Slide 1


Medicare Compliance and Fraud, Waste, and Abuse
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Launch
For Desktops
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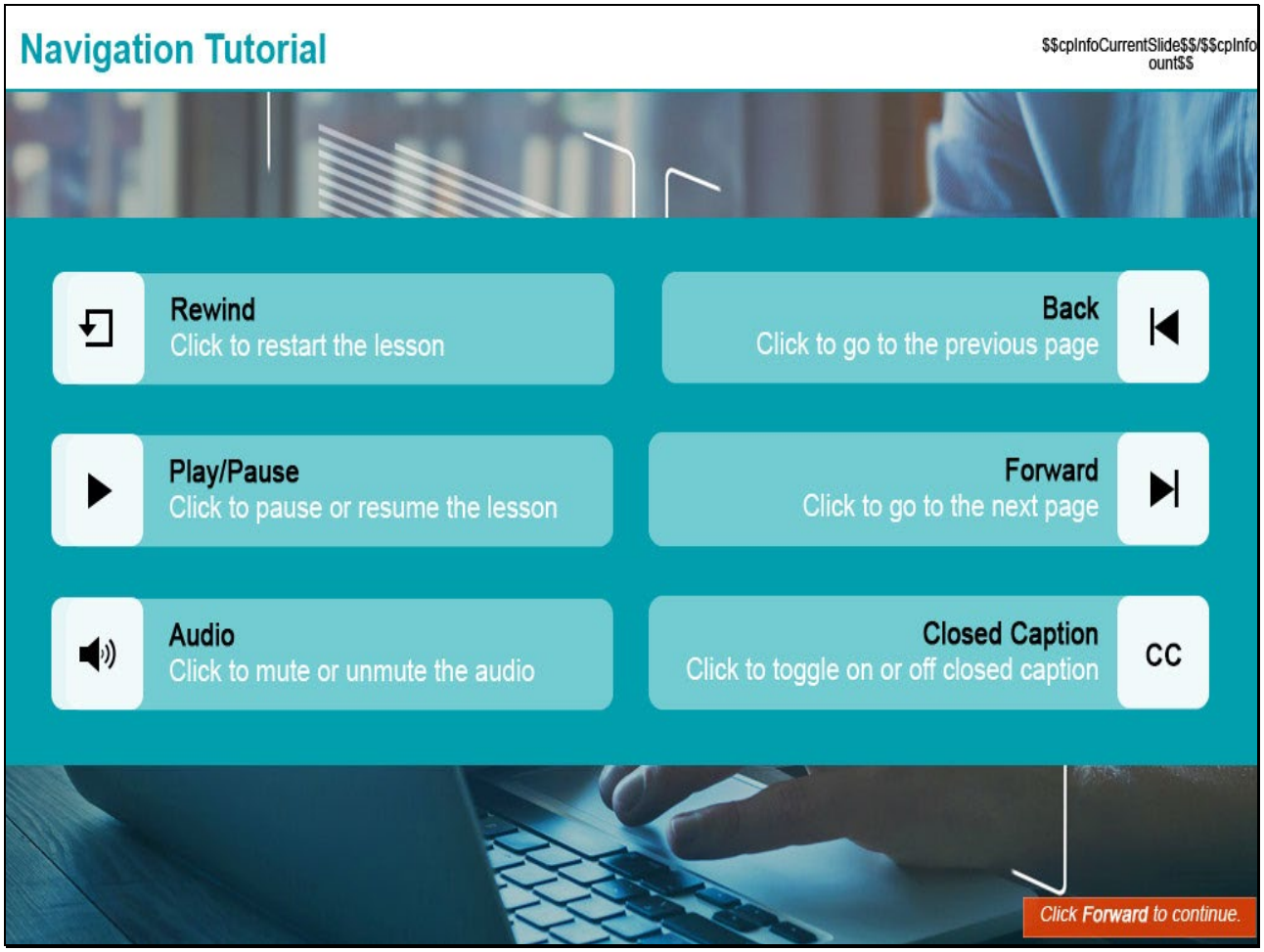
For Tablets
View the course in landscape mode.
GUIDEWELL

Slide 2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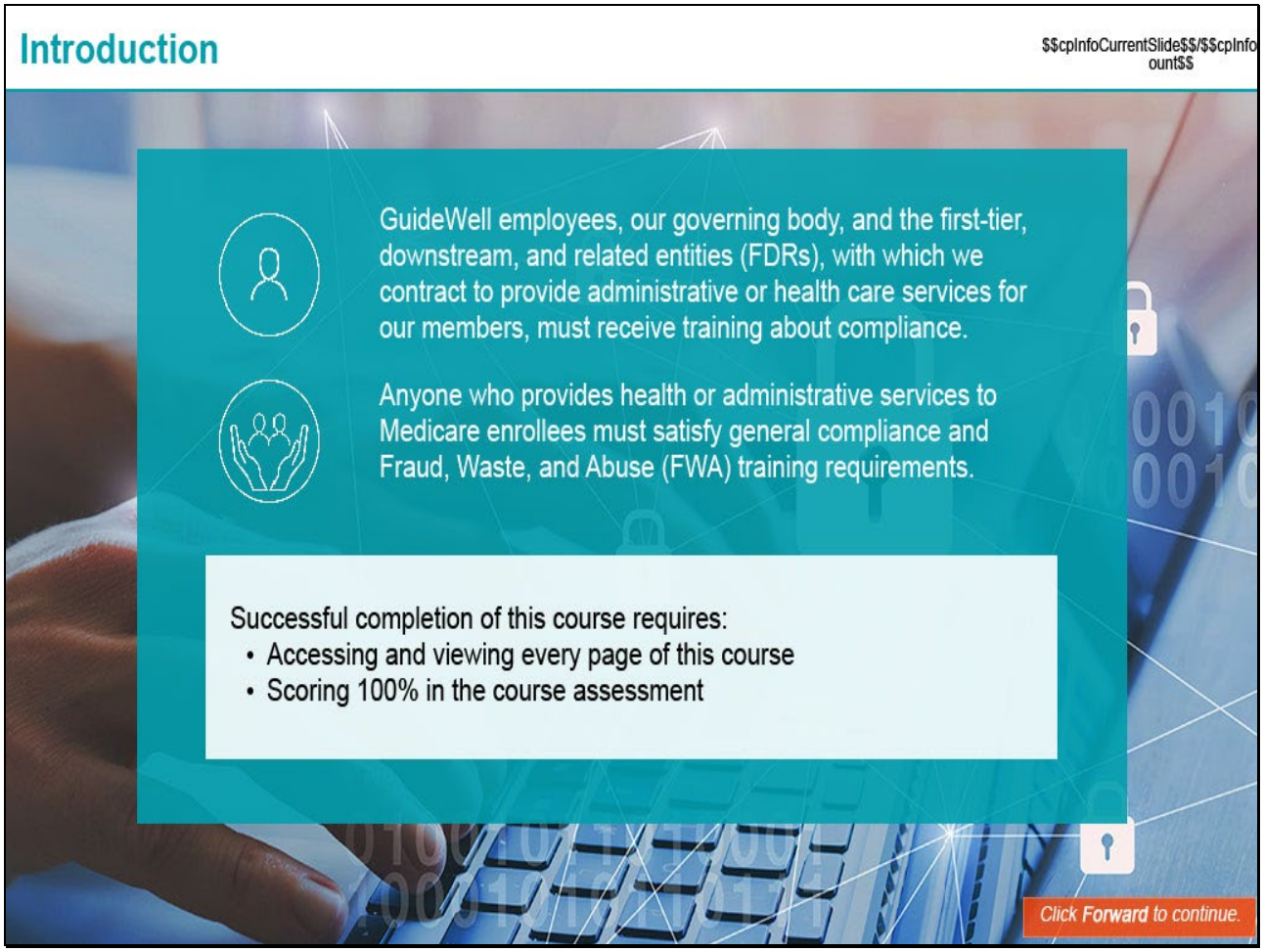


Slide notes

GuideWell is a contracting Medicare Plan Sponsor providing Medicare Parts C and D coverage to Medicare enrollees.

GuideWell employees, our governing body, and the first-tier, downstream, and related entities (FDRs), with which we contract to provide administrative or health care services for our members, must receive training about compliance with the Centers for Medicare and Medicaid Services, or CMS, program rules upon hire or contracting, and annually thereafter.

Also, anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and Fraud, Waste, and Abuse (FWA) training requirements.

In order to complete this course and comply with the CMS training requirements, you must complete the entire course.

Successful completion of this course requires accessing and viewing every page within the course and scoring 100% in the course assessment.

Slide 4

Slide notes

After completing this course, you will be able to:

Describe the Medicare program and its four parts;

Explain how a compliance program operates;

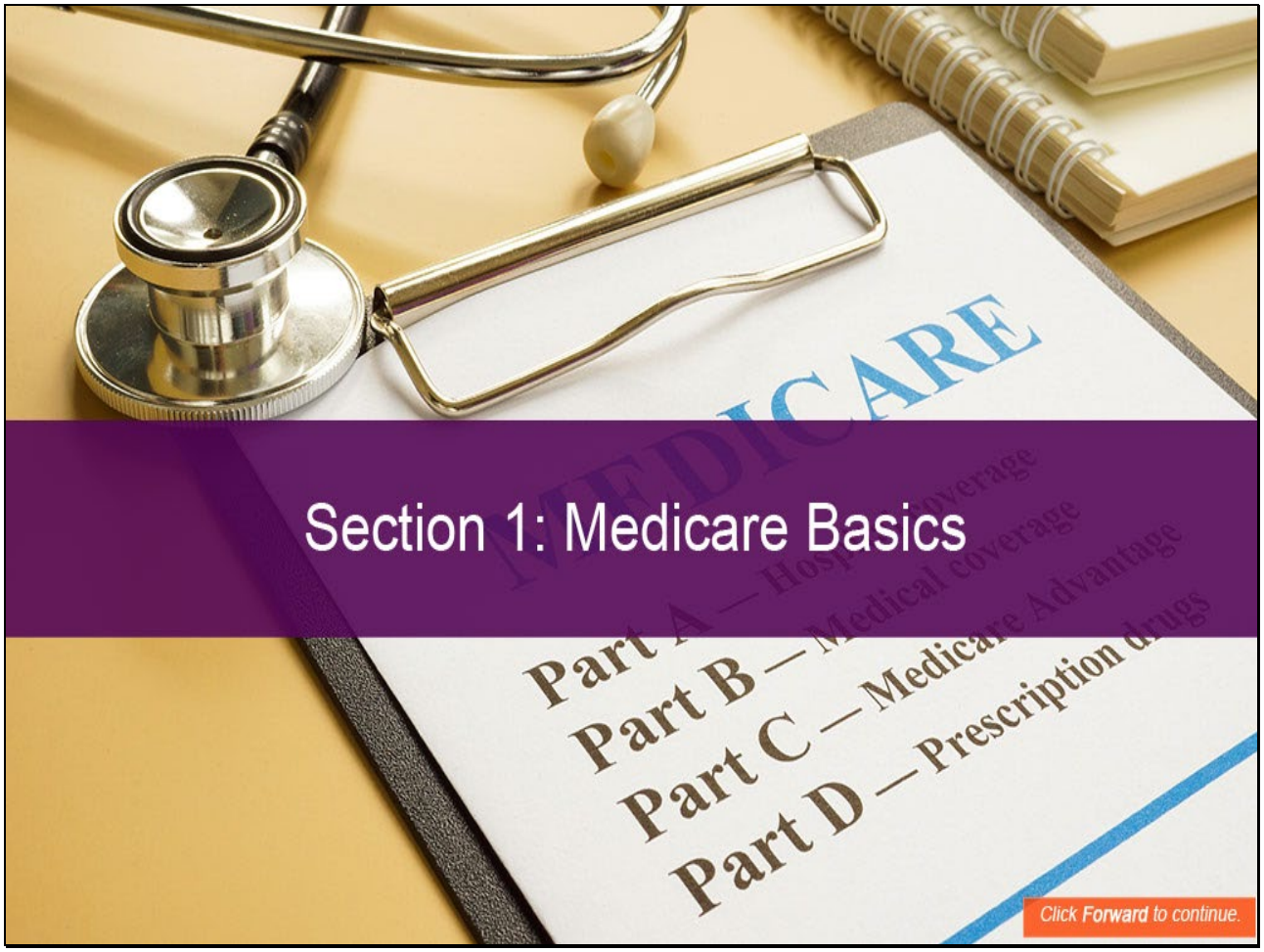
Recognize FWA in the Medicare program;

Explain the major laws and regulations pertaining to FWA and penalties associated with violations;

Report compliance program and FWA violations;

And recognize how to correct non-compliance and FWA.

Slide 5

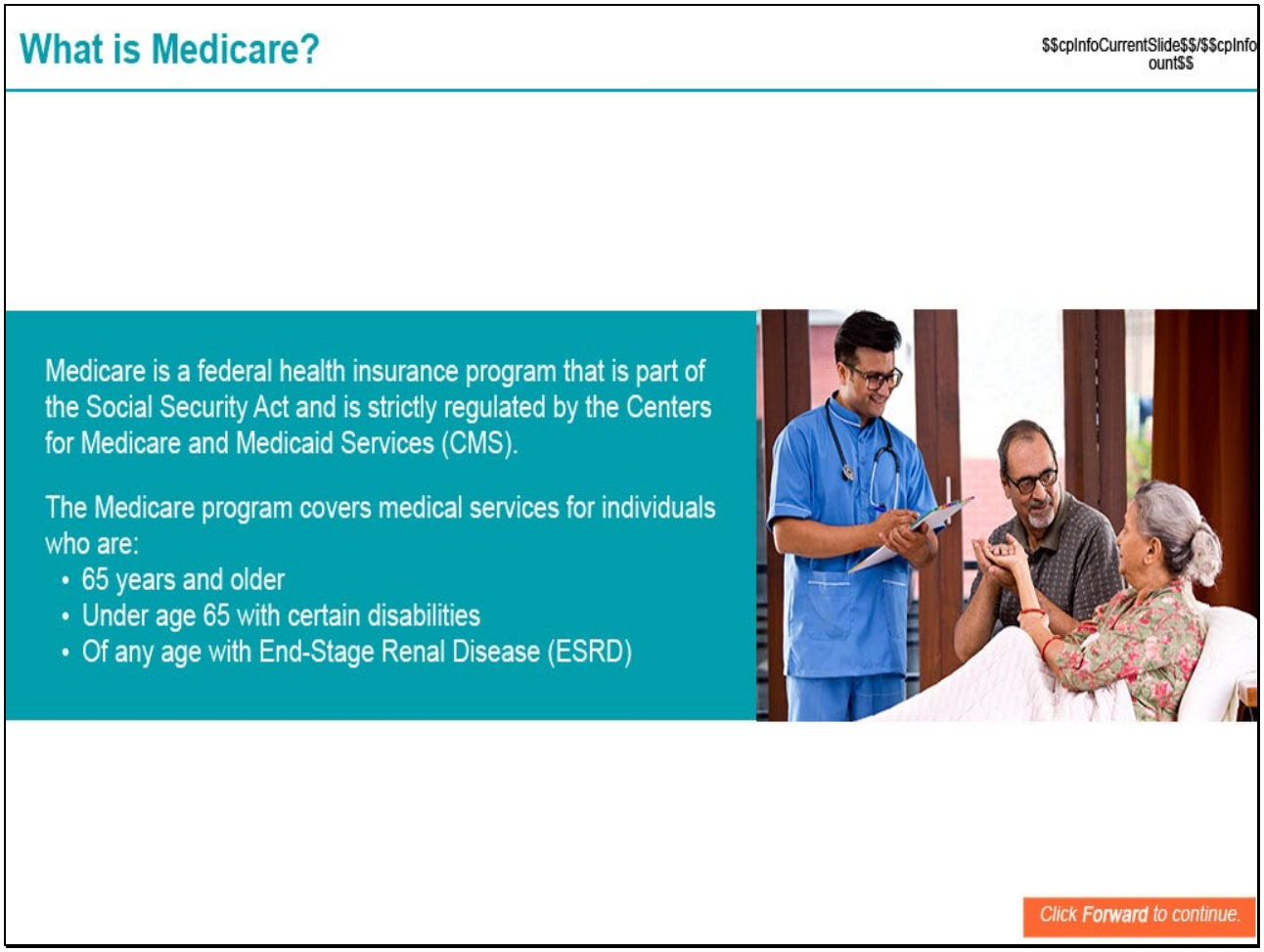


Slide notes

Section 1: Medicare Basics

In this section, we will cover the basics of Medicare.

