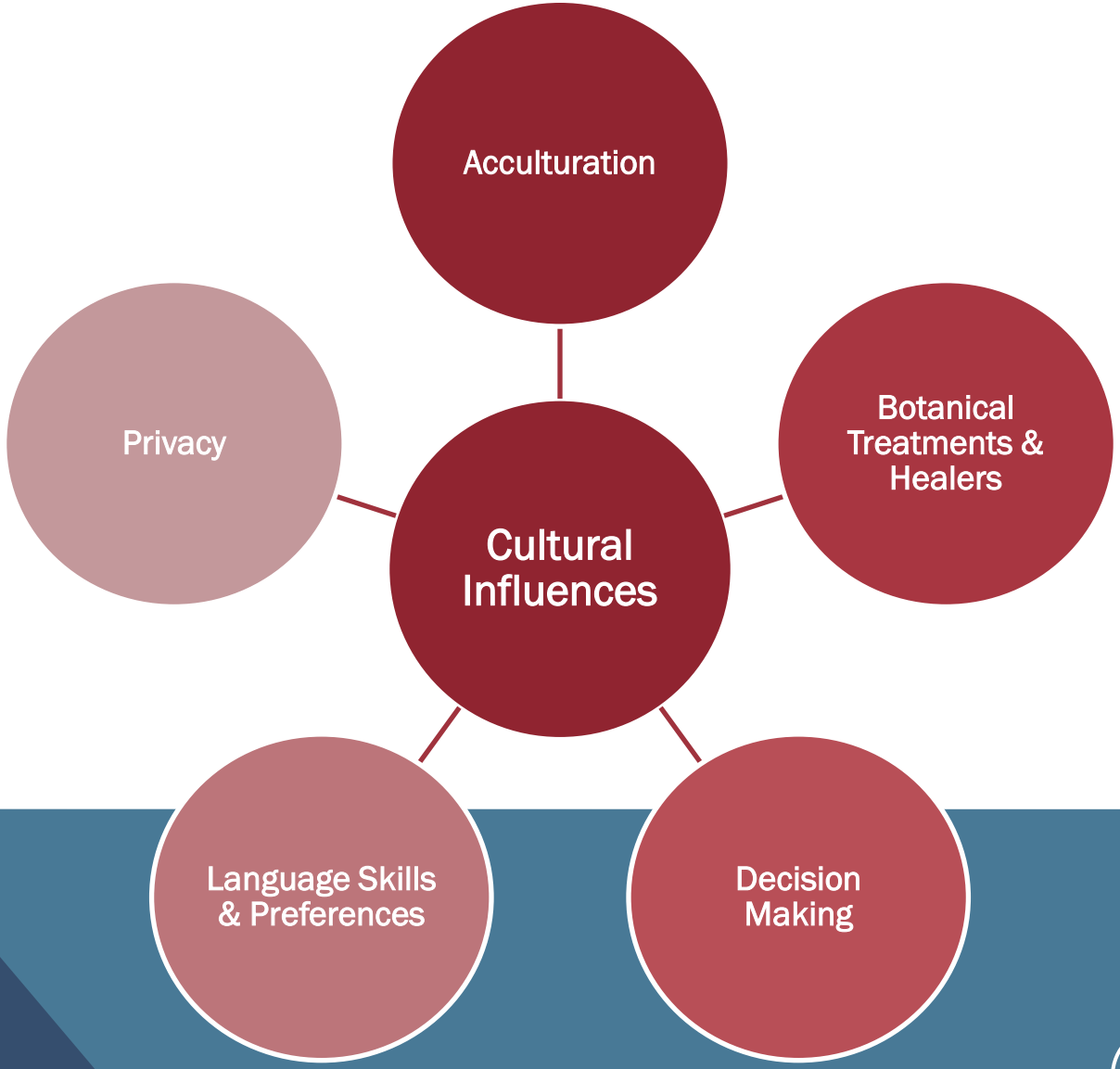
CLEAR COMMUNICATION: THE FOUNDATION OF CULTURALLY COMPETENT CARE

Did you know?

