

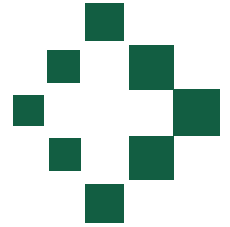
The logo consists of a stylized cross made of dark green squares of varying sizes, arranged in a grid-like pattern.

VIVA MEDICARE

2026 Compliance and Fraud, Waste, and
Abuse Training

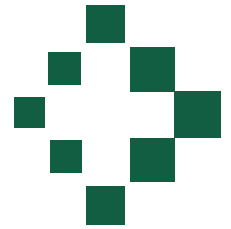


Compliance Program Requirements

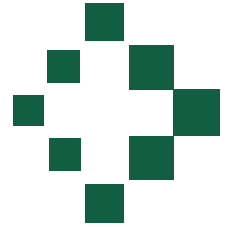


- The **Centers for Medicare & Medicaid Services (CMS)** requires that all sponsors implement and maintain an **effective compliance program** for their **Medicare Part C & Part D plans**. We also require this of our **First-Tier, Downstream, or Related Entity (FDR)**. An effective compliance program must:
 - **Articulate and demonstrate** the organization's commitment to **legal and ethical conduct**.
 - Provide clear guidance on how to handle **compliance questions and concerns**.
 - Offer direction on how to **identify and report compliance violations**.

Seven Elements of an Effective Compliance Department



Seven Core Compliance Program Requirements



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

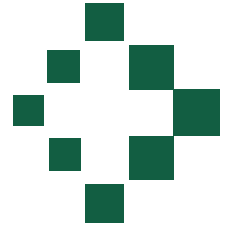
1. Written Policies, Procedures, and Code of Conduct

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

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

The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program. The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

Seven Core Compliance Program Requirements



3. Effective Training and Education

This covers the elements of the compliance plan as well as preventing, detecting, and reporting FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

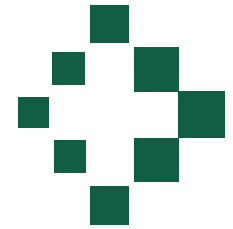
4. Effective Lines of Communication

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

5. Well Publicized Disciplinary Standards

Sponsor must enforce standards through well-publicized disciplinary guidelines.

Seven Core Compliance Program Requirements



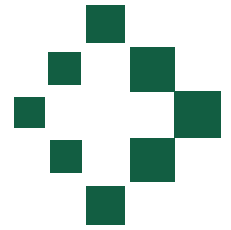
6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

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. Sponsors must ensure FDR's performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D programs comply with Medicare Program requirements.

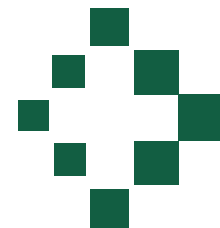
7. Procedures and System for Prompt Response to Compliance Issues

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

Provider Risk and Responsibilities

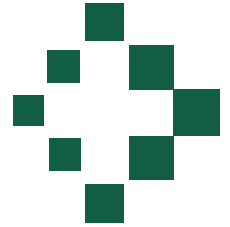


Key Risk Areas Providers Must Know



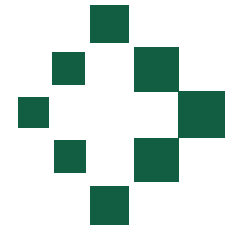
- **Access to Care**
 - Providers must:
 - Deliver medically necessary services
 - Follow accepted clinical standards
 - Participate in timely prior authorization process
 - Risk examples:
 - Denying or delaying medically necessary treatment
 - Refusing to schedule Medicare Advantage patients
 - Not following UM documentation requirements

Key Risk Areas Providers Must Know



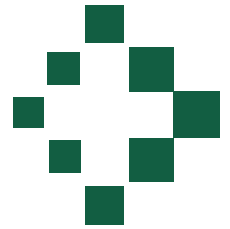
- **Accurate Coding and Risk Adjustment**
 - The OIG emphasizes that diagnoses used for risk adjustment must be fully supported in the medical record.
 - Providers must NOT:
 - Add diagnoses that aren't supported
 - Submit diagnoses from screenings alone
 - Use templates or EMR prompts to inflate HCCs
 - Providers must:
 - Document based on face-to-face encounters
 - Ensure conditions are monitored, evaluated, assessed, or treated (MEAT) when required
 - Risk areas OIG highlights:
 - Overuse of health risk assessments (HRAs)
 - Unsupported diagnoses from chart reviews
 - EMR “prompting” features that add inaccurate diagnoses

Key Risk Areas Providers Must Know



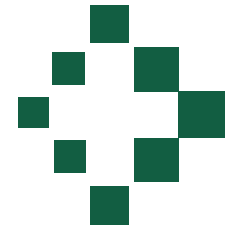
- **Quality of Care and Star Ratings**
 - Providers directly impact the health plan's Star Ratings.
 - Risk areas include:
 - Gaps in chronic disease management
 - Failure to follow clinical guidelines
 - Delayed access to specialists
 - Submitting inaccurate quality data

Key Risk Areas Providers Must Know



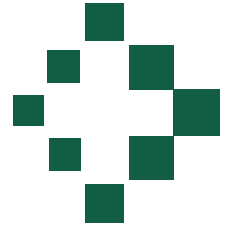
- **Marketing and Beneficiary Communications**
 - Providers may not:
 - Steer patients to specific Medicare Advantage plans
 - Use misleading plan materials
 - Accept payments from plans for referrals
 - Providers may:
 - Provide factual, neutral information
 - Answer patient questions about their care
 - Refer patients to CMS resources