Slide 6

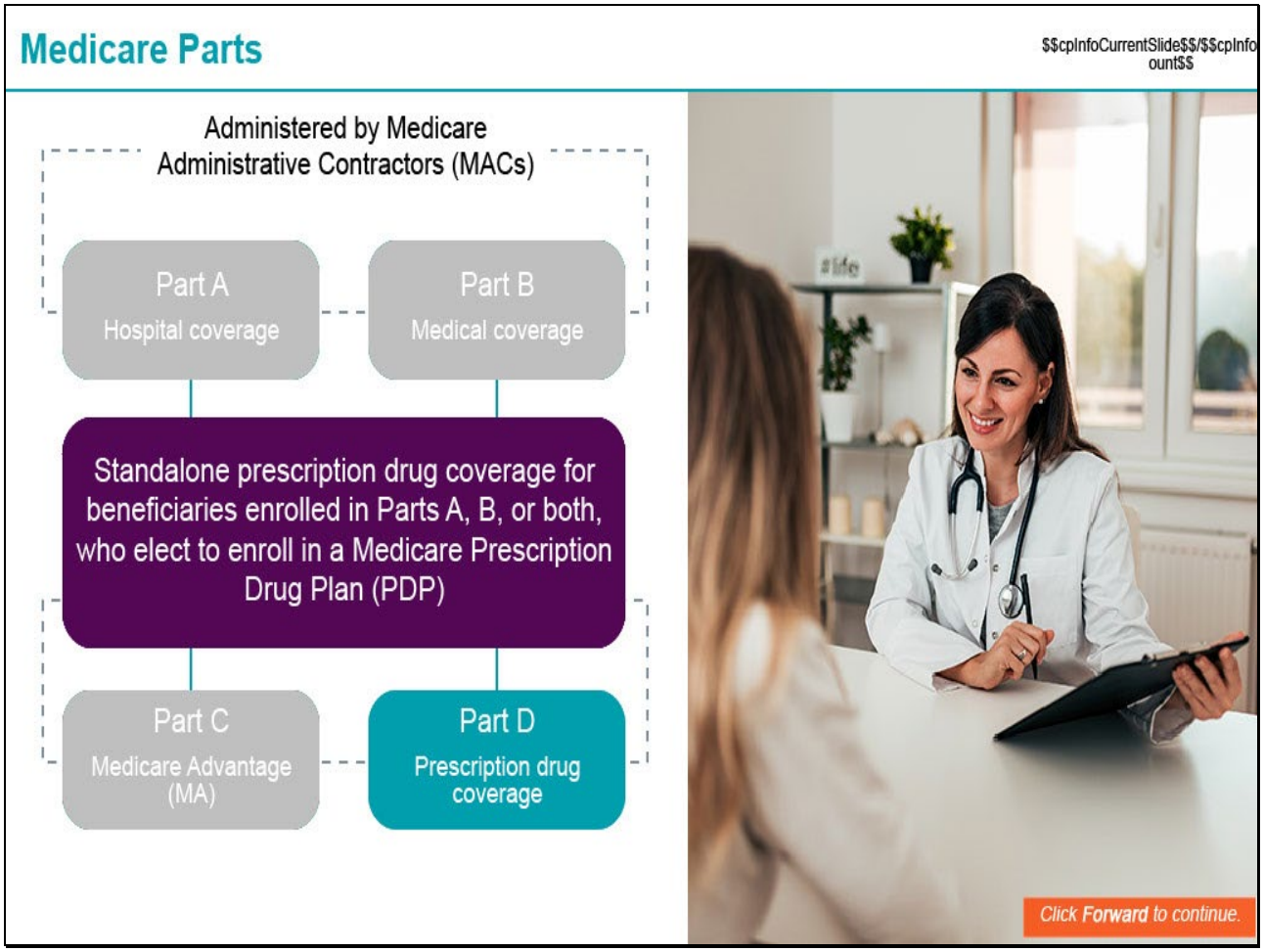


Slide notes

Medicare is a federal health insurance program that is part of the Social Security Act and is strictly regulated by the Centers for Medicare and Medicaid Services (CMS).

The Medicare program covers medical services for individuals who are of age 65 and older, individuals under age 65 with certain disabilities that would qualify the individual for social security, and individuals of any age with End-Stage Renal Disease (ESRD).

Slide 7



Slide notes

The Medicare program consists of four parts: A, B, C, and D.

All parts are federally funded programs strictly regulated by CMS.

Parts A and B, also known as Original Medicare, are administered by Medicare Administrative Contractors (MACs) such as GuideWell's subsidiaries,

First Coast Service Options (FCSO) and Novitas Solutions.

Parts C and Part D plans are approved by CMS, but unlike Original Medicare Parts A and B, these plans are developed, offered, and administered by Medicare-approved private organizations or Plan Sponsors, like GuideWell.

Part A helps cover inpatient care in hospitals, at-home care, skilled nursing facility care, hospice care, and home health care.

Part B helps cover medical costs, such as doctor visits, screenings, therapy, emergency and ambulatory care, medical supplies and equipment, and lab services.

Medicare Part C is also called Medicare Advantage (MA). MA plans are a coverage option available to Medicare beneficiaries.

Essentially, Part C replaces Original Medicare Parts A and B, and may include benefits not covered in Parts A and B, such as vision, dental, and hearing.

It may also include additional supplemental benefits, such as gym membership and transportation.

Except for hospice care, Part C plans offer the same services covered by Parts A and B.

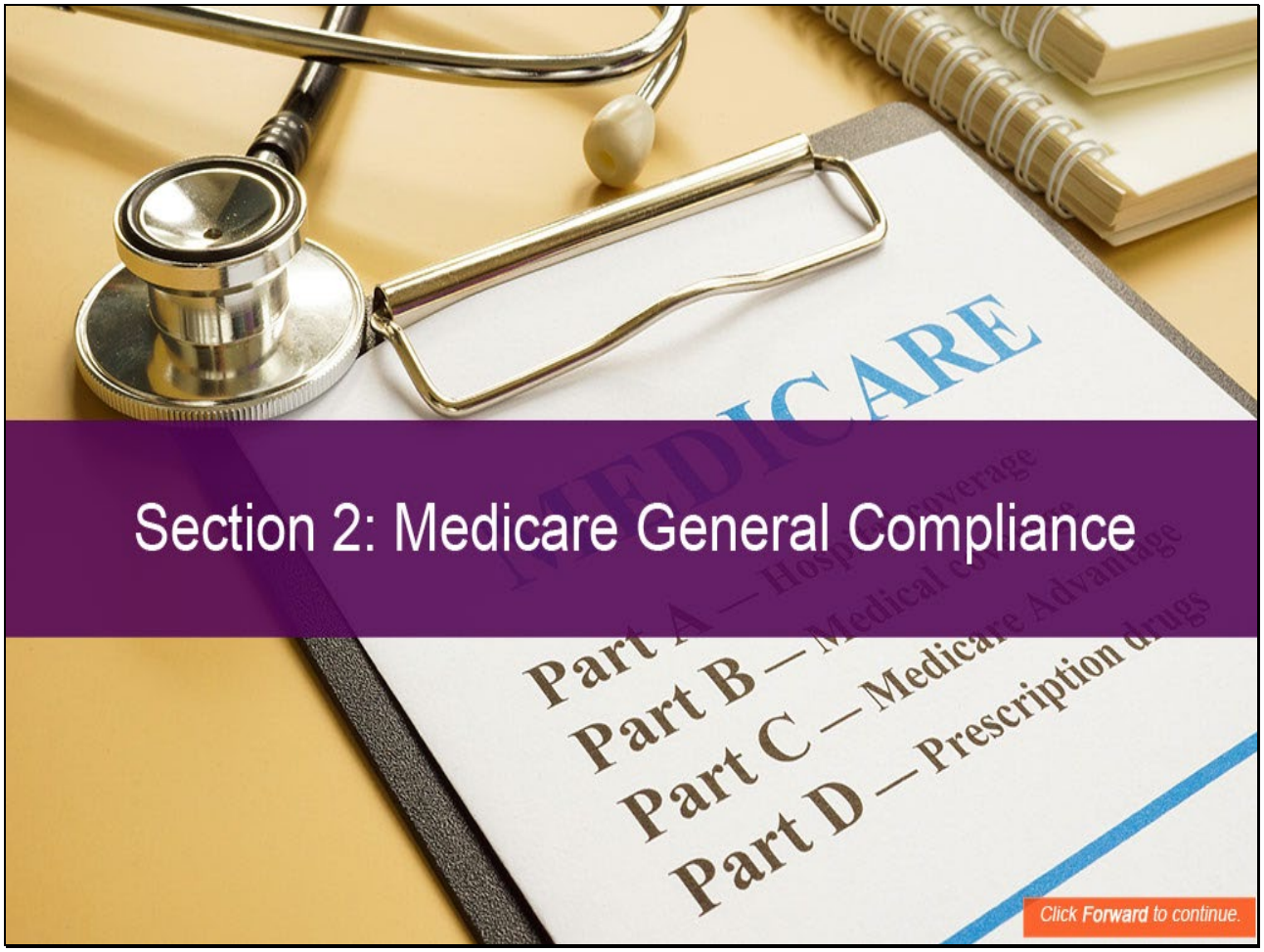
MA is only available to beneficiaries enrolled in, or eligible for, Original Medicare.

Medicare Part D, also referred to as the Medicare Prescription Drug benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A, Part B, or both, who elect to enroll in a Medicare Prescription Drug Plan (PDP).

Part D benefits are often included in MA plans and, if so, are referred to as Medicare Advantage Prescription Drug plans, or MA-PDs.

Now that you have reviewed the basics of Medicare, let’s proceed to the next section.

Slide 8

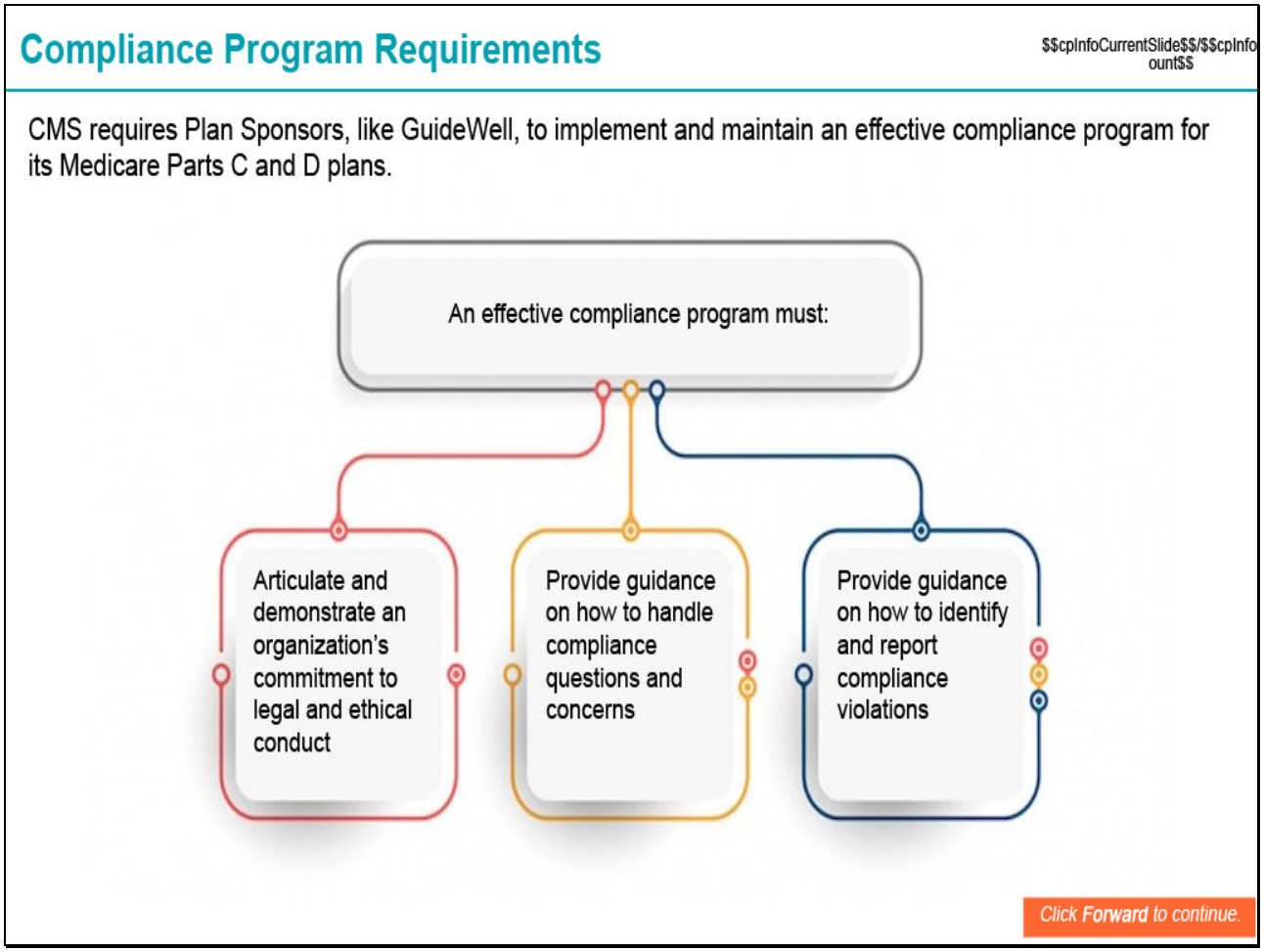


Slide notes

Section 2: Medicare General Compliance

In this section, we will explain the requirements of Medicare compliance.