- 20% of people living in the U.S. speak a language other than English at home
- The Hispanic population has grown by 43% in the U.S. between 2000 and 2010
- 17% of the foreign born population in the U.S. are classified as newly arrived (arriving in 2005 or later)
- 1 out of 2 adult patients has a hard time understanding basic health information
- Average physician interrupts a patient within the first 20 seconds

CLEAR COMMUNICATION BENEFITS

CULTURAL INFLUENCES



CLEAR COMMUNICATION

- I tell you I forgot my glasses because I am ashamed to admit I don't read very well
- I don't know what to ask and am hesitant to ask you
- When I leave your office I often don't know what I should do next

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Use a variety of instruction methods
- Encourage Questions & use Ask Me 3™
- Use Teach Back

HERE'S WHAT YOUR TEAM CAN DO…

CLEAR COMMUNICATION

- I put medication into my ear instead of my mouth to treat an ear infection.
- I am confused about risk and information given in numbers like % or ratios – how do I decide what I should do.

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Use specific, plain language on prescriptions
- Use qualitative plain language to describe risks and benefits, avoid using just numbers.

HERE'S WHAT YOUR TEAM CAN DO…

CLEAR COMMUNICATION

- My English is pretty good but at times I need an interpreter
- When I don't seem to understand, talking louder in English intimidates me
- If I look surprised, confused or upset I may have misinterpreted your nonverbal cues

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Office staff should confirm interpreter needs during scheduling
- Match the volume and speed of the patient's speech
- Mirror body language, position, eye contact
- Ask the patient if you are unsure

HERE'S WHAT YOUR TEAM CAN DO…

CLEAR COMMUNICATION

- I am not able to make important decisions by myself
- I am more comfortable with a female doctor
- Its important for me to have a relationship with my doctor
- I use botanicals and home remedies but don't think to tell you

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Confirm decision making preferences
- Office staff should confirm preferences during scheduling
- Spend a few minutes building rapport
- Ask about the use of home remedies & healers

HERE'S WHAT YOUR TEAM CAN DO…

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

INTERPRETER TIPS

- 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

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, from homosexual to bisexual and heterosexual

*(lesbian, gay, bisexual, and transgender)

CULTURAL COMPETENCE & THE LGBT* COMMUNITIES

Some LGBT Terminology

Orientation (cont'd)

- **Bisexual:** One whose sexual or romantic attractions and behaviors are directed at both sexes to a significant degree. Bisexuality is a distinct sexual orientation.
- **MSM:** Men who have sex with men. Usually identify as gay.
- **WSW:** Women who have sex with women. Usually identify as lesbian.

*(lesbian, gay, bisexual, and transgender)

CULTURAL COMPETENCE & THE LGBT* COMMUNITIES

Some LGBT Terminology (cont'd)

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.

*(lesbian, gay, bisexual, and transgender)

