2019 Annual Training

General Compliance

Fraud, Waste, Abuse

HIPAA, and CMS Models of Care Training

Timely Access Requirements

San Francisco Health Plan Provider Training

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General Compliance Training

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 benefits to Jade Medicare members. This applies to all employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this training as "Provider Offices") and the entities with which they contract to provide administrative or health care services for enrollees on behalf of the Provider Office (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.

Course Objectives

This lesson outlines effective compliance programs. When you complete this course, you should be able to correctly:

- Recognize how a compliance program operates; and
- Recognize how compliance program violations should be reported.

Compliance Program Requirement

Jade and Centers for Medicare & Medicaid Services (CMS) requires Provider Offices to implement and maintain an effective compliance program. An effective compliance program should:

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

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

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 Provider Office'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 Provider Office 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 Provider Office's senior management and governing body must be engaged and exercise reasonable oversight of the Provider Office'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.

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 Provider Office and First-Tier, Downstream, or Related Entity (FDR) levels.
5. **Well-Publicized Disciplinary Standards** Provider Office 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 Provider Office's and FDR's operations to evaluate compliance with state and federal requirements as well as the overall effectiveness of the compliance program. **NOTE:** Provider Offices must ensure that FDRs performing delegated administrative or health care service functions concerning the Provider Office's compliance program comply with state and federal requirements.
7. **Procedures and System for Prompt Response to Compliance Issues** The Provider Office must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Compliance Training–Provider Offices and their FDRs

Jade expects that all Provider Offices will apply their training requirements and "effective lines of communication" to their FDRs. Having "effective lines of communication" means that employees of the Provider Office and the Provider Office's FDRs have several avenues to report compliance concerns.

Ethics–Do the Right Thing!

As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!

- Act fairly and honestly;
- Adhere to high ethical standards in all you do;
- Comply with all applicable laws, regulations, and CMS requirements; and
- 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.

Non-Compliance Affects Everybody

Without programs to prevent, detect, and correct non-compliance, we all risk:

Harm to beneficiaries, such as:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care

Less money for everyone, due to:

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits

How to Report Potential Non-Compliance

Employees of a Provider Office

- Call the Medicare Compliance Officer; or
- Call the Compliance Hotline 628-228-2720

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

- Talk to a Manager or Supervisor; or
- Call the Compliance Help Line

Beneficiaries

- Call Jade's Compliance Hotline or Customer Service; 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 Provider Office must offer reporting methods that are:

- Anonymous;
- Confidential; and
- Non-retaliatory.

What Happens After Non-Compliance Is Detected?

After non-compliance is detected, it must be investigated immediately and promptly corrected. However, internal monitoring should continue to ensure:

There is no recurrence of the same non-compliance;

- Ongoing compliance with compliance program 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!

Combating Fraud, Waste, and Abuse Training Course

Introduction

- This course consists of two lessons:
  - Lesson 1: What is FWA?
  - Lesson 2: Your Role in the Fight Against FWA

- 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.

What is FWA?

Lesson 1

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 medical expenses. 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 medical expenses. 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.

Examples of FWA

Examples of actions that may constitute fraud include:

- Knowingly billing for services not furnished or supplies not provided, including billing the payor 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 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 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 medical expenses, 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).

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.

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.

- EXAMPLES

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 Health Care 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.

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 health care program (including the Medicare Program).

Damages and Penalties

- Violations are punishable by:
  - A fine of up to $25,000;
  - Imprisonment for up to 5 years; or
  - Both.

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)

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).

Damages and Penalties

- Federal law claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around $23,800 may be imposed for each service provided. There may also be around a $159,000 fine for entering into an unlawful arrangement or scheme.

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 (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Failing to grant OIG timely access to records;
- Knowing of an overpayment and failing to report and return it;
- Making false claims; or
- Paying to influence referrals.

Damages and Penalties

- The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:
  - Claimed for each service or item; or
  - Of remuneration offered, paid, solicited, or received.

EXAMPLE
A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted claims to Medicare Part D for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

Exclusion

- No 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 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 on the System for Award Management website.
- If looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same.

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

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.

Damages and Penalties

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

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.

Summary Lesson 1: What is FWA?

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.

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

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

Where Do I Fit In?

As a person who provides health or administrative services to a patient/member, you are either an employee of a:

- Provider Office (Medicare Advantage Organizations [MAOs] and Prescription Drug Plans [PDPs]);
- 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 Provider Office, health promotion provider, or SilverSneakers®).

What Are Your Responsibilities?