Slide 9



Slide notes

CMS requires Plan Sponsors, like GuideWell, to implement and maintain an effective compliance program for its Medicare Parts C and D plans.

An effective compliance program must articulate and demonstrate an organization's 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.

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Slide 10

Slide notes

An effective compliance program fosters a culture of compliance within an organization and, at a minimum, prevents, detects, and corrects non-compliance and FWA.

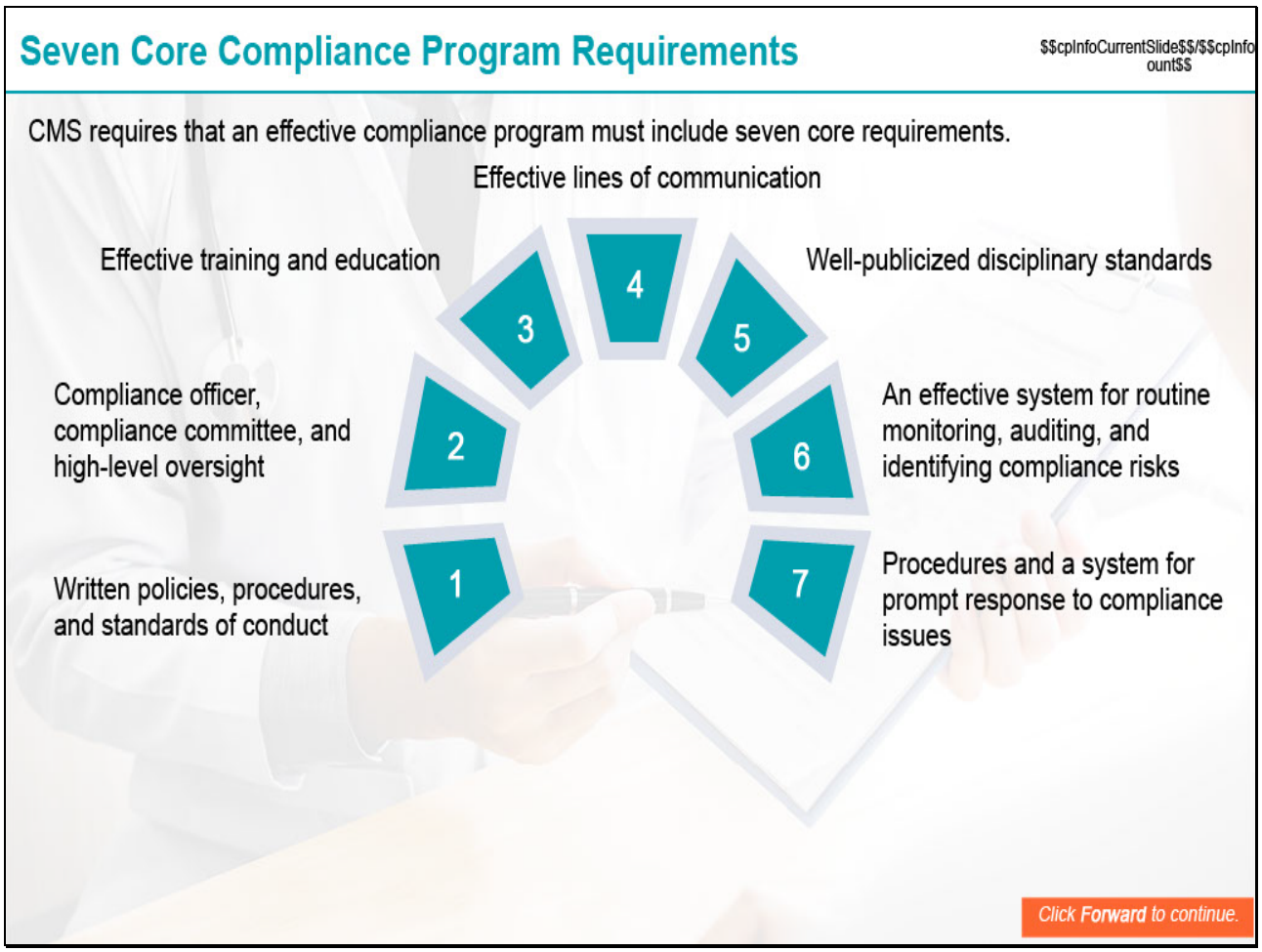
It is also fully implemented and is tailored to an organization's unique operations and circumstances, has adequate resources, promotes the organization's standards of conduct, and establishes clear lines of communication for reporting non-compliance and FWA.

Additionally, it must, at a minimum, include the seven core compliance program requirements.

Remember, an effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as FWA.

Let's review the seven core compliance program requirements.

Slide 11



Slide notes

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

Written policies, procedures, and standards of conduct

Compliance officer, compliance committee, and high-level oversight

Effective training and education

Effective lines of communication

Well-publicized disciplinary standards

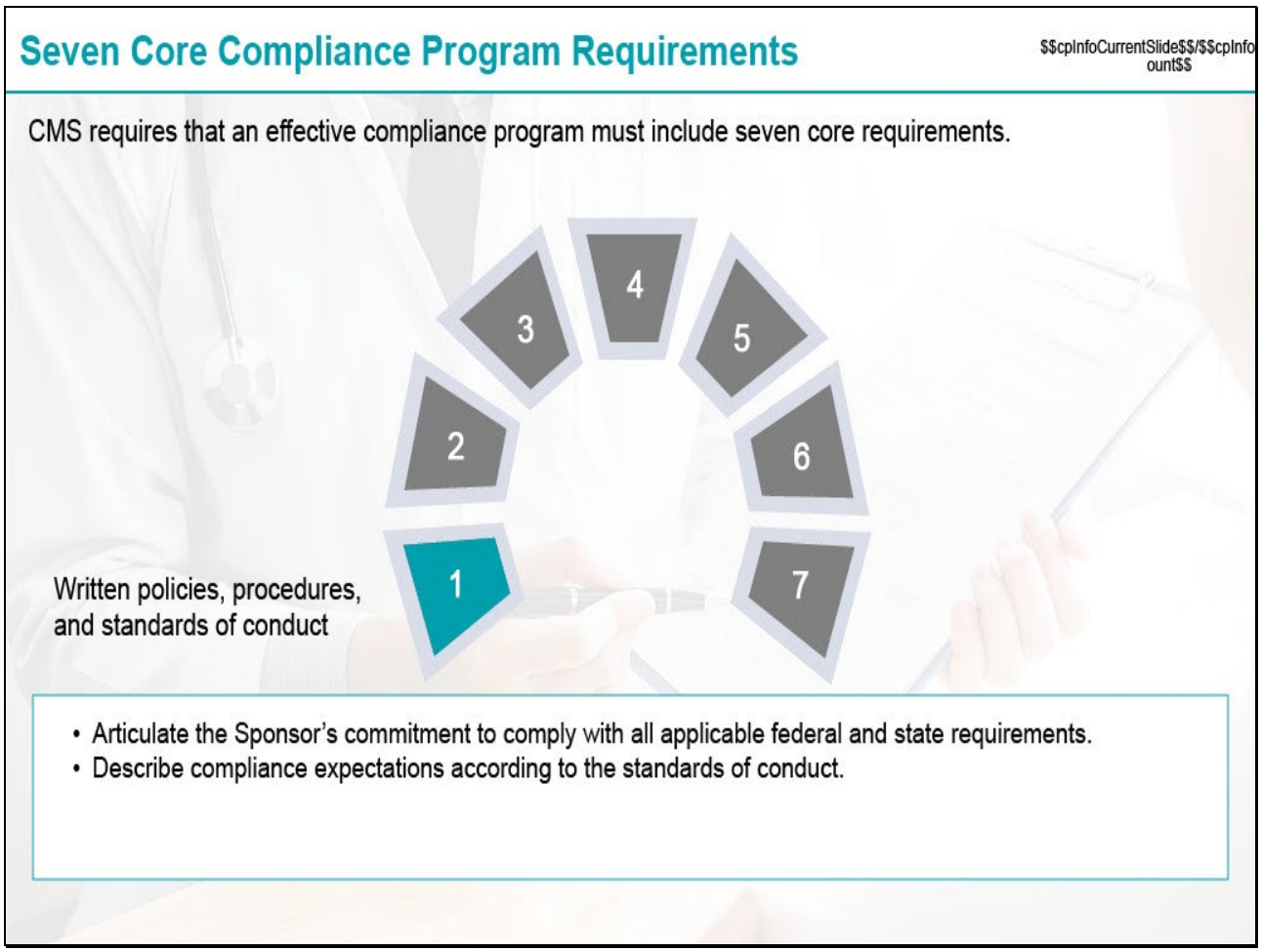
An effective system for routine monitoring, auditing, and identifying compliance risks

And procedures and a system for prompt response to compliance issues

Let’s learn about these.

Click the Forward button to continue.

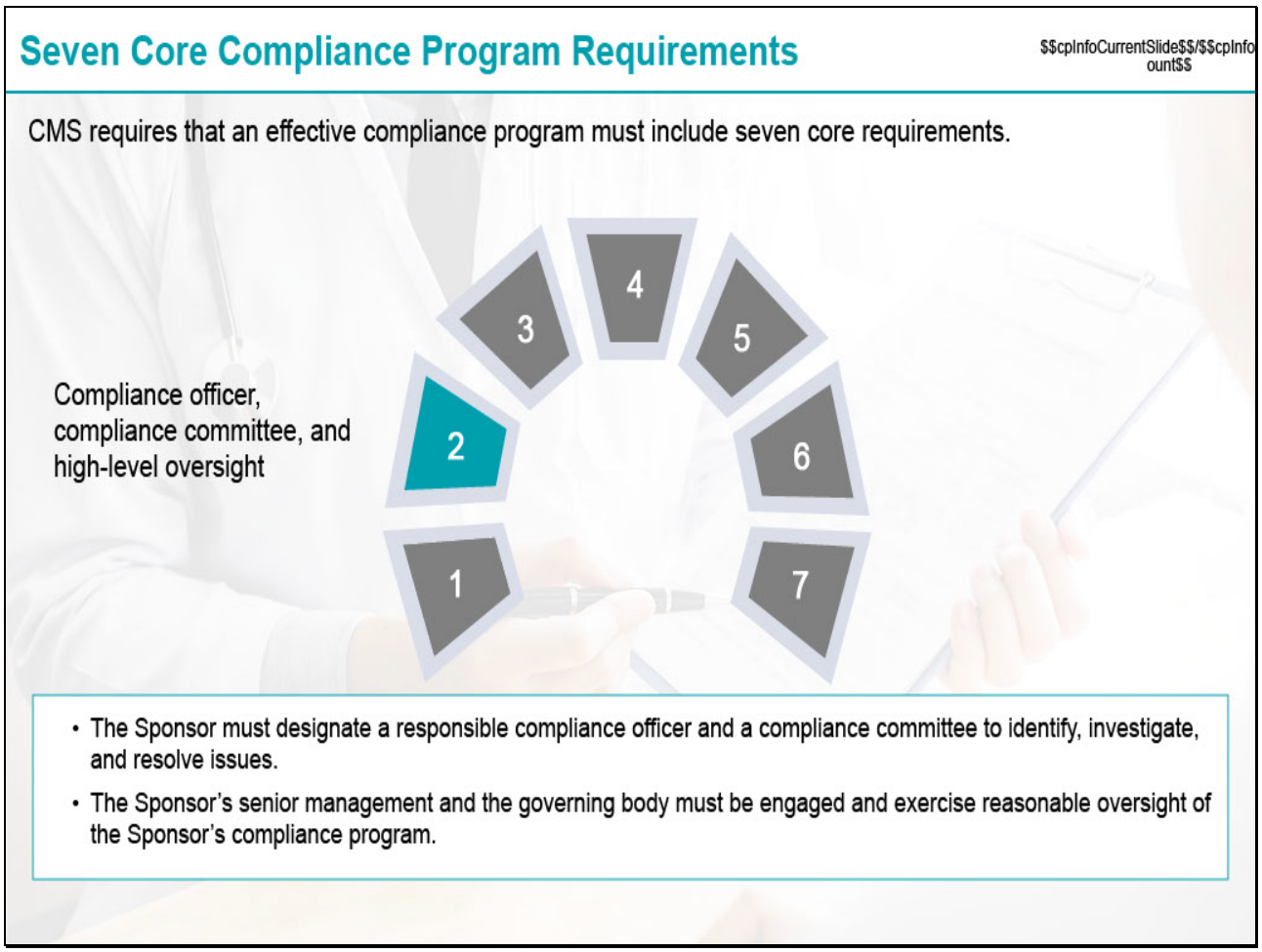
Slide 12



Slide notes

Written policies and procedures articulate the Sponsor's commitment to comply with all applicable federal and state requirements and describe compliance expectations according to the standards of conduct.

