Fraud, Waste, and Abuse Training and General Compliance Training
This is the CMS General Compliance/FWA training created by CMS and modified with VIVA specific reporting information.

This training applies to:

- **VIVA Health:**
  - VIVA Health Administration, L.L.C.,
  - VIVA Health, Inc.,
  - Triton Health Systems, L.L.C.

- Hereafter, this training refers to all three entities as VIVA, We or Our.
This training module consists of two parts:

(1) **Fraud, Waste, and Abuse (FWA) Training** and

(2) **General Compliance Training**.

All persons who provide health or administrative services to Part C and D Medicare or Alabama Medicaid members must satisfy general compliance and FWA training requirements. This module may be used to satisfy both requirements.
Part 1: Fraud, Waste, and Abuse Training
Every year millions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone. Including YOU.

This training will help you detect, correct, and prevent fraud, waste, and abuse. YOU are part of the solution.
When you finish this training, you should be able to:

- Recognize FWA in the Medicare Program;
- Identify the majority of laws and regulations pertaining to FWA;
- Recognize potential consequences or penalties associated with violations;
- Identify methods of preventing FWA;
- Identify how to report FWA;
- Recognize how to correct FWA;
Fraud is *Knowingly* and *Willfully* executing, or attempting to execute, a scheme or artifice (trickery) to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

18 United States Code §1347
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 up to:

- 10 years imprisonment and
- criminal fines of $250,000
Fraud: Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.
**Waste**: overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

**Abuse**: includes actions that may, directly or indirectly, result in unnecessary costs. 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 definitions of FWA, refer to:

- Chapter 21, Section 20 of the Medicare Managed Care Manual
- Chapter 9, Section 20 of the Prescription Drug Manual
Fraud Examples:

- 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.
Waste Examples:

- 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.
Abuse Examples:

- 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.
There are differences between fraud, waste, and abuse.

One of the primary differences is intent and knowledge.

**Fraud** requires the person to have an intent to obtain payment and the knowledge that their actions are wrong.

**Waste** and **abuse** may involve obtaining an improper payment, but does not require the same intent and knowledge.
In order to detect fraud, waste, and abuse you need to know the **Law**.

The following slides 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.
False Claims Act makes 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 in support of a false claim;
- Presents a false claim for payment or approval;

31 United States Code § 3729-3733
A Medicare 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.

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.
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.
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
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.
Health Care Fraud Statute Example:

- 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.
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.

18 U.S.C. Section 1347
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 (which includes the Medicare program).

42 United States Code §1320a-7b(b)
Anti-Kickback 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;
  - Plead 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.
Anti-Kickback Statute violations are punishable by:

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

Social Security Act (the Act), Section 1128B(b)
Stark Statute prohibits:

A physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an:

- ownership/investment interest or
- a compensation arrangement (exceptions apply).

42 United States Code §1395nn
Stark Statue 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.

Damages and Penalties:

- Medicare Claims tainted by an arrangement that does not comply with Stark Statute are not payable.
- Up to a $15,000 fine for each service provided.
- Up to a $100,000 fine for entering into an arrangement or scheme.
Civil Monetary Penalty Law (CMP)

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.
CMP 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.

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.
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 Office of Inspector General. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).

The 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.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901
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 of 1996 (P.L. 104-191)

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 who has access to protected health care information, you are responsible for adhering to HIPAA.
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.

Damages and Penalties:

- Violations may result in Civil Monetary Penalties.
- In some cases, criminal penalties may apply.
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
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
Answer: A

Fraud is intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse also cause unnecessary costs but are not the result of intentional actions.
Which of the following is NOT potentially a penalty for violation of a law or regulation prohibiting Fraud,

Select the correct answer

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

Civil Monetary Penalties and Exclusion from participation in Federal health care programs are both penalties for FWA, but deportation is not used as a FWA penalty.
As a person who provides health care or administrative services to a Medicare Part C or Part D or Alabama Medicaid member you are either a:

- VIVA Employee
- First Tier Entity
  - Examples: PBM, a Claims Processing Company, contracted Sales Agent
- Downstream Entity
  - Example: Pharmacy
- Related Entity
  - Example: Entity that has a common ownership or control of VIVA Health, Inc.
Where Do I Fit in the Healthcare Program?