- You play a vital part in preventing, detecting, and reporting potential FWA, as well as non-compliance.
  - FIRST, you must comply with all applicable statutory, regulatory, and other requirements, including adopting and using an effective compliance program.
  - SECOND, you have a duty to the medical group to report any compliance concerns, and suspected or actual violations that you may be aware of.
  - THIRD, you have a duty to follow Jade's Code of Conduct that articulates your and Jade'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 CMS and DMHC guidance; and
- Verify all information provided to you.

Stay Informed About Policies and Procedures

- Familiarize yourself with Jade's policies and procedures.
- Jade has policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.
- Standards of Conduct describe Jade's expectations that:
  - All employees conduct themselves in an ethical manner;
  - Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA; and
  - Reported issues will be addressed and corrected.
- Standards of Conduct communicate to employees and FDRs that compliance is everyone's responsibility, from the top of the organization to the bottom.

Report FWA to Compliance

- Everyone must report suspected instances of FWA. Jade's Code of Conduct clearly state this obligation. Jade 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 Jade's compliance department. The compliance department will investigate and make the proper determination.

Reporting FWA Outside Your Organization

- If warranted, Jade Compliance Department will report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the Department of Justice (DOJ), 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.

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 federal requirements.
- Develop a plan to correct the issue. Consult Jade'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 specific actions;
- Document corrective actions addressing non-compliance or FWA committed by a Provider Office'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 Provider Office, pharmacy, or other entity involved in the delivery of health plan 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 Provider Office 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)?

Summary Lesson 2: Your Role in the Fight Against FWA

- As a person who provides health or administrative services to a patient/member, 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. Jade has a mechanism for reporting potential FWA. You are able to make anonymous reports. Jade cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.

HIPAA

Health Insurance Portability and Accountability Act

Who Needs Training and Why

- All individuals who has access to "Protected Health Information" are Federally required to be trained
- This presentation is designed to
  - Familiarize you with
    - HIPAA regulations; and
    - Policies and Procedures regarding protected health information (PHI)
  - Ensure Federal compliance

What exactly is HIPAA?

- Overseen by: Department of Health & Human Services (HHS) and enforced by Office for Civil Rights (OCR)
- HIPAA contains Regulations on:
  - Privacy of health information
  - Security of health information
  - Notification of breaches of confidentiality
  - Penalties for violating HIPAA

What is Protected by HIPAA?

- Protected Health Information (PHI)
  - Any Individually Identifiable Health Information (IIHI)
    - Created or received by a health care provider, health plan, or health care clearinghouse
    - Relating to the past, present of future physical or mental health or condition of an individual (including information related to payment for health care)
    - Transmitted in any form or medium—paper, electronic and verbal communications

EXAMPLES

- Medical charts
- Problem logs
- Photographs and videotapes
- Communications between health care professionals
- Billing records
- Health plan claims records
- Health insurance policy number

What is PHI?

- Health information that directly or indirectly identifies someone.
  - Direct identifiers: individual's name, SSN, driver's license numbers
  - Indirect identifiers: information about an individual that can be matched with other available information to identify the individual.
  - Examples of identifiers include:
    - Name
    - Address
    - Dates (Birth, Admission, Discharge, Death)
    - Contact Information
    - Social Security Numbers
    - Medical Record Number
    - Member ID
    - Account Numbers
    - License Numbers
    - Photographs
    - Any other unique identifying number, characteristic, or code

The Use and Disclosure of PHI

- Employees may use or disclose PHI without an individual's written authorization only for:
  - The treatment;
  - The payment; or
  - For Health Care Operations, of the individual.

- The use or disclosure of PHI is limited to the minimum amount necessary to perform your assigned task.
- Individuals and members expect their health information to be kept private and confidential
  - Do not access PHI that you do not need
  - Do not discuss PHI with others that do not need to know
  - Do not provide PHI to anyone not authorized to receive it

- The misuse of PHI can result in disciplinary actions, including termination

Safeguarding PHI

- Do not leave computer station unattended without locking your screen
- Do not use work computers for personal use (surfing the interview, checking personal emails, etc.)
- Dispose of PHI in shredder bins, NEVER place PHI in the trash
- When using PHI, think about:
  - Where you are
  - Who might overhear
  - Who might see
- Avoid:
  - Discussing PHI around others who do not need to know
  - Leaving records accessible for other to see
  - Leaving computers unattended and unlocked
  - Sending PHI in email, if you must, remember to secure your email

What to do when a HIPAA violation occurs

- Take prompt and appropriate action to correct the situation and/or minimize harmful effects
- Notify your supervisor immediately of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI and/or company data
- Notify Jade Compliance Officers of the occurrence

Questions, Contacts, References

- If you have any questions regarding this annual training, contact:
  - Jade Compliance Department
    - 628-228-2720
    - compliance@jadehcmg.com
- Jade Compliance Hotline: 628-228-2720

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CMS Models of Care Training

What is Models of Care?

