VIVA HEALTH®

FALL 2017

The Vendor Vine

VIVA HEALTH, Inc. provides this newsletter as a resource to its contracted entities that meet the CMS definition of a first tier, downstream or related entity (FDR). This newsletter is published annually and will be available on our website at ***http://www.vivahealth.com/FDR.***

We hope you will find this newsletter helpful! We value your feedback and suggestions! If there are topics you would like for us to address in a future newsletter, please let us know. You can reach out to one of the contacts listed in the "Your VIVA HEALTH Contacts" box on the last page of this newsletter.

VIVA MEDICARE EARNS HIGH MARKS FROM U.S. NEWS & WORLD REPORT AND CMS

Highest Star Rating in Alabama for a Medicare Advantage Plan

Highest Members' Rating of a Plan given in Alabama

U.S. News & World Report has named VIVA MEDICARE as **one of the country's best** Medicare Advantage plans, the only Medicare plan in Alabama to make the prestigious 2018 ranking. VIVA MEDICARE'S ranking is based off the overall quality score it earned from CMS.

For 2018, VIVA MEDICARE earned **4.5 out of 5 stars** from Medicare on its Medicare quality performance, the **first and only** Alabama-based health plan to achieve that distinction. The score is based on 48 different quality measures that illustrate everything from customer service to how well the plan helps its members stay healthy. In addition, VIVA MEDICARE received the highest members' rating of a plan given in Alabama according to the 2018 *Medicare & You* Handbook for the **eighth year in a row.**

We appreciate our FDRs' support in helping us achieve these excellent ratings!

Viva Health's ANNUAL COMPLIANCE AND OFFSHORE ATTESTATION

FDRs are required to complete Viva Health's Annual Compliance and Offshore Attestation. This form is available on our website at ***https://www.vivahealth.com/FDR.***

If you have not done so already, please go to our website to obtain the form, complete it, and return it to Viva Health by November 30, 2017. Please remember, the attestation must be completed by an authorized representative of your organization.

FDR COMPLIANCE PROGRAM EFFECTIVENESS (CPE) REVIEWS

Viva Health conducts Compliance Program Effectiveness (CPE) audits of FDRs. An initial CPE audit is conducted prior to Viva Health delegating and/or contracting with an FDR to provide services on Viva Health's behalf. Subsequent CPE audits are performed by Viva Health at a minimum of every three years (audits may be conducted more frequently if deemed necessary by Viva Health).

CPE audits focus primarily on the following Seven Elements of an Effective Compliance Program as required by the Office of Inspector General's Compliance Guidance for Medicare Advantage Organizations in 64 FR 61893:

Element I: Written Policies, Procedures, and Standards of Conduct

Element II: Compliance Officer, Compliance Committee, and High Level Oversight

Element III: Effective Training and Education

Element IV: Effective Lines of Communication

Element V: Well Publicized Disciplinary Standards

Element VI: Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks

Element VII: Procedures and System for Prompt Response to Compliance Issues

During these audits, Viva Health reviews documentation provided by the FDRs that validate the FDRs' compliance with these seven elements. Viva Health also selects samples to further validate that FDRs are following their own documented procedures.

Should you have any questions regarding the documentation that is required for these audits, please let us know (see "Your Viva Health Contacts" listed on the last page of this newsletter). We appreciate your cooperation and compliance!

CMS PROGRAM AUDITS

CMS has many tools to evaluate a Medicare Advantage plan's compliance, but one of their most intensive methods is the CMS Program Audit. During the eight weeks of a Program Audit, CMS takes a deep look into the Medicare Advantage plan's Part C and Part D operations. Because an FDR may be called upon to participate in a Program Audit, we want to provide you with information about the process.

CMS PROGRAM AUDIT TIMELINE

Weeks 1-3	Weeks 4-6	Week 7	Week 8
Universe prep	Universe integrity testing and sample selection	Sample review webinars	Compliance Program review

Weeks 1–3: Universe prep

From the time that Viva Health is notified of an upcoming audit, we have three weeks to produce up to 47 specific audit universes from which CMS will draw their samples. Each universe has very specific data elements and criteria. Some of the data comes from Viva Health, and some of the data comes from FDRs.

Weeks 4–6: Universe integrity testing and sample selection

During this part of the audit, CMS reviews the universes and conducts data integrity tests with Viva Health to ensure the universe data is correct and meets the criteria. If a universe cannot pass the integrity tests within three attempts, this is an automatic audit failure and corrective action is required. During this time, CMS also targets the samples they want to review during Week 7. From this point on, CMS only targets samples that appear to be out of compliance – no more random sampling occurs.