Health Plan

- Independent Practice Associations (First Tier)
- Call Centers (First Tier)
- Health Services/Hospital Group (First Tier)
- Fulfillment Vendors (First Tier)
- Field Marketing Organization (First Tier)
- Credentialing (First Tier)
- PBM (First Tier)

- Providers (Downstream)
- Radiology (Downstream)
- Hospitals (Downstream)
- Mental Health (Downstream)
- Agents (Downstream)
- Pharmacy (Downstream)
- Quality Assurance Firm (Downstream)
- Claims Processing Firm (Downstream)
You are a vital part of the effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Medicare or Medicaid requirements.

- **SECOND** you have a duty to the Medicare and/or Medicaid Programs to report any violations of laws that you may be aware of.

- **THIRD** you have a duty to follow VIVAs Compliance Program that articulates your and VIVA’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 date/billing;
- Ensure you coordinate with other payers;
- Make sure you are up to date with FWA policies and procedures, laws, regulations, policies;
- Verify all information provided to you;
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
Everyone must report suspected instances of FWA. 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 using the link found on the VIVA Health Provider webpage:

http://vivamedicaremember.com/FraudComplaint/

The VIVA Compliance Department area will investigate and make the proper determination.
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.
You may report potential fraud as listed in the previous slide or to the following:

**HHS Office of Inspector General**
Office of Inspector General  
Phone: 800-447-8477 or TTY 800-377-4950  
Fax: 800-223-8164  
Email: HHSTips@oig.hhs.gov  
Online: https://forms.oig.hhs.gov/hotlineoperations

**Medicare Parts C and D**  
**National Benefit Integrity Contractor (NBI MEDIC)**  
Phone: 877-772-3379

For all other Federal health care programs:  
CMS Hotline: 800-MEDICARE (800-633-4227 or TTY 877-486-2048)

HHS and US Department of Justice (DOJ)  
https://www.stopmedicarefraud.gov
Medicaid

- Medicaid Program Integrity Division
- Phone: (866)452-8930
- Address:
  AL Medicaid Program Integrity Division
  PO Box 5624
  Montgomery, AL 36103-5624
Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves money and ensures you are in compliance with Laws and Regulations.
Develop a plan. Consult the VIVA Compliance Department to find out the process for the corrective action plan development.

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing non-compliance or FWA committed by a Sponsor’s employee or FDR’s employee and include consequences for failure to satisfactorily complete the corrective action; and
- Once started, continuously monitor corrective actions to ensure they are effective.
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.
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 slides present issues that may be potential fraud, waste, or abuse.
Key Indicators: Potential Member Issues

- Does the prescription look altered or possibly forged?
- Does the member’s medical history support the services being requested?
- Have you filled numerous identical prescriptions for this member, possibly from different doctors?
- Is the person receiving the service/picking up the prescription the actual member (identity theft)?
- Is the prescription appropriate based on member’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 for services not provided?
- Does the provider write for diverse drugs or primarily only for controlled substances?
- Is the provider performing unnecessary services for the member?
Is the provider writing for 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, etc. being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generics provided when the prescription requires that brand be dispensed?
Key Indicators: Potential Pharmacy Issues

- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?

- Is VIVA Health being billed for prescriptions that are not filled or picked up?

- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?

- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?
Does the manufacturer promote off label drug usage?

Does the manufacturer provide samples, knowing that the samples will be billed to a health care program?
Key Indicators: Potential Sponsor Issues

- Does VIVA encourage/support inappropriate risk adjustment submissions?
- Does VIVA lead the member to believe that the cost of benefits are one price, only for the member to find out that the actual costs are higher?
- Does VIVA offer cash inducements for members to join the plan?
- Does VIVA use unlicensed agents?
FWA 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.
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 member normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?