CULTURAL COMPETENCE & THE LGBT* COMMUNITIES

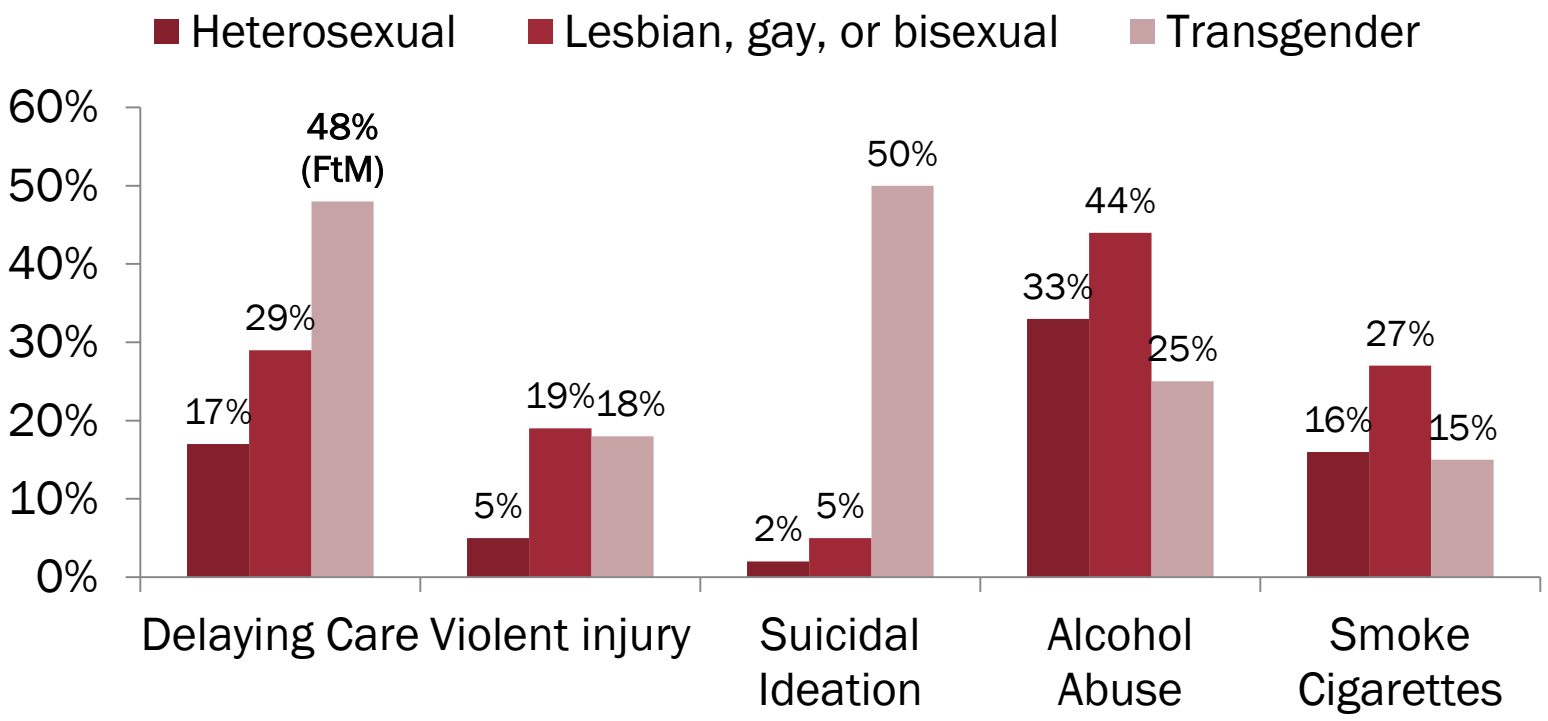
Some LGBT Terminology (cont'd)

Gender Identity (cont'd)

- **MtF:** Male-to-female; a person who was assigned the male sex at birth but identifies and lives as a female. Also trans woman.
  - MtF persons will still need to have prostate exams according to standard guidelines.
- **FtM:** Female-to-male; a person who was assigned the female sex at birth but identifies and lives as a male. Also trans man or trans male.
  - FtM persons will need to have breast exams and Pap tests according to standard guidelines
- **Transsexual:** Medical term for people who have used surgery or hormones to modify their bodies. Some trans people find this term offensive.

*(lesbian, gay, bisexual, and transgender)

HEALTH DISPARITIES OF LGBT POPULATIONS



CULTURAL COMPETENCE & LGBT COMMUNITIES

- We come to you with an extra layer of anxiety
  - Verbally or physically abused
  - Rejected by families due to our sexual and gender identity
  - Discriminated against within the health care setting
- We've experienced harshness such as with rough blood draws, rude "orders," or ridicule

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- 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
- Listen to how patients refer to themselves and loved ones (pronouns, names)
  - Use the same language they use
  - If you're unsure, ask questions