- Models of Care (MOCs) are considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan (SNP) are identified and addressed.
- In 2003, SNPs (Special Needs Plans) were created under the Medicare Modernization Act to provide direct care to individuals with special needs.
- In 2011, the Patient Protection and Affordable Care Act (ACA) requires all SNPs to submit MOCs that follow an approval process based on CMS standards. The National Committee for Quality Assurance (NCQA) must review and approve these MOCs

http://snpmoc.ncqa.org/what-is-a-model-of-care/

What is a Special Needs Plan (SNP)?

- A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be anyone of the following:
  - An institutionalized individual
  - A dual eligible
  - An individual with a severe or disabling chronic condition as specified by CMS.

- A SNP may be any type of MA CCP, including either a local or regional preferred provider organization plan, a health maintenance organization plan, or an HMO Point of Service plan. There are three types of SNPs:
  - Chronic Condition SNP (C-SNP)
  - Dual Eligible SNP (D-SNP)
  - Institutional SNP (I-SNP)

https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/index.html

Elements of Models of Care (MOC)

- SNP Population
- Care Coordination/ Care Transitions Protocol
- Provider Network
- MOC Quality Measurement

Description of the Overall SNP Population

- Jade Health Care Medical Group provides services to Special Needs Plan members in San Francisco County and Northern San Mateo County.
- Some of the factors that Jade identify include, but not limited to are:
  - Age
  - Ethnicity
  - Gender
  - Language Barriers and health literacy
  - Incidence and prevalence of major disease and chronic conditions
  - Significant barriers to health care services associated with cultural beliefs or socioeconomic status.

Most Vulnerable Beneficiaries

- Individuals of special needs are at the highest risk of poor health outcomes
- Identify the most vulnerable beneficiaries through multiple hospital admissions, high pharmacy utilization, high cost, or combination of medical, psychosocial, cognitive and functional challenges.
- Identify how different demographic factors combine to negatively affect the health status of these members.
- Identify and develop special services to meet the needs of the most vulnerable members
- Jade has arrangements with Sutter Pacific Medical Foundation , UCSF Medical Center , UCSF Benioff Children's Hospital, Stanford Hospital and Clinics, and Lucile Packard Children's Medical Group at Stanford and CPMC for tertiary care services (Pre-Authorization is Required).

Language Assistance Program

- Jade provides language assistance services information available to all contracted providers and their office staff. Providers are encouraged to facilitate a member's access to their plan's language assistance services. This service is available to all members. When language assistance services are required by a CCHP/ SFHP member, you can get an interpreter at no cost to you or the member by the following below instructions:
- To get an interpreter during Jade/CCHP Member Services' hours, please call Jade/CCHP Member Services at **1-415- 834-2118** or TTY **1-877-681-8898**, 7 days a week from 8:00 am to 8:00 pm

  To get an interpreter during all other times, please follow these instructions:

  Call 1-800-264-1552

  Use access code: **841498**

  Identify the member's preferred spoken language to the operator.

  Providers should document a member's preferred language in their chart and inform members of the availability of free languages services from their health plan. If a member refuses language assistance services, providers should document the refusal in the member's chart.

Care Coordination

- Jade assists its member physicians to meet the essential care coordination roles.
- Jade Health Care Medical Group staff perform the following functions:
  - Administrative (Enrollment, member, eligibility verification, claims processing, and administrative oversight).
  - Clinical Functions (Case managers, social workers, pharmacists, behavioral health providers, and clinical oversight)

Inpatient/Outpatient Case Management

- The case manager is the link between the individual, the provider, the payer and the community.
- Jade Health Care Medical Group contracts with the Chinese Community Health Plan (CCHP) to provide Case Management on behalf of their enrolled members.
- The Provider relies on the Case Manager to coordinate care for the assigned patients.

Health Risk Assessment (HRA) Tool

- Jade has a standardized HRA tool to evaluate the medical, cognitive, functional, psychosocial and mental health needs and risks.
- The HRA may be completed through face to face, telephone, or paper based mail.
- The initial HRA must be completes within 90 days of enrollment and annually.