Slide 13

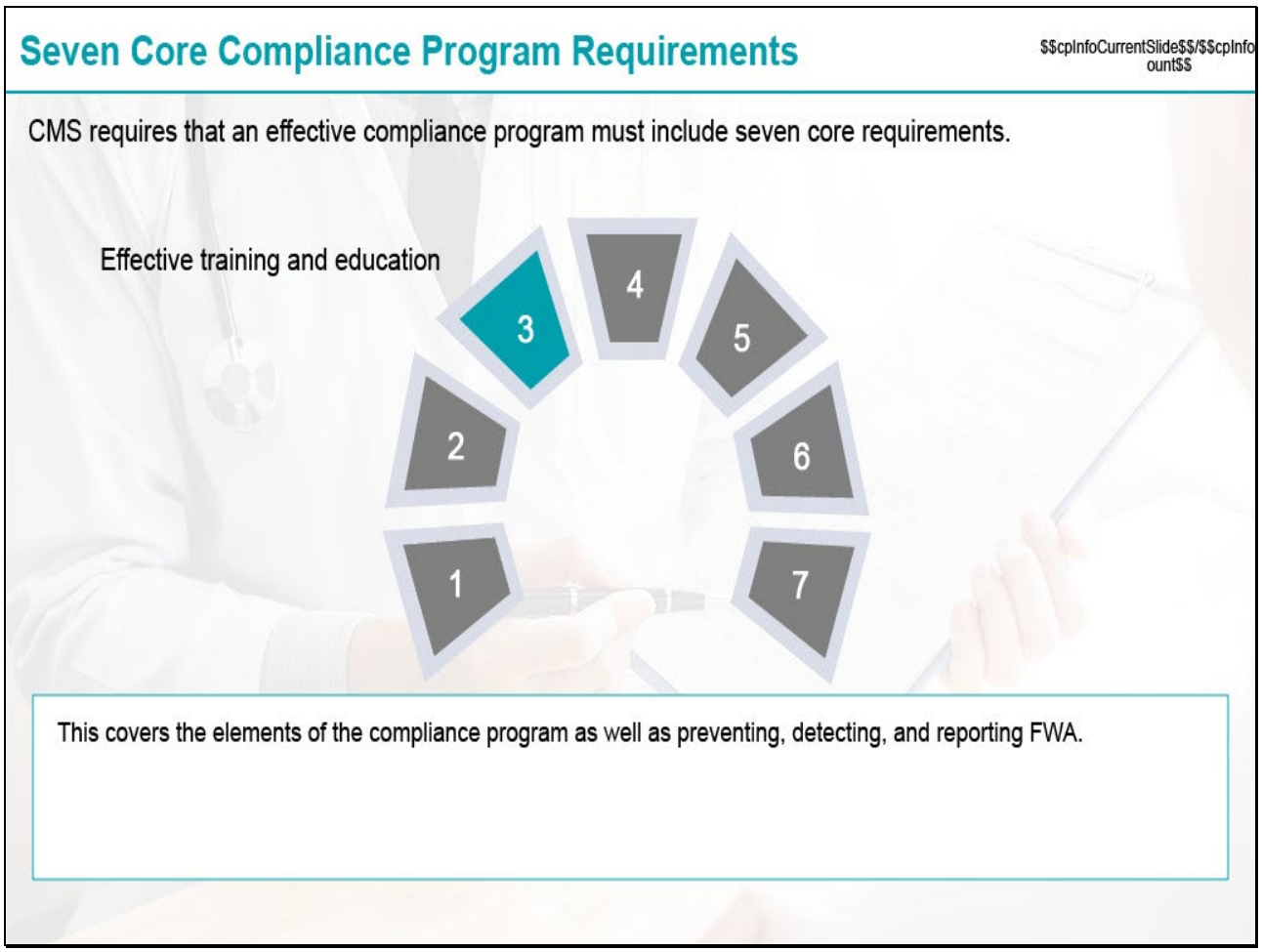


Slide notes

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 the governing body must be engaged and must exercise reasonable oversight of the Sponsor's compliance program.

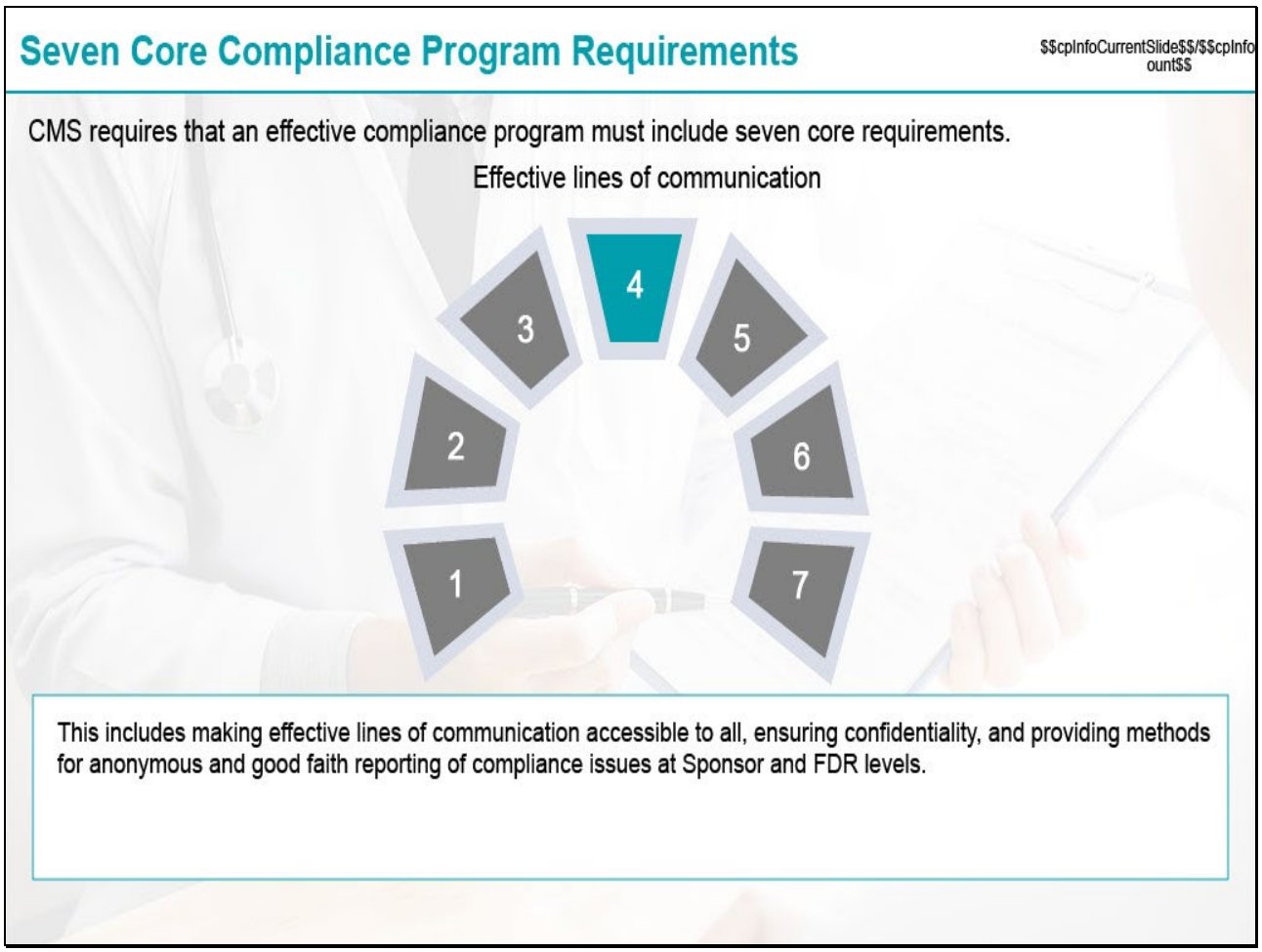
Slide 14



Slide notes

Effective training and education covers the elements of the compliance program as well as preventing, detecting, and reporting FWA.

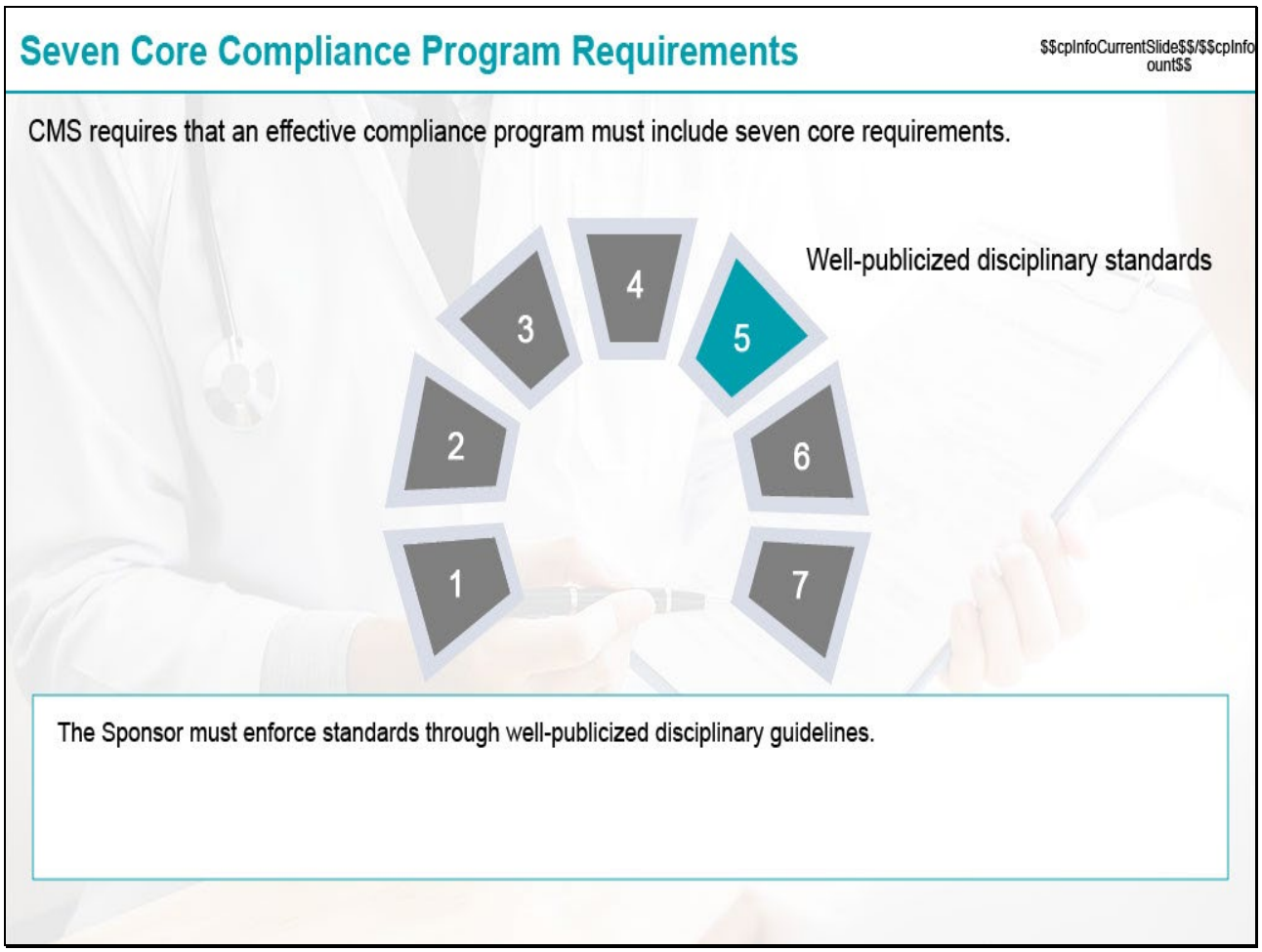
Slide 15



Slide notes

Effective lines of communication include making effective lines of communication accessible to all, ensuring confidentiality, and providing methods for anonymous and good faith reporting of compliance issues at Sponsor and FDR levels.

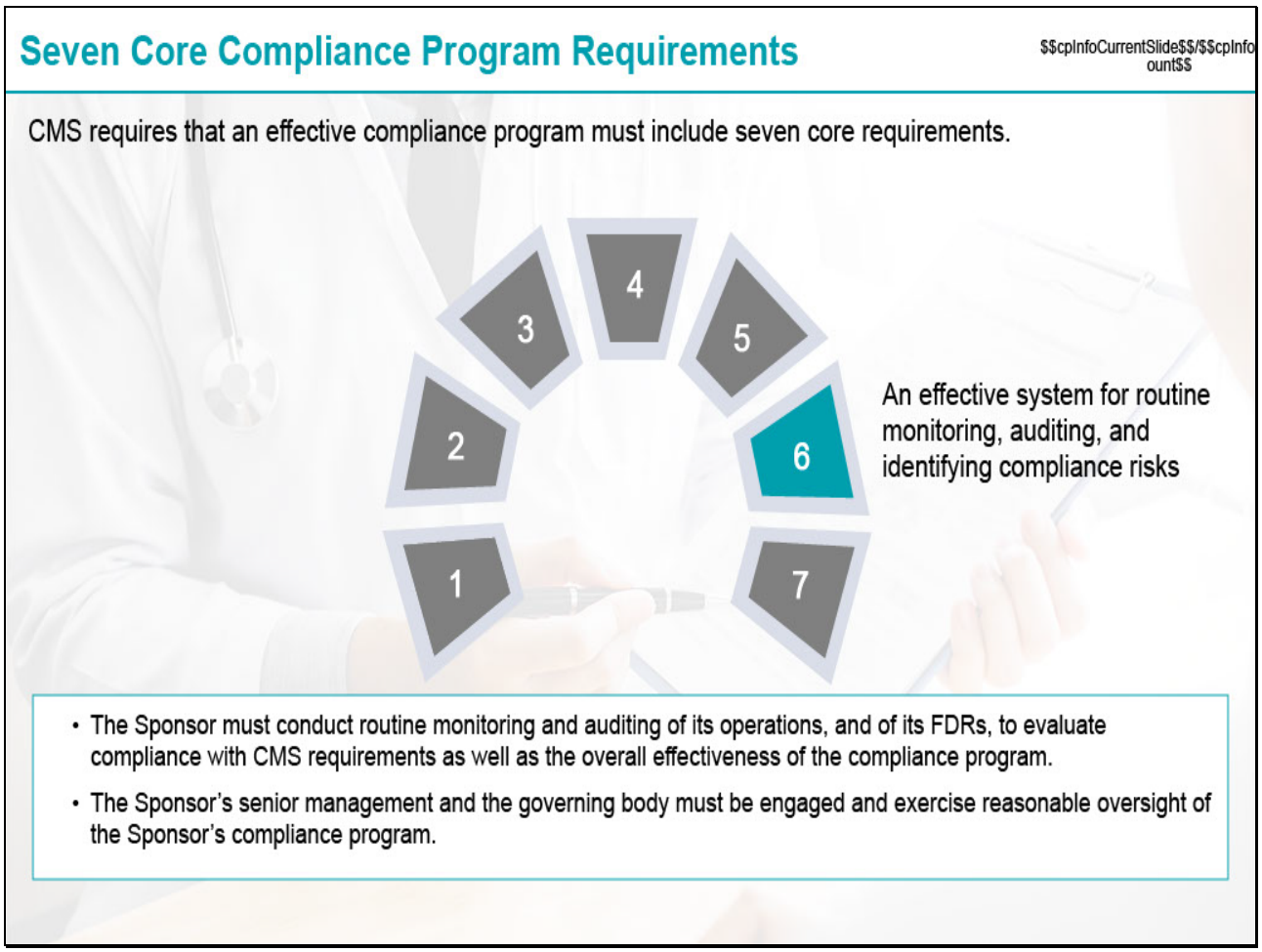
Slide 16



Slide notes

The Sponsor must enforce standards through well-publicized disciplinary guidelines.