A. Fill the prescription for 160
B. Fill the prescription for 60
C. Call the prescriber to verify quantity
D. Call the sponsor’s compliance department
E. Call law enforcement
Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor’s compliance hotline. The sponsor will provide next steps.
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?

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
Answer B

Report the incident to the Compliance Department (via compliance hotline or other mechanism)

The Compliance Department will investigate the issue and take corrective actions if a problem is identified.
You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy.

What should you do?

A. Call the local law enforcement
B. Perform another review
C. Contact your compliance department
D. Discuss your concerns with your supervisor
E. Follow your pharmacy’s procedures
Answer E

Follow your pharmacy’s procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.
CONGRATULATIONS!

You have completed Fraud, Waste, and Abuse Training.
Part 2: Compliance Training
This is the CMS General Compliance/FWA training created by CMS and modified with VIVA specific reporting information.

This training applies to:

- VIVA Health:
  - VIVA Health Administration, L.L.C.,
  - VIVA Health, Inc.,
  - Triton Health Systems, L.L.C.

- Hereafter, this training refers to all entities as VIVA, We or Our.
Compliance is **EVERYONE’S responsibility**!

As an individual who provides health or administrative services for Medicare and/or Medicaid member, every action you take potentially affects enrollees and the Medicare and/or Medicaid program.
Training Objectives

To understand our commitment to ethical business behavior

To understand how a compliance program operates

To gain awareness of how compliance violations should be reported
An effective compliance program should:

- Articulate and demonstrate an organization's commitment to legal and ethical conduct
- Provide guidance on how to identify and report compliance violations
- Provide guidance on how to handle compliance questions and concerns

Effective Compliance Program

VIVA HEALTH
A **culture of compliance** within an organization:

- **Prevents noncompliance**
- **Detects noncompliance**
- **Corrects noncompliance**
At a minimum, a compliance program must include the 7 core requirements:

1. **Written Policies, Procedures and Standards of Conduct**
2. **Compliance Officer, Compliance Committee and High Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring and Identification of Compliance Risks**
7. **Procedures and System for Prompt Response to Compliance Issues**

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual (“IOM”), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9
CMS and Alabama Medicaid expects VIVA to apply our training requirements and “effective lines of communication” to the entities with which we partner.

Having “effective lines of communication” means that employees of VIVA have several avenues through which to report compliance concerns.
Act Fairly and Honestly

Comply with the letter and spirit of the law

It is important you conduct yourself in an ethical and legal manner.

It’s about doing the right thing!

Adhere to high ethical standards in all that you do

Report suspected violations

It’s about doing the right thing!
The VIVA Compliance Program states compliance expectations and the principles and values by which we operate.

VIVA Standards of Conduct:

- Be Honest
- Know the Rules
- Ask Questions
- Do Not Be Afraid to Ask for Help
- Admit Mistakes
- Report Concerns
Noncompliance is conduct that does not conform to the law, and health care program requirements, or to an organization’s ethical and business policies.

* For more information, see the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit Manual on http://www.cms.gov
Without programs to prevent, detect, and correct noncompliance there are:

- Delayed services
- Difficulty in using providers of choice
- Denial of Benefits
- Hurdles to care

Noncompliance Harms Enrollees
Noncompliance affects EVERYBODY!

Without programs to prevent, detect, and correct noncompliance you risk:

- Higher Premiums
- Higher Insurance Copayments
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits
I’m Afraid to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

VIVA offers reporting methods that are:

- **Confidential**
- **Anonymous**
- **Non-Retaliatory**
How Can I Report Potential Noncompliance?

**VIVA Employees**
- Call the their Manager/Supervisor
- Contact any member of the Compliance Committee
- Report anonymously through the hotline

**FDR/Provider Employees**
- Talk to a Manager or Supervisor
- Call Your Ethics/Compliance Help Line
- Report through VIVA

**Members**
- Call the VIVA compliance department
- Call Medicaid Program Integrity (866)452-4930
- Call 1-800-Medicare
Correcting Noncompliance

- Avoids the reoccurrence of the same noncompliance
- Promotes efficiency and effective internal controls
- Protects enrollees

After noncompliance has been detected... It must be investigated immediately... And then promptly correct any noncompliance...
Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.

- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
VIVA is required to have disciplinary standards in place for timely enforcement of non-compliant behavior. Those who engage in noncompliant behavior may be subject to any of the following:

- Mandatory Training
- Disciplinary Action
- Re-Training
- Termination

Note: Details on VIVA disciplinary standards related to Compliance/FWA issues can be found in RAC P&P021-Compliance Program.
EVERYONE’S Responsibility!!

PREVENT
• Operate within VIVA’s ethical expectations to PREVENT noncompliance!

DETECT & REPORT
• If you DETECT potential noncompliance, REPORT it!

CORRECT
• CORRECT noncompliance to protect beneficiaries and to save money!
What Governs Compliance?

- Social Security Act:
  - Title 18

- Code of Federal Regulations*:
  - 42 CFR Parts 422 (Part C) and 423 (Part D)

- CMS Guidance:
  - Manuals
  - HPMS Memos

- CMS Contracts:
  - Private entities apply and contracts are renewed/non-renewed each year

- Other Sources:
  - OIG/DOJ (fraud, waste and abuse (FWA))
  - HHS (HIPAA privacy and security)

- State Laws:
  - Licensure
  - Financial Solvency
  - Sales Agents

* 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)
Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
What would you do in the following scenarios?
You have discovered an unattended email address or fax machine in your office which receives member appeals requests. You suspect that no one is processing the appeals. What should you do?

A) Contact Law Enforcement
B) Nothing
C) Contact your Compliance Department
D) Wait to confirm someone is processing the appeals before taking further action
E) Contact your supervisor
The correct answer is: C or E – Contact your Supervisor or the Compliance Department.

Suspected or actual noncompliance should be reported immediately upon discovery. It is best to report anything that is suspected rather than wait and let the situation play out.

Your Sponsor’s compliance department will have properly trained individuals who can investigate the situation and then, as needed, take steps to correct the situation according to the Sponsor’s Standards of Conduct and Policies and Procedures.
A sales agent, employed by the Sponsor's first-tier or downstream entity, has submitted an application for processing and has requested two things:

i) the enrollment date be back-dated by one month

ii) all monthly premiums for the beneficiary be waived

What should you do?

A) Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department

B) Make the requested changes because the sales agent is responsible for determining the member'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 CMS to report the sales agent's behavior.
The correct answer is: D - Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

The enrollment application should be processed in compliance with CMS regulations and guidance. If you are unclear about the appropriate procedure, then you can ask your supervisor or the compliance department for additional, job-specific training.

Your supervisor and the compliance department should be made aware of the sales agent's request so that proper retraining and any necessary disciplinary action can be taken to ensure that this behavior does not continue. *No one*, including the sales agent, your supervisor, or the Compliance Department, can retaliate against you for a report of noncompliance made in good faith.
You work for an MA-PD Sponsor. Last month, while reviewing a monthly report from CMS, you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan.

You spoke to your supervisor, Tom, who said not to worry about it. This month, you have identified the same enrollees on the report again.

What do you do?

A) Decide not to worry about it as your supervisor, Tom, had 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 that you cannot be identified.

C) Wait until next month to see if the same enrollees are 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 Tom again.

D) Contact law enforcement and CMS to report the discrepancy.

E) Ask Tom about the discrepancies again.
The correct answer is: **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 that you cannot be identified.

There can be no retaliation for reports of noncompliance made in good faith. To help promote reporting, Sponsors should have easy-to-use, confidential reporting mechanisms available to its employees 24 hours a day, 7 days a week.

It is best to report any suspected noncompliance to the Compliance Department promptly to ensure that the Sponsor remains in compliance with CMS requirements. Do the right thing! Compliance is everyone’s responsibility.
CONGRATULATIONS!

You have completed Compliance Training.
Certificate of Completion

This is to certify that

____________________________________
Has completed the course
Fraud, Waste and Abuse and General Compliance Training

____________________________________
Date