Week 7: Sample review webinars

During Week 7, Viva Health participates in up to six simultaneous webinars where we walk the CMS auditors through each sample to show how the sample did or did not meet CMS requirements. If an FDR's sample is selected, the FDR must either be on-site at Viva Health or participate in the webinar remotely. Typically, CMS only gives one hour's notice of the samples they select, so the FDR's audit team must be on-call and available throughout Week 7.

Week 8: Compliance Program review

During Week 8, CMS auditors come on-site to review Viva Health's Compliance Program in person.

FINAL THOUGHTS

Based on the audit findings, CMS will request and review Corrective Action Plans. Each corrective action will require subsequent validation testing to ensure the issues identified during the audit were corrected.

If your organization is responsible for any Part C or Part D function for Viva Medicare, it is critical for your organization to be audit-ready at all times. If you have questions or need assistance with being prepared for a CMS audit, please contact us (refer to the "Your Viva Health Contacts" section on the last page of this newsletter).

HIPAA – REPORTING PHI INCIDENTS

Recent headlines about breaches of data are bringing HIPAA rules and regulations to the forefront of discussions in health care. One of the topics being discussed relates to breach notification requirements.

As an FDR, your organization is also a Business Associate (BA) of Viva Health. Both Viva Health and its FDRs are responsible for implementing safeguards to ensure protected health information (PHI) is secure. This requirement is not only specified in the HIPAA regulations, but is also required in our mutually executed Business Associate Agreement (BAA).

If an FDR experiences an incident that could compromise the protected health information (PHI) of a Viva member(s), the FDR must notify Viva Health without unreasonable delay. In most cases, your BAA with Viva Health requires this notification to occur within five business days of discovering the breach. Notifications should be made to your primary Viva Health contact and to the Delegated Vendor Oversight Program Manager (see "Your Viva Health Contacts" listed on the last page of this newsletter).

In the event of a PHI incident, Viva Health will collect information from you regarding the incident and will determine if the incident meets the definition of a HIPAA breach. If Viva Health determines that the incident requires breach notification, Viva Health will make the necessary report to the Department of Health and Human Services (HHS) and to the media, when required. Viva Health will also work with you to determine mitigation steps to lessen the threat of the breach and will coordinate breach notifications to the impacted individuals.

Should you have any questions concerning PHI protection or incident reporting, please let us know – we are here to help!

CMS FRAUD PREVENTION

Following the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS is implementing a fraud prevention initiative that removes Social Security numbers from Medicare cards. The Health Insurance Claim Number (HICN), which is based on a beneficiary's Social Security number, will be replaced with a unique, randomly-assigned number called a Medicare Beneficiary Identifier (MBI). This initiative is meant to combat identity theft and safeguard taxpayer dollars.

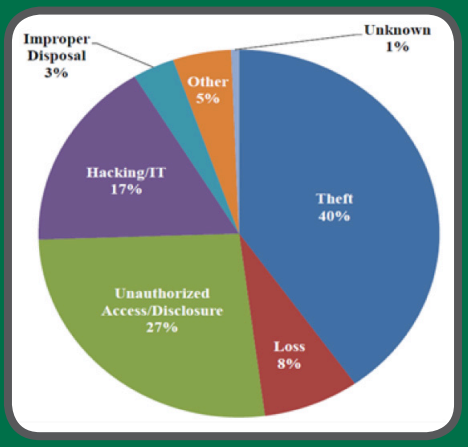
CMS will begin mailing out new cards beginning in April 2018. The implementation will include a 21-month transition period where providers will be able to use either the MBI or the HICN until January 1, 2020.

Beneficiaries will be instructed to safely and securely destroy their current Medicare cards and keep their new MBI confidential.

For more information about the MBI and transition period for providers, go to CMS's website at https://www.cms.gov/Medicare/New-Medicare-Card/index.html

DATA SECURITY

According to the Office of Civil Rights (OCR)/Department of Health and Human Services (HHS), approximately 2,017 HIPAA breaches involving 500 or more individuals occurred between September 2009 and July 2017. The breaches are represented in the chart below, categorized by type.



Approximately 175 million individuals have been affected by these breaches. Furthermore, the OCR/HHS expects to receive 17,000 complaints about breaches this year alone. It's imperative that all of us do our part to safeguard the data of our members.

YOUR Viva CONTACTS

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