Health Risk Assessment (HRA) Tool Continued

- Responses to the HRA are used to:
  - Develop and/or update the members' Individualized Care Plan (ICP)
  - To stratify members into risk categories for care coordination
- Member is reevaluated when there is a change in health status and care plan is updated annually.
- Member is provided with a copy of the ICP and encouraged to visit the PCP.
- Provider is given a copy of the ICP and the responses to the HRA.

Individualized Care Plan (ICP)

- An initial ICP is based on the members' responses to the HRA.
- Essential components of the ICP include:
  - Goals and objectives
  - Healthcare preferences
  - Specific services customized to the members' needs
  - Identification of goals met/not met – includes barriers and progress towards goals
  - Self Management Plans

Individual Care Plan (ICP) Continued

- ICP is updated when a member's health status changes or at least annually.
- ICP updates and modifications are communicated to members/caregivers and the ICT involved.
- ICP is maintained and is accessible to all care providers involved.
- Records of the ICP are maintained by HIPAA and professional standards

Interdisciplinary Care Team (ICT)

- ICT communicates regularly to manage the member's medical, cognitive, psychosocial and functional needs.
- ICT facilitates care management, assessment, care planning, authorization of services and care transitions.
- Formation of ICT depends on the member's medical and psychosocial needs based on the HRA and ICP. It typically includes Case Managers, Social Workers, Pharmacists, Medical Directors and treating physicians.
- Each member of the ICT has specific defined roles and responsibilities based on their expertise.
- Review and analyze available data to ensure improvement in the member's health status.

Care Transition Protocols

- Care transition is a movement of a member from one care setting to another as the member's health status changes.
- The Utilization Management Program at CCHP is responsible for the concurrent review and prior authorization process, which includes monitoring inpatient hospitalizations and patients in skilled nursing facilities as well as working with physicians for those patients in need of care management services.
- Admissions are reviewed on the first working day following admissions.
- The member shall be notified of decisions to terminate Skilled Nursing Facility(SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services no less than 2 days before the proposed end of the services.
- Jade Health Care Medical Group's UM Nurse will coordinate the continued care and discharge plans with the facility's Case Manager.

Primary Care Physician Referral Process

- Referrals to specialists, second opinions, elective hospital admissions or any services which require prior authorization are initiated by Primary Care Physicians or specialists through the Jade Health Care Medical Group UM department.
- Once the prior authorization has been obtained, the Primary Care Physician (PCP) shall continue to monitor the member's progress to ensure appropriate intervention and assess the anticipated return of the Member to Jade Health Care Medical Group Network.
- Each specialist provides written documentation of results and care provided/recommended to the PCP within 2 weeks of Patient encounter.
- The PCP evaluates the report information, signs and dates the report once reviewed, and formulates a follow up care plan for the Member. The follow up plan shall be included in the Member's medical record.

Provider Networks

- Jade's Provider Network includes contracted providers, Health Care plans direct providers, and a wide range of specialists to meet the needs of its SNP members Examples of providers:
  - Primary Care Physicians
  - Specialists
  - Radiology Centers
  - Physical Therapists
  - Laboratories
  - Surgical Centers

Provider Network Continued

- Jade, through policies and procedures ensures that network providers:
  - Have active licenses and certification
  - Are part of the member's ICT as needed
  - Incorporate relevant clinical information in member's ICP
  - Follow care transition protocols
  - Use clinical practice guidelines
  - Can request exception to clinical practice guidelines for members with complex healthcare needs
  - Receive MOC training initially on joining the network and annually.
  - Jade has policy and procedures to address network providers non-compliance with MOC

Role of Primary Care Physicians

- The primary care physician is responsible for:
  - Assuring reasonable access and availability to primary care services
  - Making referrals to specialist and other plan providers
  - Providing 24 hour coverage for advice and access to care
  - Communicating authorization decisions to the health plan member.

Use of Clinical Practice Guidelines (CPGs)

- Jade Health Care Medical Group uses evidence-based clinical guidelines developed by InterQual Criteria.
- InterQual Criteria identify benchmark patient care and recovery stages to enhance health care services delivery, resource management and patient outcomes.
- InterQual Criteria provides health care professionals with evidence-based clinical guidelines at the point of care.
- InterQual Criteria also supports prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.