HERE'S WHAT YOUR TEAM CAN DO…

CULTURAL COMPETENCE & LGBT COMMUNITIES

- That heteronormative assumptions and attitudes dissuade our future care-seeking
- Discrimination in healthcare may delay or defer treatment

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Anticipate that all patients are not heterosexual
  - Use "partner" instead of "spouse" or "boy/girlfriend"
  - Replace marital status with relationship status on forms

HERE'S WHAT YOUR TEAM CAN DO…

CULTURAL COMPETENCE & LGBT COMMUNITIES

- 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

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- 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 the HIPAA Privacy Rule

HERE'S WHAT YOUR TEAM CAN DO…

CULTURAL COMPETENCE & LGBT COMMUNITIES

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

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- 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?"

HERE'S WHAT YOUR TEAM CAN DO…

CULTURAL COMPETENCE & LGBT COMMUNITIES

- 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

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Always use preferred name and pronouns, even when we are not in the room
- 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

HERE'S WHAT YOUR TEAM CAN DO…

CULTURAL COMPETENCE & LGBT COMMUNITIES

- **The California Department of Public Health maintains a list of very helpful LGBT-related resources for:**
  - Affordable Care Act
  - Census and LGBT Demographic Studies
  - Drug and Alcohol Abuse
  - Gender Identity
  - Health Disparities
  - HIV/AIDS
  - Homelessness
  - LGBT Health Resources
  - LGBT Health Organizations
  - LGBT Curriculum in Schools
  - Mental Health
  - Legal
  - Teen Health

  http://www.cdph.ca.gov/programs/OMH/Pages/LGBTResources.aspx

CULTURAL COMPETENCE: REFUGEES AND IMMIGRANTS

Health Care for Refugees and Immigrants

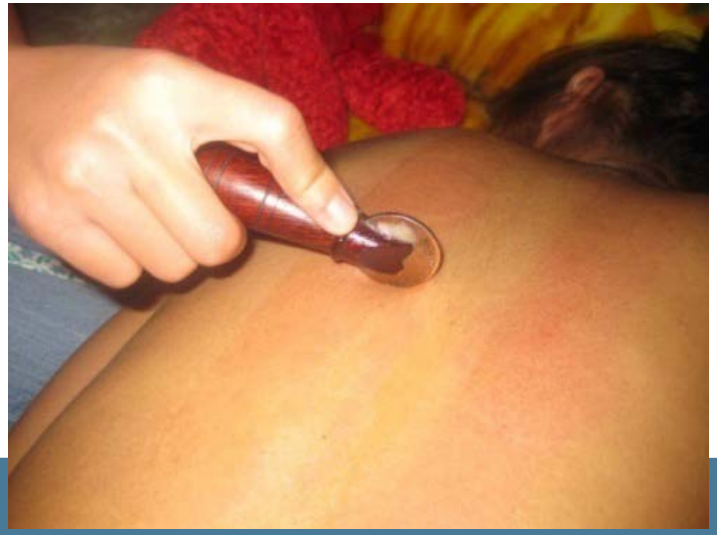
Refugees and Immigrants may:

- 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

- 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 WE WISH OUR HEALTH CARE TEAM KNEW…

- 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

HERE'S WHAT YOUR TEAM CAN DO…

COMMON OFFICE EXPECTATIONS

- 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 WE WISH OUR HEALTH CARE TEAM KNEW…