Slide 17

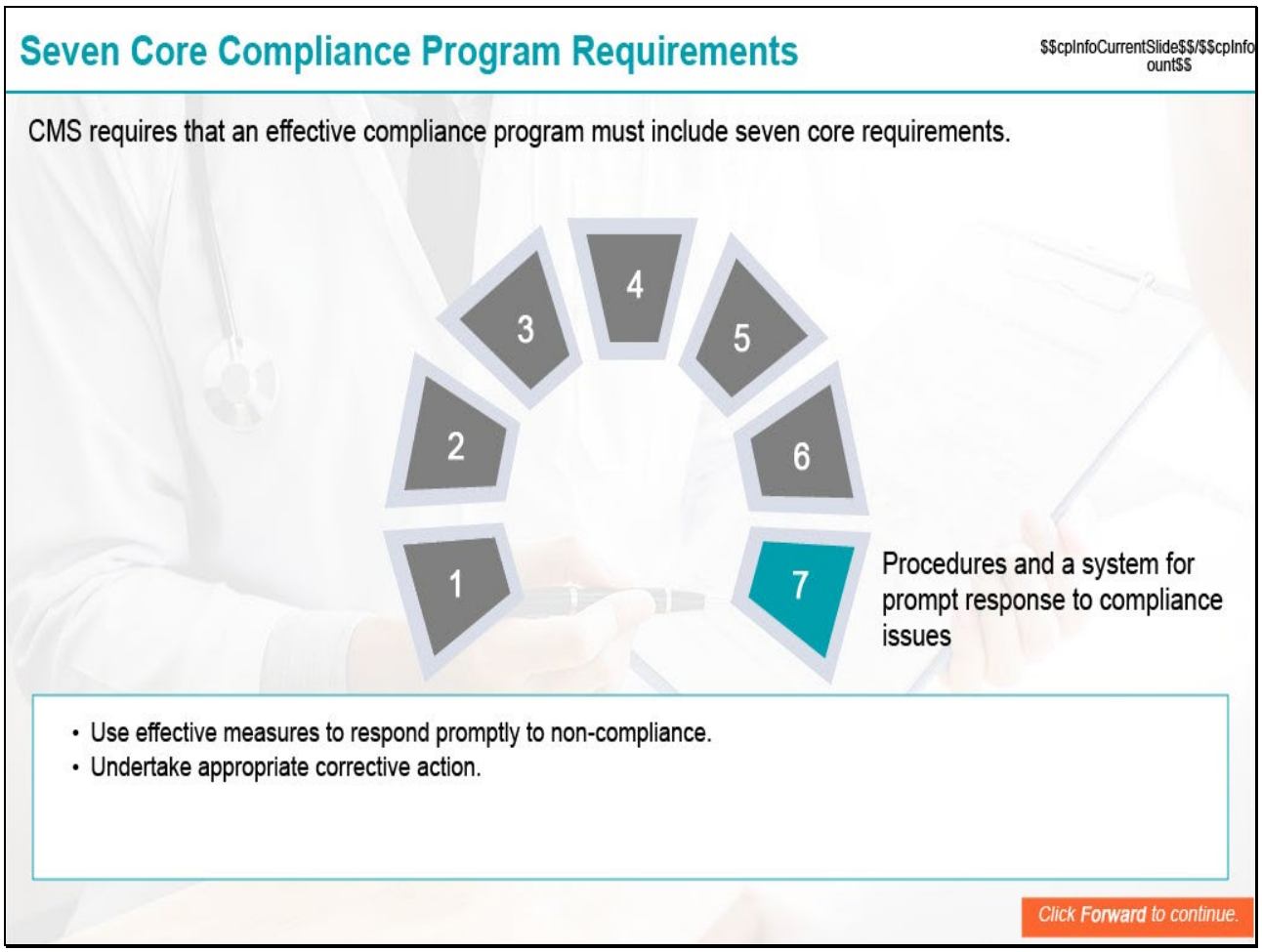


Slide notes

The Sponsor must conduct routine monitoring and auditing of its operations, and of its FDRs, to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

The Sponsor must also ensure that FDRs performing delegated administrative or health care service functions concerning its Medicare Parts C and D programs comply with Medicare requirements.

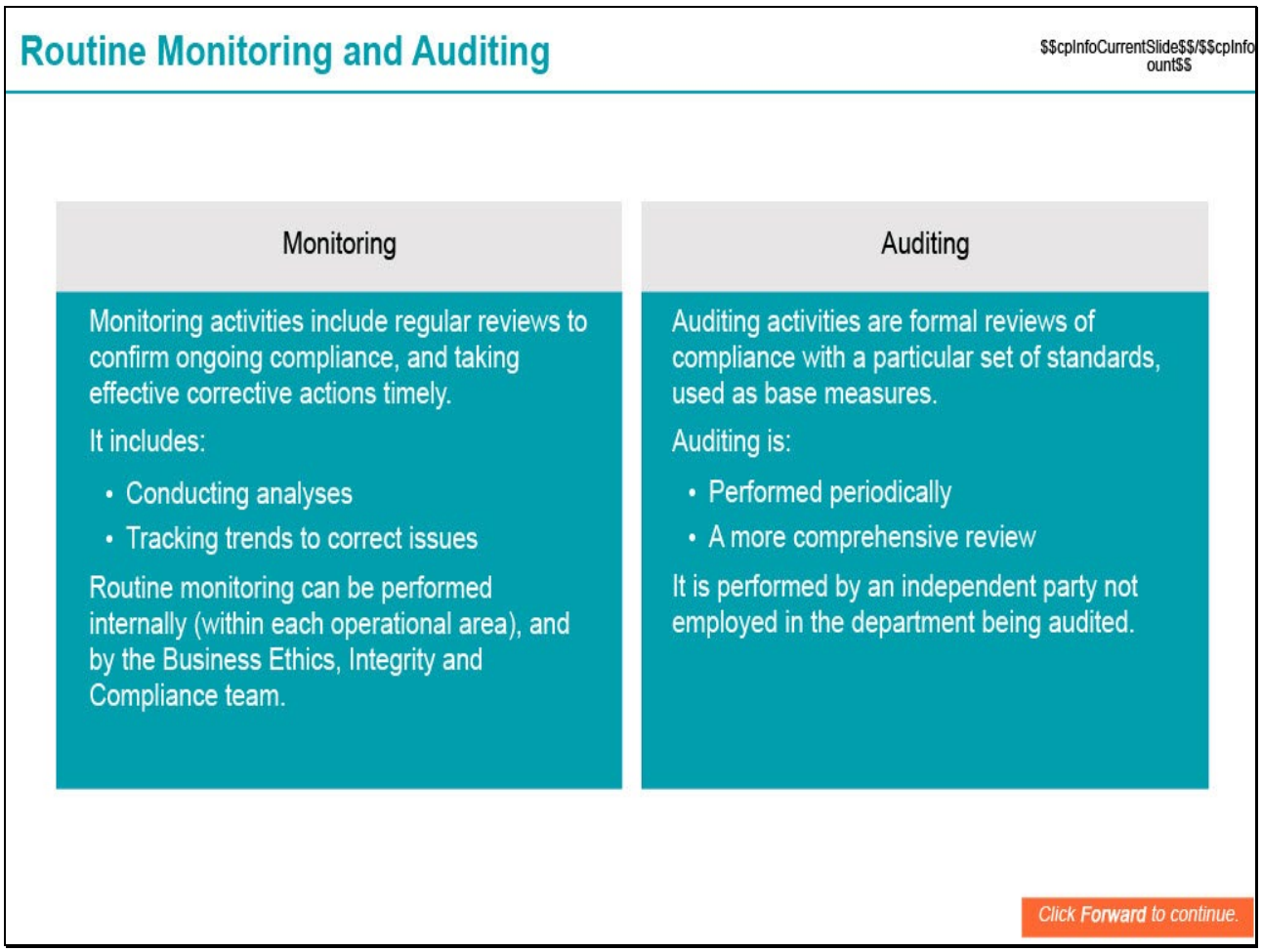
Slide 18



Slide notes

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

Slide 19



Slide notes

Monitoring activities include regular reviews to confirm ongoing compliance, and taking effective corrective actions timely.

It is an ongoing event that includes conducting analyses and tracking trends to correct issues “in real-time” at the lowest level of detection.

Routine monitoring can be performed internally (within each operational area), and by the Business Ethics, Integrity and Compliance team.

Auditing activities are formal reviews of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

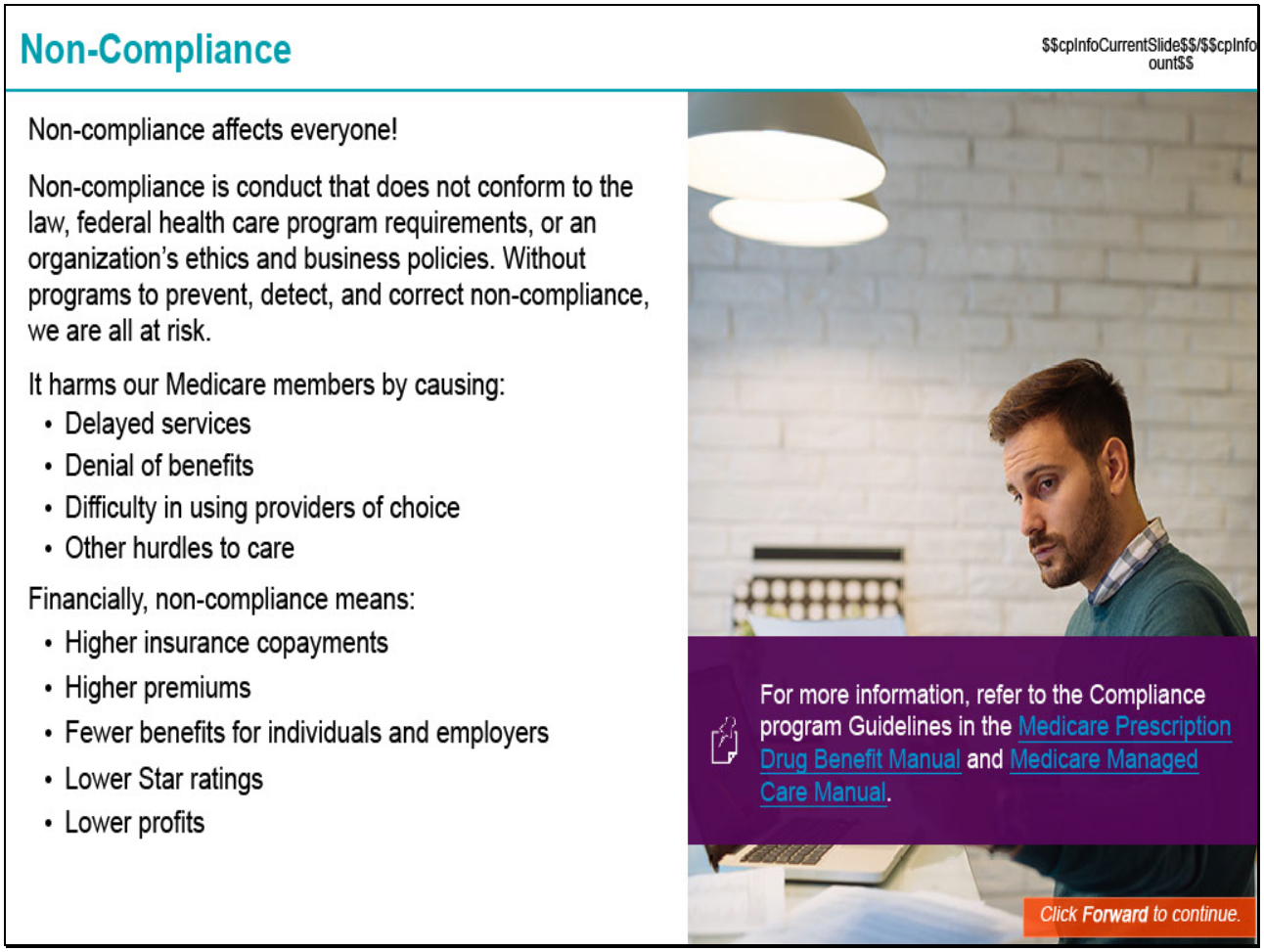
Auditing is performed periodically, though less often than monitoring.

An audit is a more comprehensive review than monitoring.

Those performing audits must be independent and not employed in the department being audited.

Click the Forward button to learn about non-compliance.

Slide 20



Slide notes

Non-compliance affects everyone! Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization's ethics and business policies.

Without programs to prevent, detect, and correct non-compliance, we are all at risk.

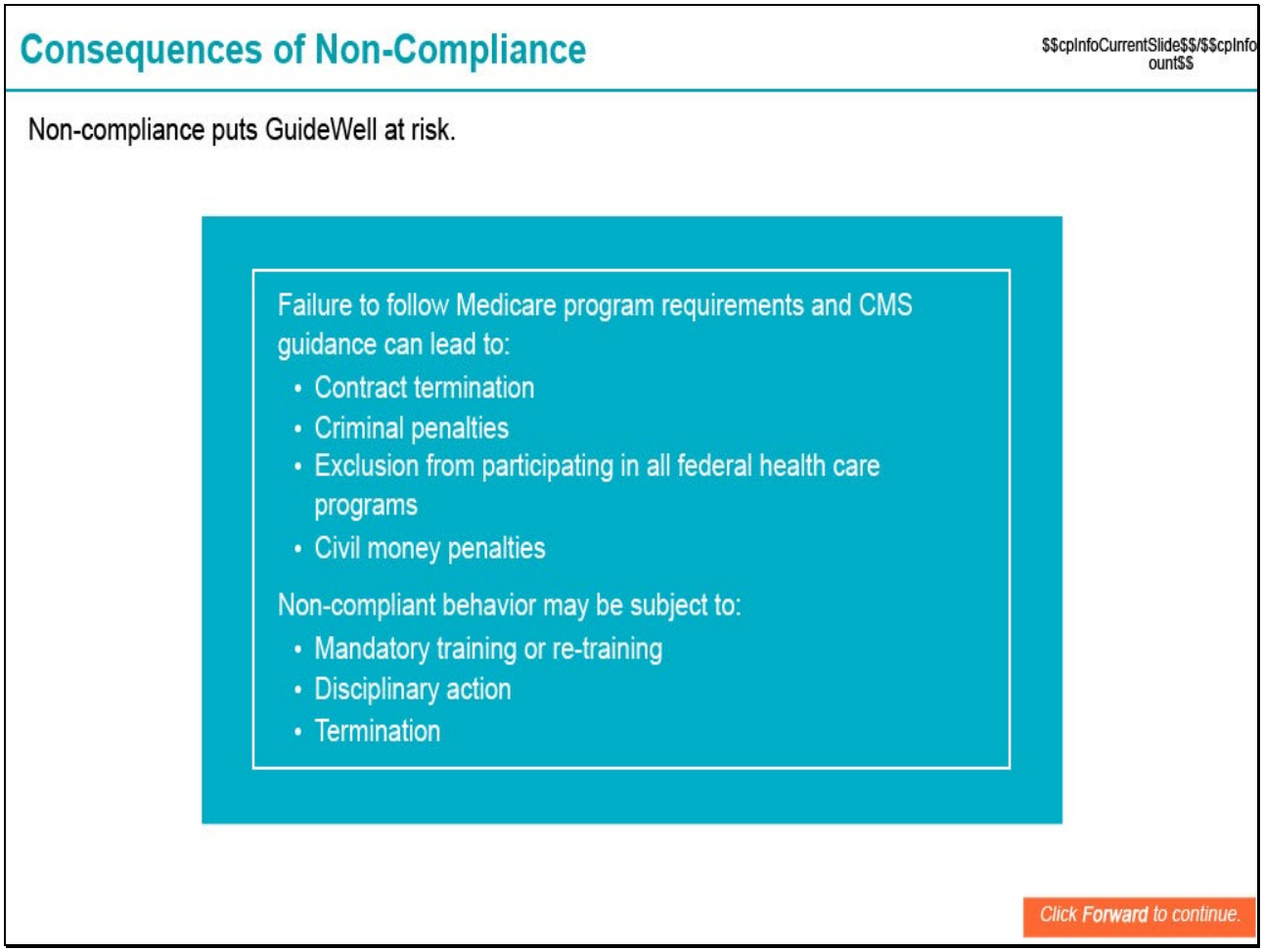
It harms our Medicare members by causing delayed services, denial of benefits, difficulty in using providers of choice, and other hurdles to care.