Key Risk Areas Providers Must Know



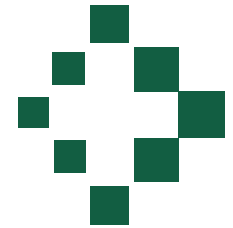
- **Third-Party Oversight**
 - Providers are considered FDRs under CMS rules if they perform administrative or health care services for Medicare Advantage enrollees.
 - Providers must:
 - Comply with health plan audits
 - Verify that staff are not on OIG's exclusion list
 - Report suspected fraud or abuse

Key Risk Areas Providers Must Know



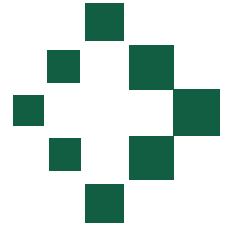
- **Provider Responsibilities Under the Health Plan's Compliance Program**
 - Providers must:
 - Treat patients fairly and without discrimination
 - Verify patient eligibility and authorization requirements
 - Maintain complete and accurate medical records
 - Submit clean claims with correct coding
 - Cooperate with audits (CMS, OIG, health plan)
 - Protect PHI per HIPAA
 - Report observed or suspected misconduct immediately

Key Risk Areas Providers Must Know

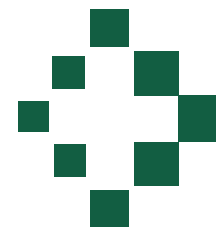


- **Identifying and Reporting Fraud, Waste and Abuse**
 - Examples of provider-side FWA:
 - Billing for services not provided
 - Misrepresenting diagnoses
 - Performing medically unnecessary services
 - Falsifying documentation
 - Marketing violations
 - Failing to disclose conflicts of interest
 - Report concerns via: No retaliation is permitted for good-faith reporting.
 - The health plan's compliance hotline: **800-621-2144**
 - OIG Hotline: **I-800-HHS-TIPS**
 - CMS Medicare Compliance & Fraud portal

Key Takeaways for Providers



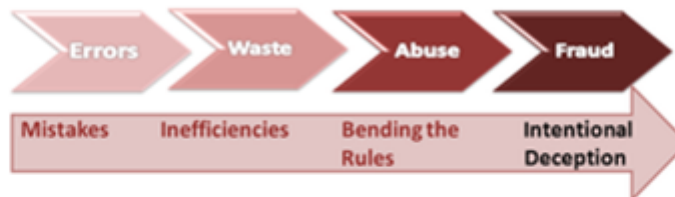
- **Providers must:**
 - Follow OIG and CMS compliance expectations
 - Document accurately and thoroughly
 - Avoid unsupported diagnoses and improper billing
 - Participate in audits and corrective actions
 - Treat patients fairly and promote access to care
 - Report concerns promptly
 - Avoid improper financial or referral arrangements



Fraud Waste and Abuse

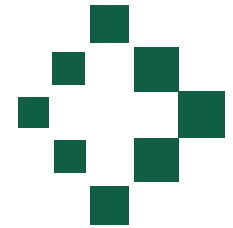
Causes of Improper Payments

- Not all improper payments are fraud, but all payments made due to fraud schemes are improper



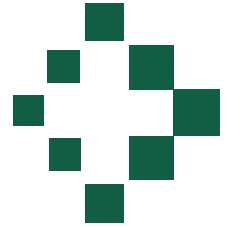
- CMS is targeting all causes of improper payments
 - From honest mistakes to intentional deception
- Most common error is insufficient documentation

Non-Retaliation Policy



- **Protected Activities:** Filing complaints, participating in investigations, or opposing unlawful/unethical actions.
- **Definition of Retaliation:** Any negative action, threat, or intimidation intended to punish and employee or provider for reporting.
- **“Good Faith” Standard:** Reports must be made with an honest belief that the information is true; maliciously making false accusations is not protected.
- **Zero Tolerance:** Violations of this policy by managers, staff or providers, are typically met with serious disciplinary actions.
- **Reporting Mechanisms:** Often includes confidential hotlines, anonymous reporting channels, or direct reporting to Compliance/ HR officers.

False Claims Act (FCA)



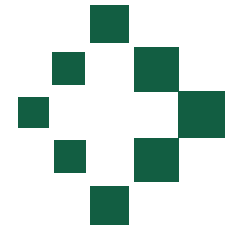
The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

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

Anti-Kickback Statute (AKS)



Makes it a crime to reward others or themselves for medical referrals

Prevents providers from profiting from referrals

Federal and state anti-kickback statutes make it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a federal or state healthcare program.

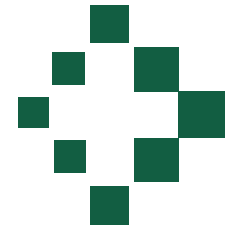
- In addition to kickbacks, some of the state level statutes prohibit fee-splitting, patient brokering, and self-referrals

Damages and Penalties

A fine up to \$25,000

- Imprisonment up to 5 years
- Civil penalties can involve fines and exclusion from government healthcare programs

Stark Law

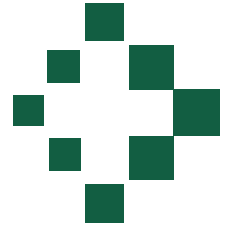


- The Physician Self-Referral Law is commonly known as the Stark Law.
- Intended to prevent healthcare providers from inappropriately profiting from referrals.
- Prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity when the physician (or a member of his or her family) has:
 - An ownership/investment interest, or a compensation arrangement

Damages and Penalties

- Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable
- Violation may also result in civil penalties and exclusion from government healthcare programs

Compliance/ FWA Reporting



- **Compliance / FWA Questions or Concerns**
 - Anonymous Reporting
 - Hotline **800.621.2144**
 - **VIVA.Alertline.com**
 - Mobile Web Application Reporting QR Code:



 VIVA MEDICARE



**THANK
YOU!**