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

HERE'S WHAT YOUR TEAM CAN DO…

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

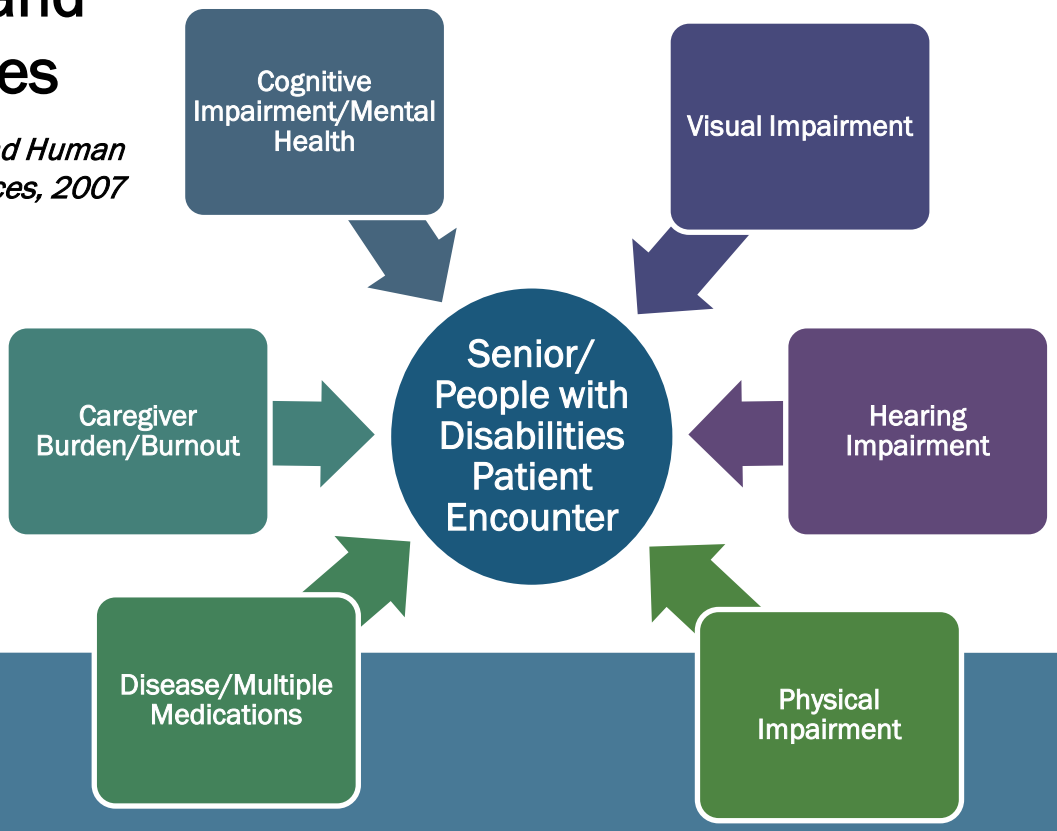
HERE'S WHAT YOUR TEAM CAN DO…

- 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



DISEASE & MULTIPLE MEDICATIONS

- Neuro-cognitive processing ability impaired
  - Pain
  - Stroke
  - Hypertension, Diabetes
  - UTI, Pneumonia
- Meds: can affect cognition
  - Pain medication
  - Anti-depressants
  - Interactions

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- Be aware
  - Slow down
  - Speak clearly
  - Use plain language
  - Recommend assistive listening devices
- Obtain thorough health history

HERE'S WHAT YOUR TEAM CAN DO…

CAREGIVER BURDEN/BURNOUT

- 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 WE WISH OUR HEALTH CARE TEAM KNEW…

- Ask about caregiver responsibilities and stress levels

- Offer caregiver support services

HERE'S WHAT YOUR TEAM CAN DO…

COGNITIVE IMPAIRMENT & MENTAL HEALTH

- Patients with dementia may need caregiver
- Older adults suffer more losses
  - May be less willing to discuss feelings
  - High suicide rates for 65+
- Communicate with patient & caregiver
- Assess for depression, dementia/ cognitive ability

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

HERE'S WHAT YOUR TEAM CAN DO…

VISUAL IMPAIRMENT

Macular Degeneration:

Diabetic Retinopathy:

Cataract:

Glaucoma:

Problems

- Reading, depth perception, contrast, glare, loss of independence

Solutions

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

AaBbCc Sans-serif font

AaBbCc Serif font

AaBbCc Serif font (red serifs)