Financially, non-compliance means higher insurance copayments, higher premiums, fewer benefits for individuals and employers, lower Star ratings, and lower profits.

Click the links displayed on the screen for more information on CMS guidelines.

Click the Forward button to learn about the consequence of non-compliance.

Slide 21



Slide notes

It is important to understand the consequences of non-compliance. It puts GuideWell at risk.

Failure to follow Medicare program requirements and CMS guidance can lead to serious consequences, including contract termination, criminal penalties, exclusion from participating in all federal health care programs, and civil money penalties.

Additionally, GuideWell must have disciplinary standards for non-compliant behavior.

Those who engage in non-compliant behavior may be subject to any of these actions, such as mandatory training or re-training, disciplinary action, and termination.

Slide 22

Slide notes

Now that you've read the general compliance guidelines, how do you know what is expected of you in a specific situation?

The standards of conduct (or Code of Conduct) state the organization's compliance expectations and its operational principles and values. Organizational standards of conduct vary.

The organization should tailor the standards of conduct content to its individual organization's culture and business operations.

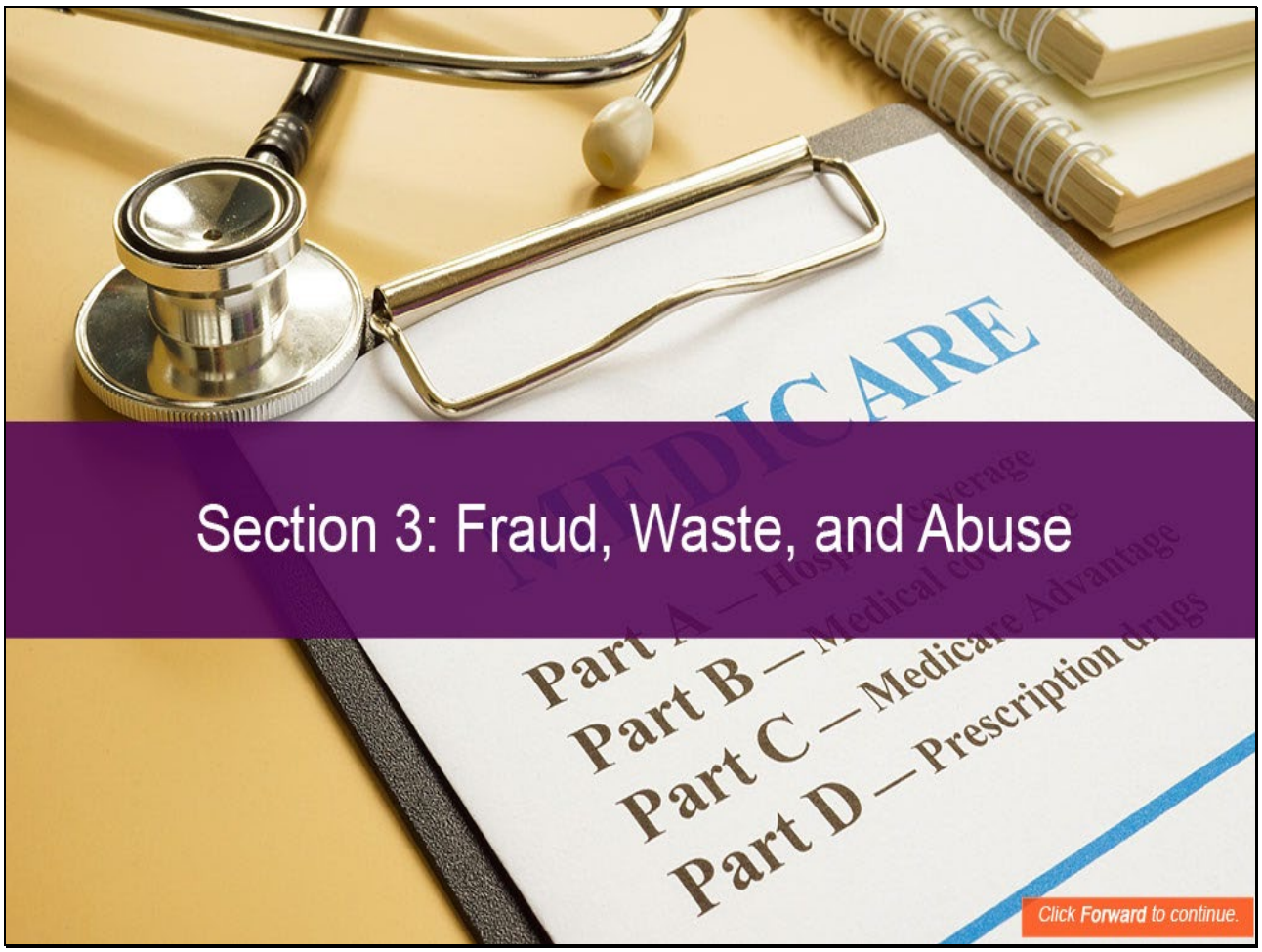
Reporting standards of conduct violations and suspected non-compliance is everyone's responsibility.

The organization's standards of conduct and policies and procedures should identify this obligation and provide you with information on how to report suspected non-compliance.

At GuideWell, we have adopted the Compass Code of Ethical Business Conduct as our standards of conduct.

Click the link on your screen to view GuideWell's Compass Code of Conduct.

Slide 23



Slide notes

Section 3: Fraud, Waste, and Abuse

This section describes fraud, waste, and abuse and the laws that prohibit it.

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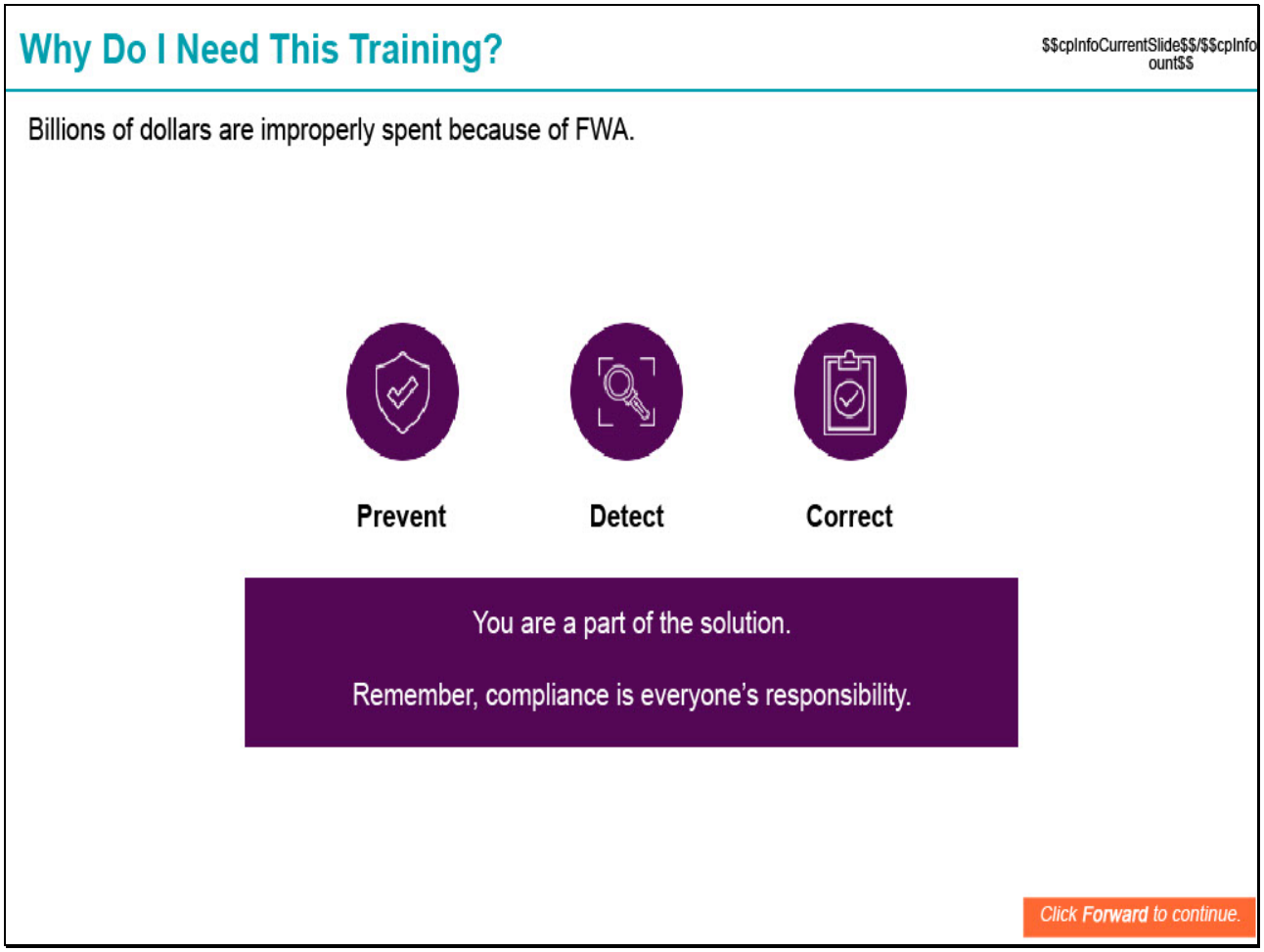

Slide notes

Every year, billions of dollars are improperly spent because of FWA. It affects everyone, including you.

This course helps you understand how to prevent, detect, and correct FWA. You are a part of the solution.

Remember, compliance is everyone's responsibility!

As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare program, or the Medicare Trust Fund.

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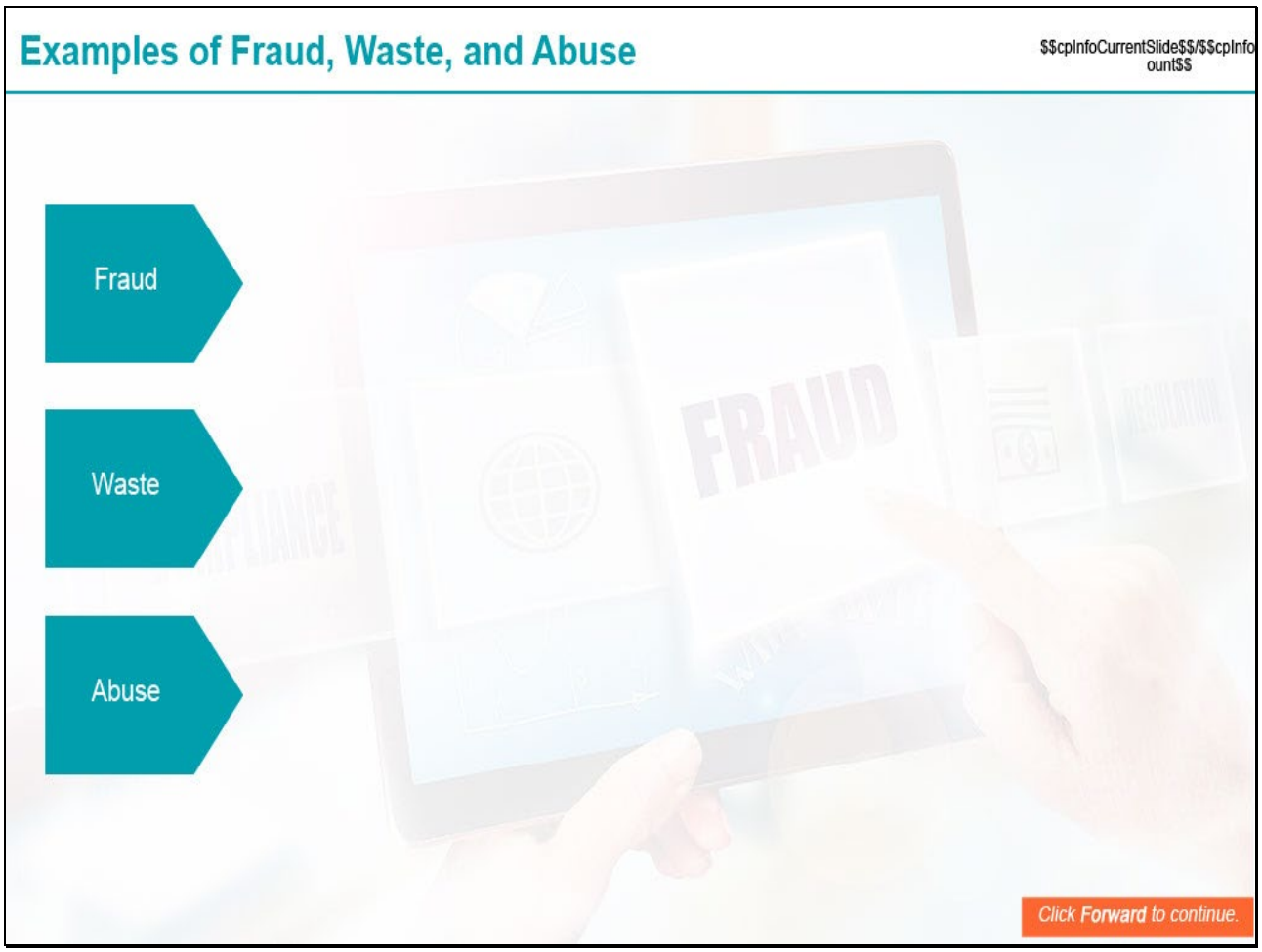
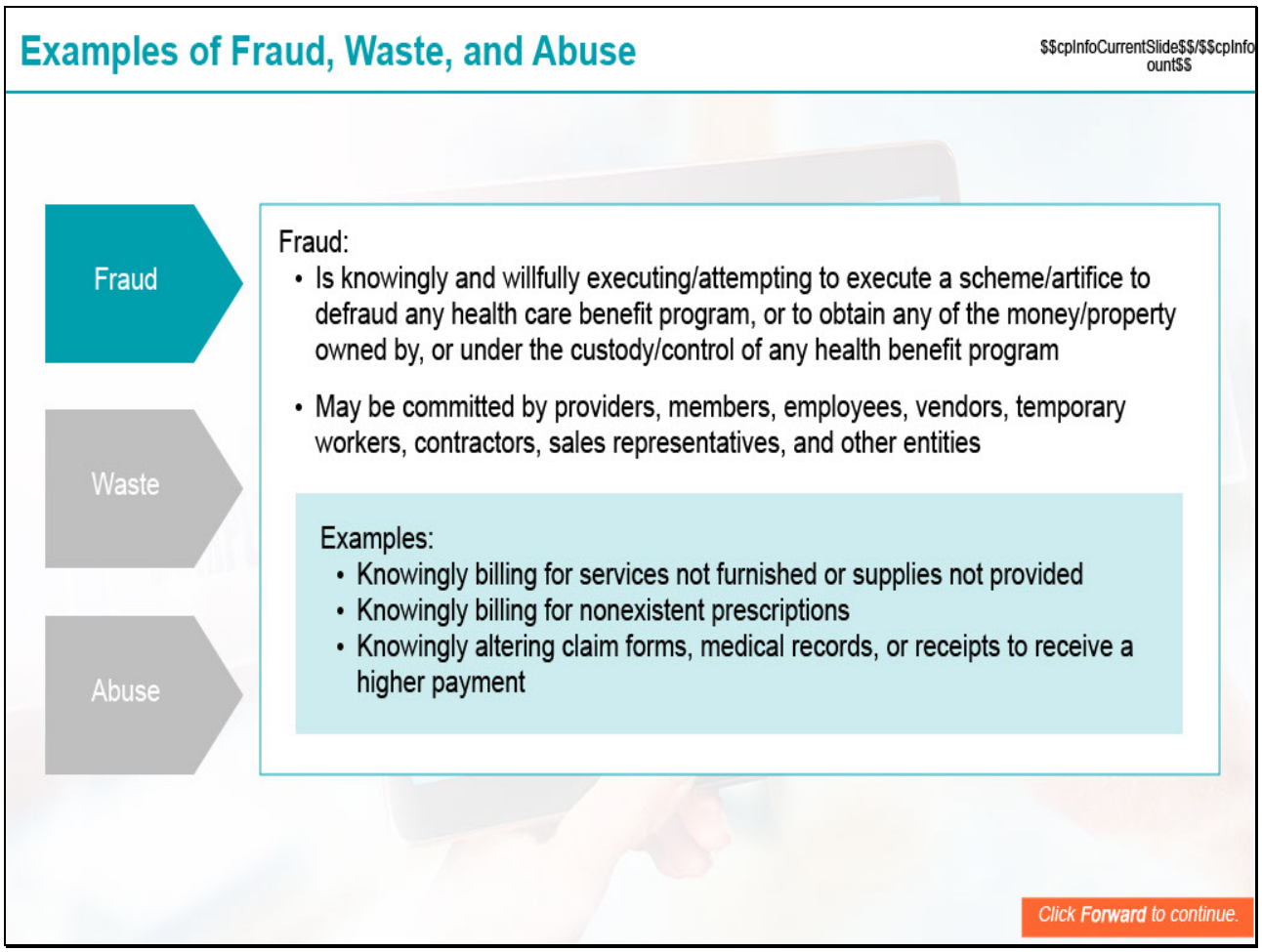