Use of Clinical Practice Guidelines (CPGs) continued

- Jade has a process for management of exceptions to CPGs when a member has complex healthcare needs by utilizing out-of-network practitioners through the Primary Care Physician referral process.
- Compliance with approved guidelines is monitored through:
  - An annual review of delegated group decisions
  - The member appeals process
  - Review of patient medication profiles in the Medication Therapy Management (MTM) program
  - HEDIS reporting

MOC Quality

- Jade has a quality Improvement Plan (QIP) that is specific to the MOC and designed to the meet the health care needs of its members.
- Jade collects, analyses and evaluates various data sources in order to report on the MOC quality performance improvement
- Specific HEDIS health outcome measures are identified in order to measure the impact that the MOC has on the SNP members.
- SNP member satisfaction surveys are utilized in order to assess overall satisfaction with the MOC
- All health outcomes and satisfaction survey findings are utilized to modify the MOC QIP on an annual basis.
- The annual evaluation of the QIP is shared with providers and stakeholders.

TIMELY ACCESS REGULATIONS

- State regulations require plans to assure timely access for its commercial member plans regulated under the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).
- Timely access involves physician offices being able to offer appointments within certain time frames. If your office is unable to provide an appointment within the time frame, you could refer the patient to the Chinese Hospital clinics for a one-time appointment. Please note that the waiting time in an office for scheduled appointments should not exceed 15 minutes. Jade Health Care Medical Group conducts appointment access surveys, provider satisfaction surveys, and member satisfaction surveys to identify trends or problems.

TIMELY ACCESS REGULATIONS

COMMERCIAL NON-EMERGENT MEDICAL APPOINTMENT ACCESS STANDARDS	
Appointment Type	**Must Offer Appointment Within**
Non-urgent Care appointments for Primary Care (PCP)	10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	48 hours of request
Urgent Care appointments that require prior authorization	96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 15 minutes

TIMELY ACCESS REGULATIONS

MENTAL HEALTH EMERGENT STANDARDS AND NON-EMERGENT APPOINTMENT ACCESS STANDARDS	
Appointment Type	**Must Offer Appointment Within**
Non-urgent appointments with a physician mental health care provider	10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider	10 business days of request
Urgent Care appointments	48 hours of request
Access to Care for Non-Life Threatening Emergency	6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for Mental Illness	Must Provide Both: 1 follow-up encounter with a mental health provider within 7 calendar days after discharge Plus 1 follow-up encounter with a mental health provider within 30 calendar days after discharge.

AFTER HOURS INSTRUCTIONS

- Jade Health Care Medical Group requires that each physician office's automated message or answering service will provide appropriate after hours emergency instructions and will have a healthcare professional available to return patient calls within 30 minutes. Every after-hours caller is expected to receive emergency instructions, whether a line is answered live or by recording. Callers with an emergency are expected to be told to hang up and dial 911, or to go to the nearest emergency room.
- After hours calls (defined as those hours which are not normal medical group business hours) may be managed by a telephone system which pages a provider or an on-call provider for patient triaging or authorization of care.
- The answering service shall give the following information to the patient. "If you feel that your problem is a life-threatening call 911 immediately."
- If a physician uses an answering machine, the message must include:

  - Have a number to connect to a message pager or physician directly.
  - A phone number to connect to a covering physician or answering service.
  - Instructions to call 911 if the problem is a life-threatening emergency or go to the nearest ER
  - Assurance that the member will receive a call back within 30 minutes.
- If the physician uses an answering service, the physician must instruct the service to let their patients know that if they feel they have a serious acute medical condition that they should seek immediate care by calling 911 or going to the nearest emergency room. If a message is left for the physician, the answering service will assure that the member will receive a call back within 30 minutes.

San Francisco Health Plan Provider Training

- All San Francisco Health Plan providers are required to read the Summary of Key Information (SOKI) document and signed the practitioner orientation attestation form when completed.
- This document highlights some of San Francisco Health Plan's (SFHP) programs and requirements.
- If you have any questions or concerns about the contents inside the Summary of Key Information (SOKI, provider issues, network and contracting, credentialing, payment disputes, and etc. Please contact San Francisco Health Plan directly.

  Telephone: 1(415) 547-7818 ext. 7084

  Hours of Operation: Monday through Friday, 8:30am to 5:00pm

  Email: provider.relations@sfhp.org

What Next?

- Congratulations and thank you for completing this training, the next step is to fill out and complete the 2019 Provider Attestation Form and send it in to one of the following below:
  - Email: info@jadehcmg.com
  - Fax: 1 (415) 217 – 4178

NOTICE

- Please remember all Jade Providers are required to complete their annual compliance training; and Attestation forms must be completed and submitted yearly

Thank You