HEARING IMPAIRMENT

Presbycusis: Gradual, bilateral, high-frequency hearing loss

- Consonant sounds are high frequency
- Word distinction difficult
- Speaking louder does NOT help

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- **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**
  - Air conditioner, TV, hallway noise etc.
  - Audible Solutions- offer listening devices

HERE'S WHAT YOUR TEAM CAN DO…

PHYSICAL IMPAIRMENT

Pain & reduced mobility is common due to:

- Osteoarthritis
- Changes in feet, ligaments and cushioning
- Osteoporosis
- Stroke

HERE'S WHAT WE WISH OUR HEALTH CARE TEAM KNEW…

- 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

HERE'S WHAT YOUR TEAM CAN DO…

REFERENCES

Culture and Cultural Competency

U.S. Department of health and Human Services (n.d.). *The Office of Minority Health. Retrieved from http://minorityhealth.hhs.gov/*

Clear Communication: The Foundation of Culturally Competent Care

Health Industry Collaboration Effort, Inc. (2010, July). *Better communication, better care: Provider tools to care for diverse populations. Retrieved from http://www.iceforhealth.org/library/documents/ICE_C&L_Provider_Tool_Kit.10-06.pdf*

Molina HealthCare, & California Academy of Family Physicians (2004, April). *Medical jargon & clear communication. Retrieved from www.familydocs.org/assets/Multicultural_Health/MedicalJargon.pdf*

U.S. Department of Health and Human Services, Office of Minority Health (n.d.). Handouts: Theme 1: BATHE Model (1.3). In *The facilitator's guide: Companion to: A physician's practical guide to culturally competent care (pp. 145-145). Retrieved from https://www.thinkculturalhealth.hhs.gov/includes/downloadpdf.asp?pdf=Physicians_QIOFacilitator_GuideMEDQIC.pdf*

Weiss, B. D. (2007). *Health literacy and patient safety: Help patients understand; Manual for clinicians (2nd ed.). Chicago, IL: American Medical Association Foundation. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf*

REFERENCES (CONTINUED)

Culture Competence & the LGBT Communities

Agency for Healthcare Research and Quality (AHRQ) (2012). *National healthcare disparities report, 2011. Rockville, MD: Retrieved from http://www.ahrq.gov/qual/nhdr11/nhdr11.pdf*

California Department of Public Health (2012). *Lesbian, gay, bisexual and transgender (LGBT) resources. Retrieved from http://www.cdph.ca.gov/programs/OMH/Pages/LGBTResources.aspx*

Krehely, J. (2009, December). *How to close the LGBT health disparities gap. Retrieved from http://www.americanprogress.org/issues/2009/12/pdf/lgbt_health_disparities.pdf*

National Coalition of Anti-Violence Programs (NCAVP) (2011). *Hate violence against the lesbian, gay, bisexual, transgender, queer, and HIV-Affected communities in the United States in 2010. Retrieved from http://avp.org/documents/NCAVPHateViolenceReport2011Finaledjlfinaledits.pdf*

Substance Abuse and Mental Health Services Administration (SAMHSA) (2012). *Top health issues for LGBT populations information & resource kit. Retrieved from http://stor.samhsa.gov/shin/content//SMA12-4684/SMA12-4684.pdf*

YouTube. Re-examining LGBT Healthcare. Retrieved from http://www.youtube.com/watch?v=XqH6GU6Trzl

REFERENCES (CONTINUED)

Culture Competence: Refugees and Immigrants

Administration for Children and Families, Department of Health and Human Services (2012). *Office of Refugee Resettlement. Retrieved from http://www.acf.hhs.gov/programs/orr/*

Cultural Competence: Seniors and People with Disabilities

California Caregiver Resource Centers (2005). *California Caregiver Resource Centers. Retrieved from http://www.cacrc.org/californiacrc/jsp/home.jsp*

Family Caregiver Alliance (FCA) (n.d.). Retrieved from http://www.caregiver.org/caregiver/jsp/home.jsp

Developed By:
Industry Collaboration Effort (ICE)
Cultural and Linguistic Services Main Team
Cultural Competency Training Workgroup
Approved on January 18, 2013 by ICE Leadership

Click on 'Close' to return to main menu.
If in full-screen mode click on 'Escape' and then 'Close'.

Special Needs Plan (SNP) Model of Care - Basics

Developed By:

SCAN Health Plan - 2014

TRAINING GOALS

- Describe the importance and goals of SNP program
- Describe the three types of SNPs
- Explain SCAN's SNP Model of Care
- Define SCAN's SNP roles and responsibilities

OVERVIEW

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

Let’s meet some members and learn about their special needs.

OVERVIEW

Mrs. Smith

- Mrs. Smith is a 74-year old woman with Diabetes. She is confused about how to take her medications, and needs help managing her health condition.

Mr. Jones

- Mr. Jones is an 82-year old retired painter. He sometimes has difficulty determining what services and doctors are covered by Medicare, and which ones are covered by Medi-Cal/Medicaid. He would like assistance with coordinating the care he needs.

Mrs. Chen

- Mrs. Chen is a 76-year old woman who uses a cane, has difficulty getting in or out of the shower without assistance, and sometimes forgets to take her medication. Her family and friends visit her several times a week to check on her and help. She would like to remain in her own home and not go to a nursing home.

OVERVIEW

Mrs. Smith, Mr. Jones, and Mrs. Chen represent special groups of individuals who have previously found it difficult to access proper health care coverage through most providers.

Why would these people benefit from being in a Special Needs Plan?

What can SCAN do to help?

Individuals who have multiple health problems, are frail, or low income, may find it more challenging to navigate through a complex health care system.

This can prevent them from getting the right health care, in the setting, and at the right time.

Helping these individuals is what SCAN's mission is all about. SCAN has developed several types of Special Needs Plans to help care for these types of members.

OVERVIEW

What's a SNP?

In 2003 Congress created a new type of Medicare Advantage program called the 'Special Needs Plan' or SNP. It is administered by the Centers for Medicare and Medicaid (CMS).

SNPs were created for people who:

- ✓ Have a specific chronic condition like Diabetes or End-Stage Renal Disease (ESRD)
- ✓ Are eligible for both Medicare and Medi-Cal/Medicaid insurance
- ✓ Qualify to be in a nursing home

Did you know?

- Not all Medicare Advantage Plans offer SNPs

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

Let's take a look at the various types of SNPs.

SNP TYPES & MODEL OF CARE

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
- SCAN has 3 different C-SNPs: Heart First, SCAN Balance, Village Health

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.
- SCAN D-SNP plan names: “Connections” and “Connections at Home”

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 long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility (ICF) for the developmentally disabled, inpatient psychiatric facility, or an assisted living facility (ALF).
- Institutional Equivalent SNPs may enroll Medicare Advantage (MA) eligible individuals living in the community, but requiring an institutional level of care.
- SCAN is an Institutional Equivalent I-SNP known as “Healthy at Home” plan.

SNP TYPES & MODEL OF CARE

Model of Care Requirements

Each SNP is required to develop a Model of Care which describes how SCAN will serve its SNP members.

CMS requires that each Model of Care have at least the following elements:

- ✓Initial Assessment
- ✓Care Plan
- ✓Care Management & Care Coordination
- ✓Annual Assessment
- ✓Care Transitions Program
- ✓Interdisciplinary Team

SNP TYPES & MODEL OF CARE

Initial Assessment

- All SNP members must have an assessment within **90 days** of enrollment
- SCAN does this in several ways depending on the SNP type. Some members will receive a phone call, while some members may have an in-home assessment.

Care Plan

- Based on the initial assessment, a plan of care will be developed within **90 days** of enrollment, and updated annually at minimum.

Care Management & Care Coordination

- The Model of Care requires that plans have programs to coordinate services and help members access needed resources.
- SCAN has programs like Complex Care Management, Disease Management, and the SCAN Buddy Program to help our members.

SNP TYPES & MODEL OF CARE

Annual Assessment

- All SNP members must be re-assessed annually to determine if they are receiving all of the care and support they need.
- Depending on the SNP type, these assessments may be conducted by phone or in-person.

Care Transitions Program

- This program must be offered to all SNP members that have been hospitalized OR are planning on going to the hospital (for a planned surgery).
- Care Transitions coaches offer support, review medications, and help our members schedule follow-up appointments with their doctors.

Interdisciplinary Team

- All Models of Care must have a team of professionals to ensure member healthcare needs.
- This team collaborates with Primary Care Doctors and Specialists to ensure the members health care needs are being met.
- SCAN's interdisciplinary team includes: Geriatricians, Medical Directors, Nurses, Social Workers, a Nutritionist, a Behavioral Health Specialist, and other health care professionals.

ROLES

Roles in SNP

SCAN's three SNPs are organization-wide programs that rely on the participation and expertise of many departments. There are many people at SCAN who care for and support SNP members, depending on their needs. Let's meet a few of them.

ROLES

Care Managers

- Conduct annual telephone assessments for members in the *Healthy at Home* plan
- Conduct face-to-face initial and annual assessments for "Connections at Home" plan
- Refer members to Care Management, if needed

Care Navigators

- Conduct diagnosis verifications with providers for members enrolled in C-SNPs
- Complete initial and annual assessments on the phone for C-SNP & D-SNP "Connections" members
- Helps coordinate benefits/continuity of care
- Make outbound calls to members for "SCAN Buddy" activities

Primary Care Physician

- Oversees ongoing medical care
- Helps develop a plan of care to meet member needs

ROLES

Pharmacist

- Reviews member medications with the team
- Provides member education
- Advises on geriatric appropriate drugs
- Provides consultation to care managers, physicians, and members

Complex Care Managers

- Provides Case Management and Disease Management Services to members via telephone
- Helps coordinate care with physicians, specialists, and caregivers

Geriatrician

- Provides expertise in caring for seniors with a broad range of complex health needs
- Participates in Interdisciplinary Care Team meetings

ROLES

Nutritionist

- Provides expertise for members with dietary needs
- Participates in Interdisciplinary Care Team meetings

Care Transition Coach

- Supports and coaches members who are planning to have surgery or just had a recent hospitalization

Behavioral Health Specialist

- Provides ongoing expertise for members with behavioral health needs
- Participates in Interdisciplinary Care Team meetings

ROLES

Member Services Representative

Provides support to members with questions about benefits and accessing services

PAL (Personal Assistance Line)

A special Member Services department for Dual-Eligible members

Conducts welcome calls to D-SNP members

Medical Management

Provides oversight of our contracted providers to ensure SNP members are receiving the care they need

ROLES

Health Care Informatics

This department analyzes our data and helps identify members who would benefit from Case Management and other SCAN programs

They also lead quality initiatives to improve care for SNP members

Your Role

ALL staff members have an important part to play in making each SNP a success: this includes Marketing, Sales, Enrollment, and all the "behind-the-scenes" roles in Compliance, Finance, and Provider Services

Your Role

YOUR role is to understand the goals and scope of each program and how we coordinate care and communicate with our SNP members.

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

SCAN Health Plan

Special Needs Plan (SNP) Model of Care – Basics
https://www.scanhealthplan.com/flash/model-of-care/player.html

Centers for Medicare & Medicaid Services (CMS)

Special Needs Plans
http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNPQuality.html

YOU'VE COMPLETED THE TRAINING!

Now that you have learned all about compliance, let's return to the training center and take the quiz.

Let's see what you've learned!

Questions? Contact:

Kelly Scheerer, CHC, CPC, CPMA
General Compliance Analyst

EPIC MANAGEMENT, L.P.

Phone: 909.786.0822
Internal Extension: 4822

Click on 'Close' to return to main menu.
If in full-screen mode click on 'Escape' and then 'Close'.