Slide notes

This course will help you become familiar with the definitions and scenarios involving fraud, waste, and abuse and how to help combat potential fraudulent, abusive, or wasteful situations.

Click the Forward button to learn about fraud.

Slide 26



Slide notes

Fraud is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program, or to obtain (using false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any health benefit program.

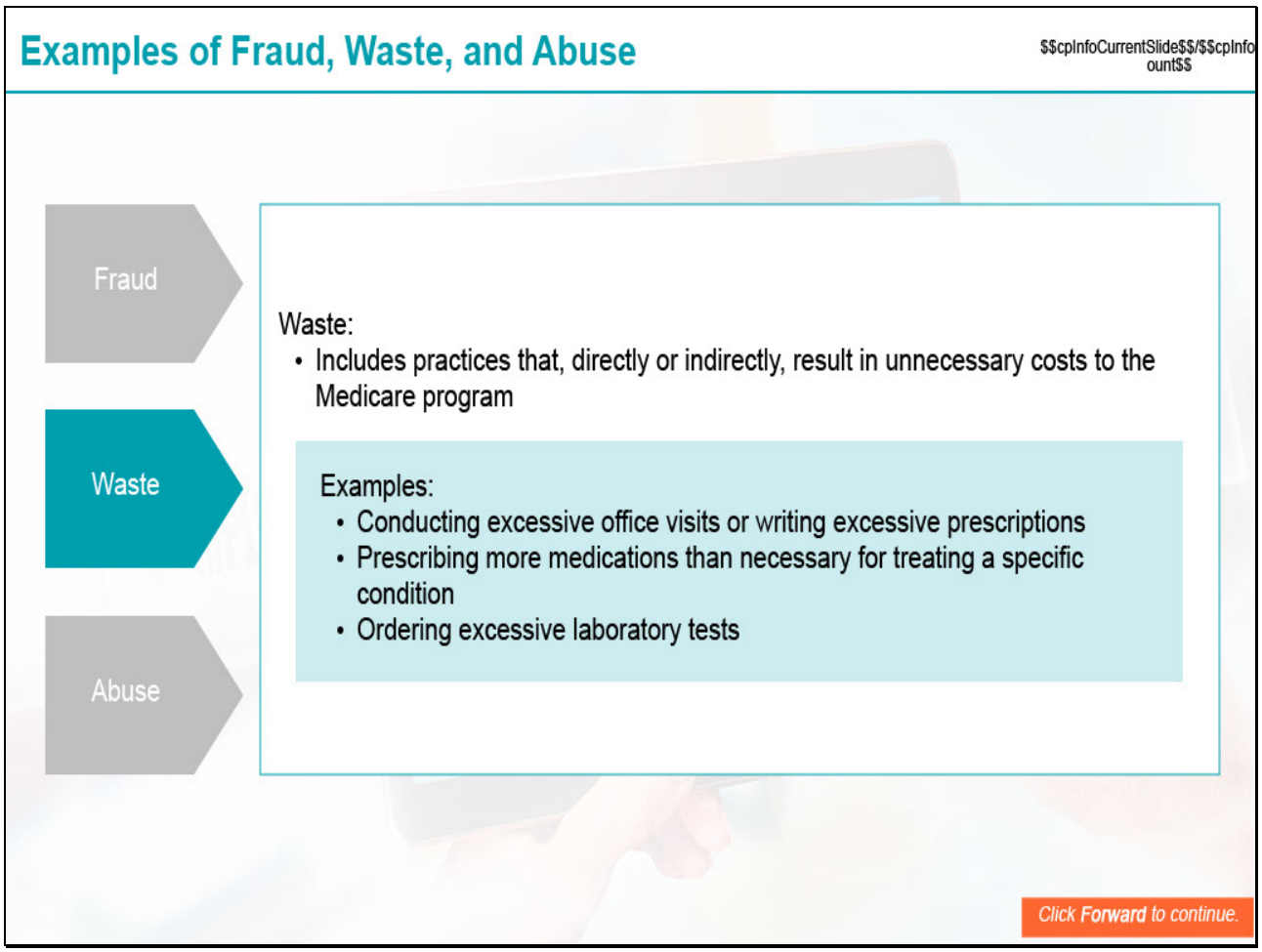
In other words, fraud is intentionally submitting false information to the government or a government contractor to get money or a benefit.

Fraud may be committed by providers, members, employees, vendors, temporary workers, contractors, sales representatives, and other entities.

Examples of actions that may constitute Medicare fraud include knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep; knowingly billing for nonexistent prescriptions; and knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Click the Forward button to next learn about waste.

Slide 27



Slide notes

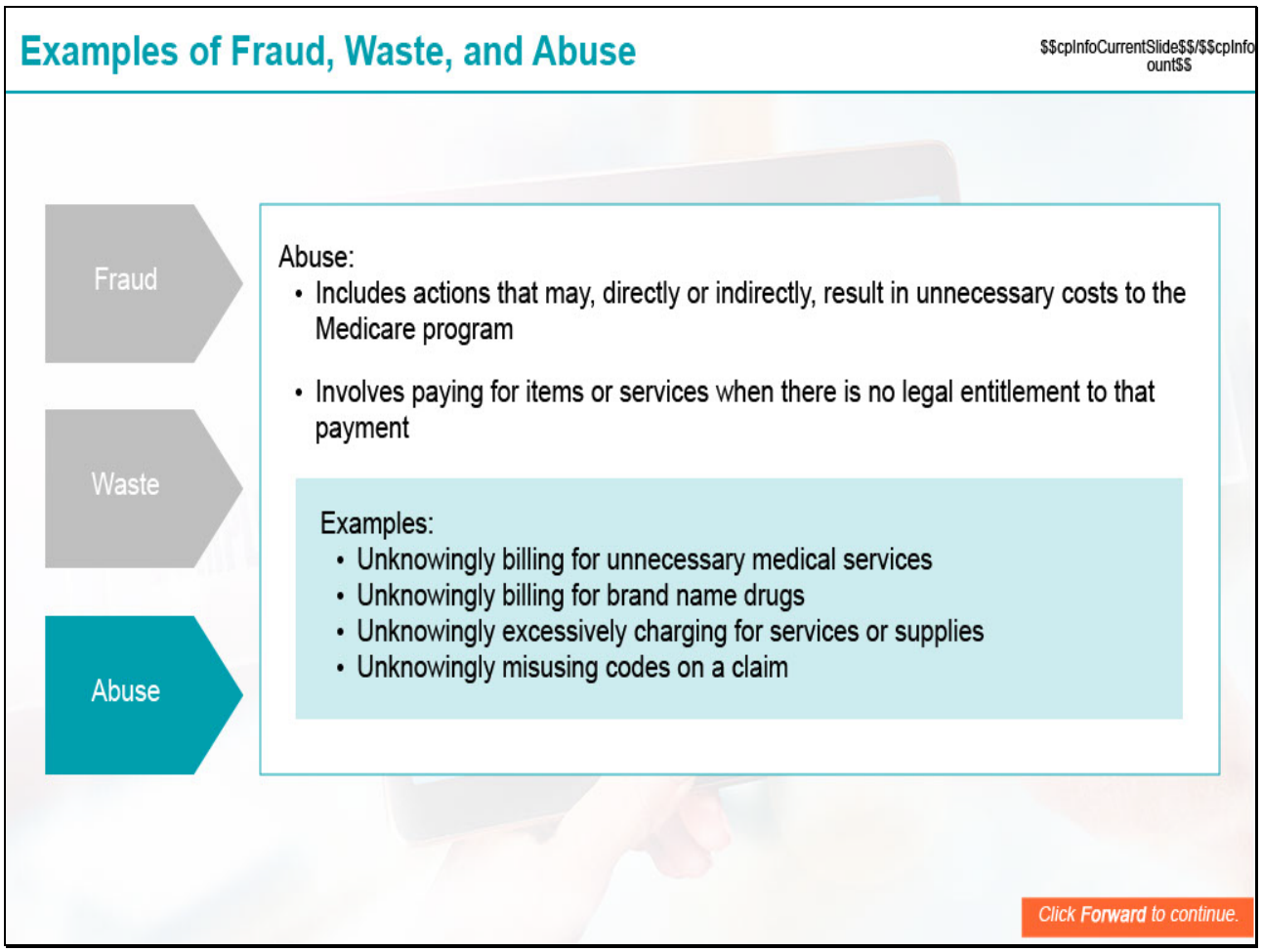
Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare program, such as overusing services.

Waste is generally not considered to be caused by criminally negligent actions, but rather by the misuse of resources.

Examples of actions that may constitute Medicare waste include conducting excessive office visits or writing excessive prescriptions, prescribing more medications than necessary for treating a specific condition, and ordering excessive laboratory tests.

Click the Forward button to next learn about abuse.

Slide 28



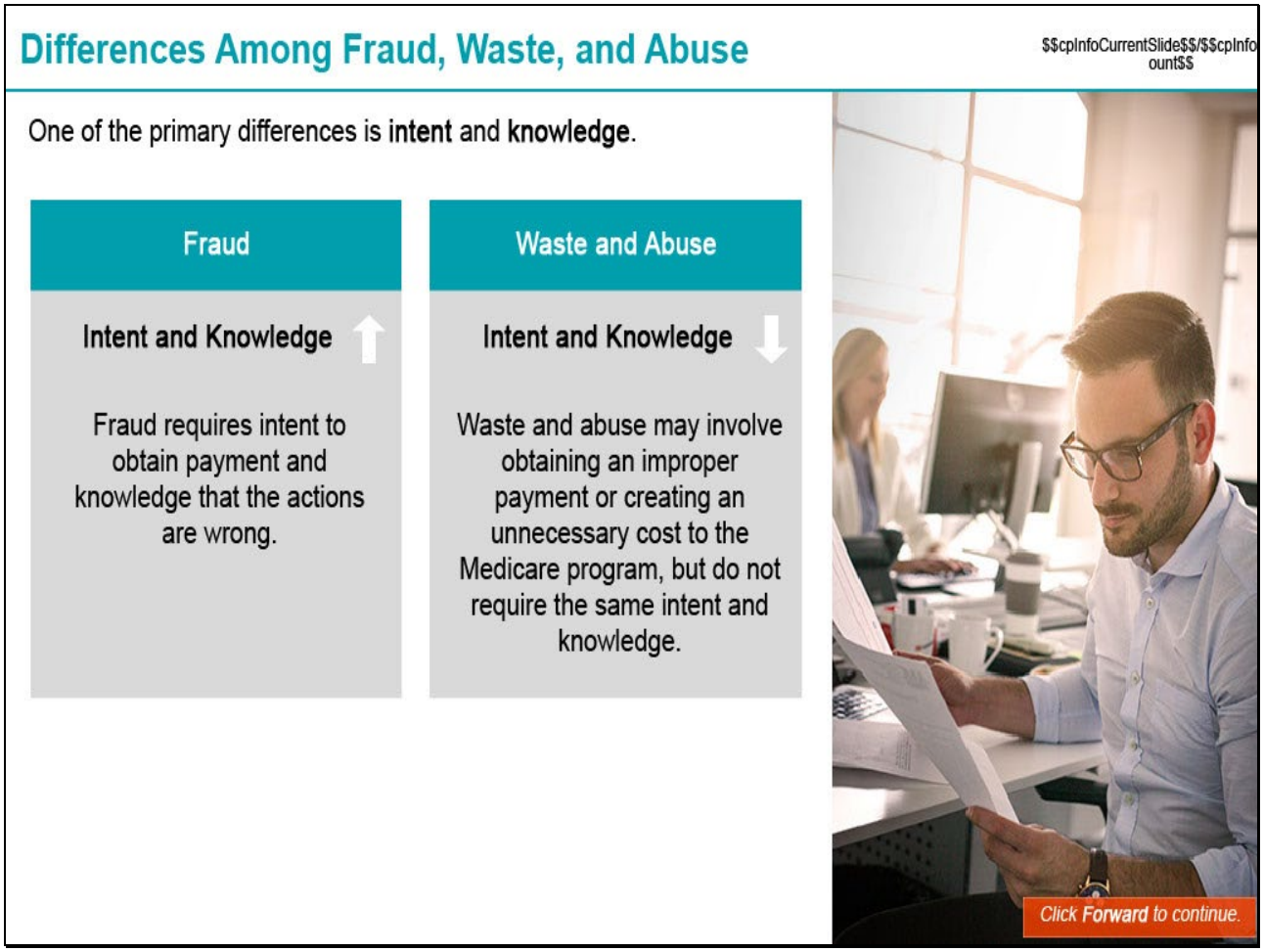
Slide notes

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare program.

Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of actions that may constitute Medicare abuse include unknowingly billing for unnecessary medical services, unknowingly billing for brand name drugs when generics are dispensed, unknowingly excessively charging for services or supplies, and unknowingly misusing codes on a claim, such as upcoding or unbundling codes.

Slide 29



Slide notes

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge.

Fraud requires intent to obtain payment and knowledge that the actions are wrong.

Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare program, but do not require the same intent and knowledge.

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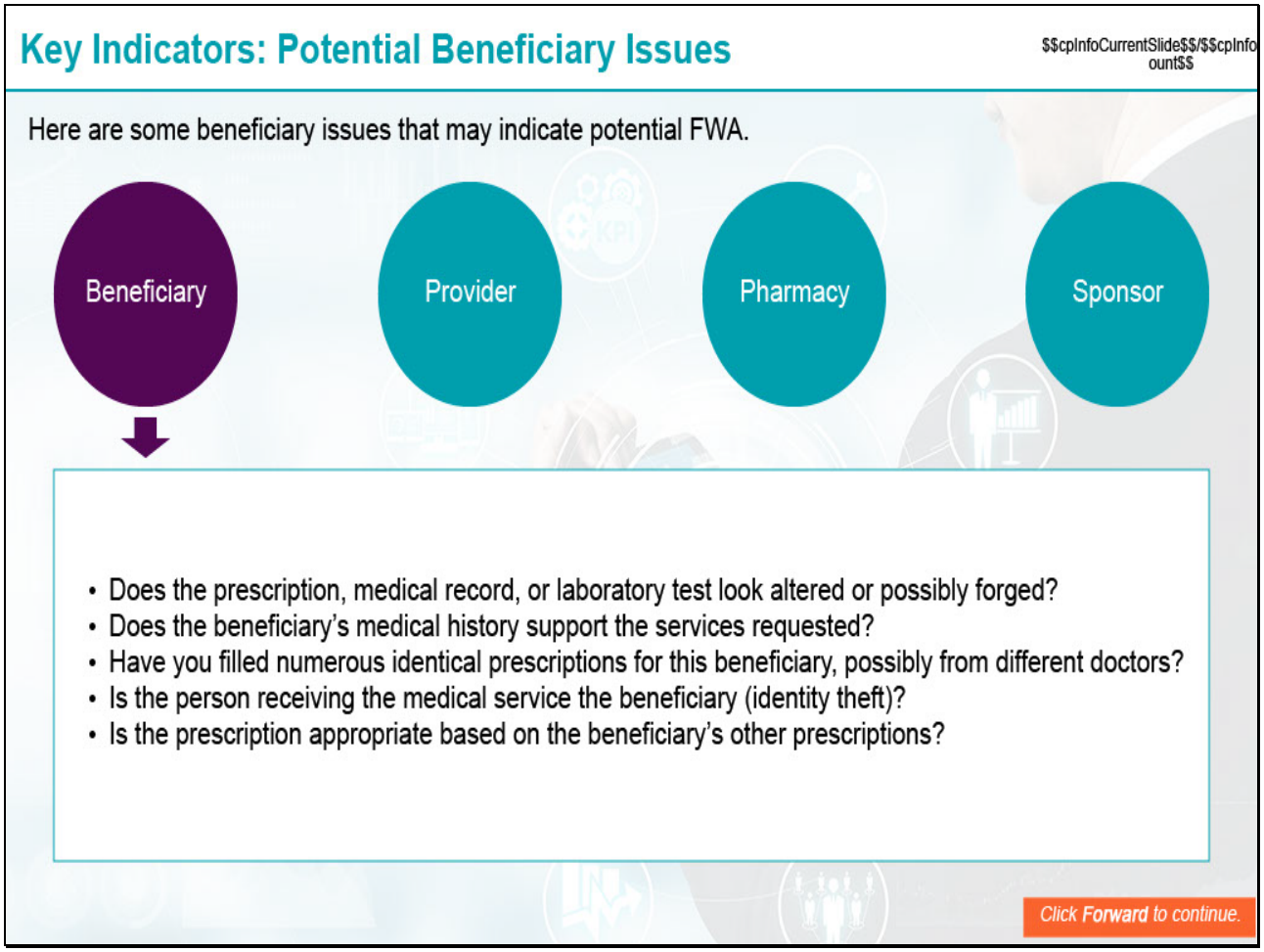
Slide notes

The following sections list some key issues that may indicate signs of FWA at the beneficiary, provider, pharmacy, or Sponsor level.

These lists include questions to ask yourself depending on your role as an employee of a Sponsor, pharmacy, or another entity involved in delivering Medicare Parts C and D benefits to enrollees.

Slide 31



Slide notes

Here are some beneficiary issues that may indicate potential FWA.

Does the prescription, medical record, or laboratory test look altered or possibly forged?

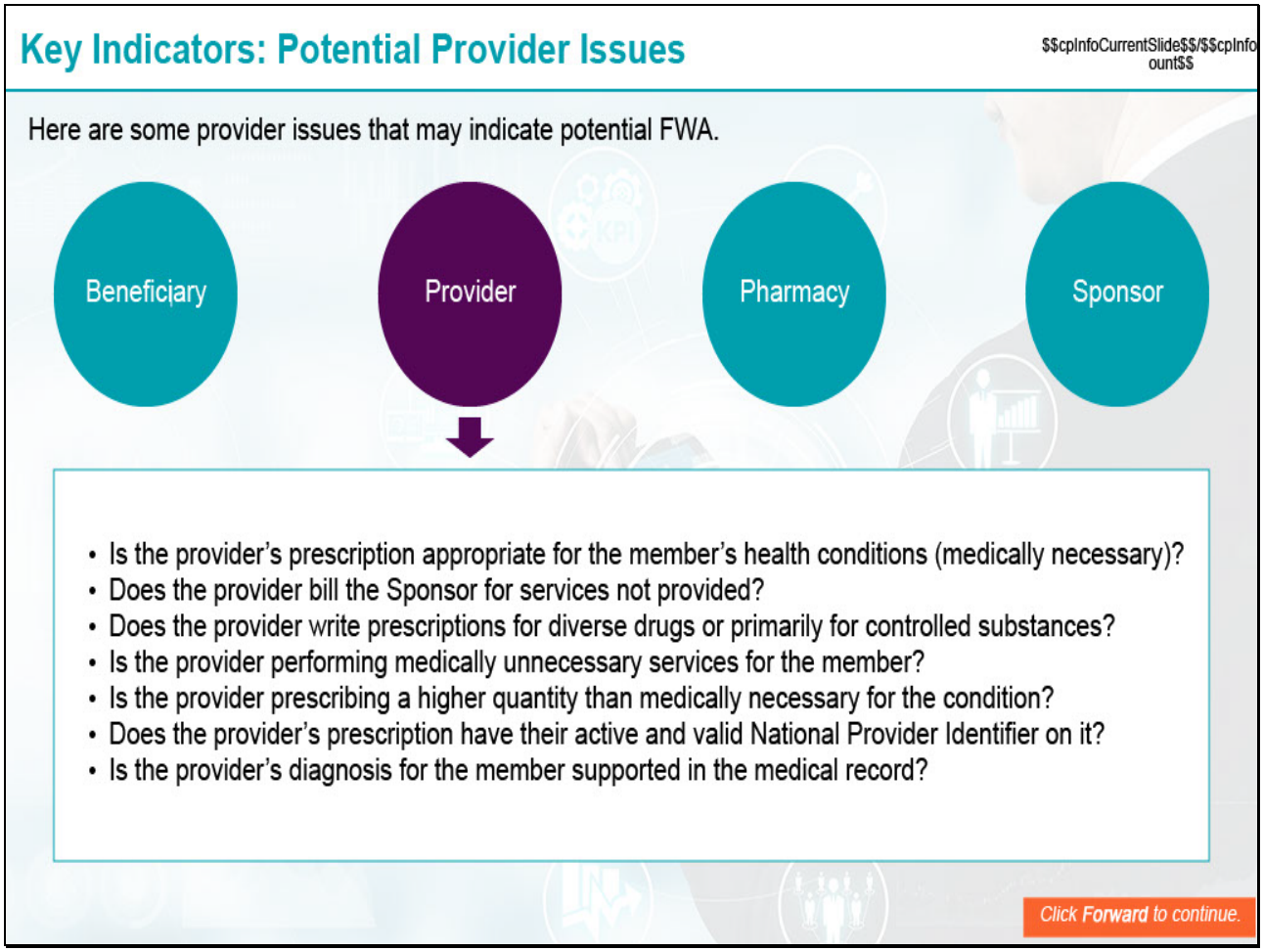
Does the beneficiary's medical history support the services requested?

Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?

Is the person receiving the medical service the beneficiary (or is this a case of identity theft)?

Is the prescription appropriate based on the beneficiary's other prescriptions?

Slide 32



Slide notes

Here are some provider issues that may indicate potential FWA.

Is the provider's prescription appropriate for the member's health conditions? Is it medically necessary?

Does the provider bill the Sponsor for services not provided?

Does the provider write prescriptions for diverse drugs or primarily for controlled substances?

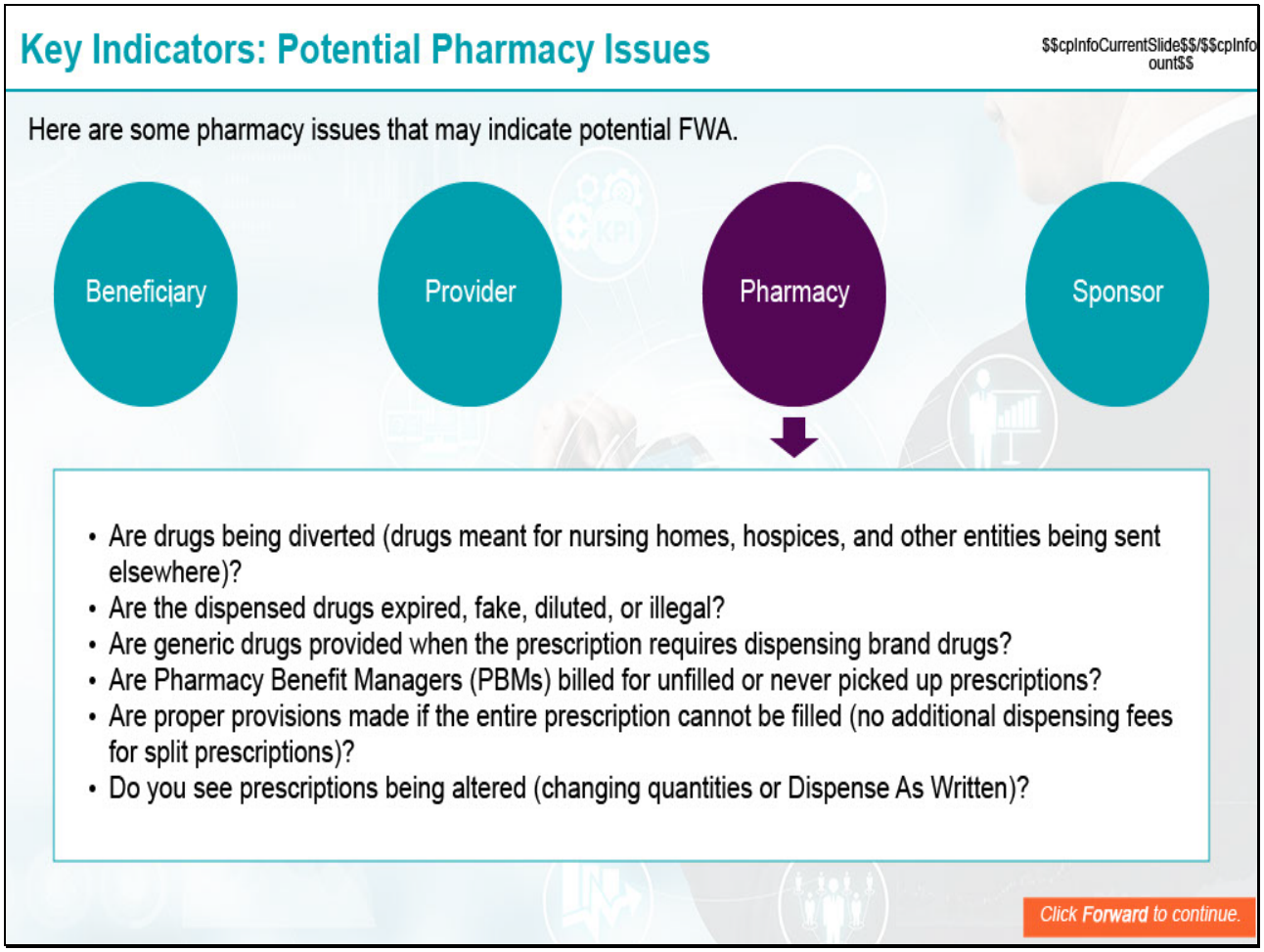
Is the provider performing medically unnecessary services for the member?

Is the provider prescribing a higher quantity than medically necessary for the condition?

Does the provider's prescription have their active and valid National Provider Identifier on it?

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

Slide 33



Slide notes

Here are some pharmacy issues that may indicate potential FWA.

Are drugs being diverted? For example, are drugs meant for nursing homes, hospices, and other entities being sent elsewhere?

Are the dispensed drugs expired, fake, diluted, or illegal?

Are generic drugs provided when the prescription requires dispensing brand drugs?

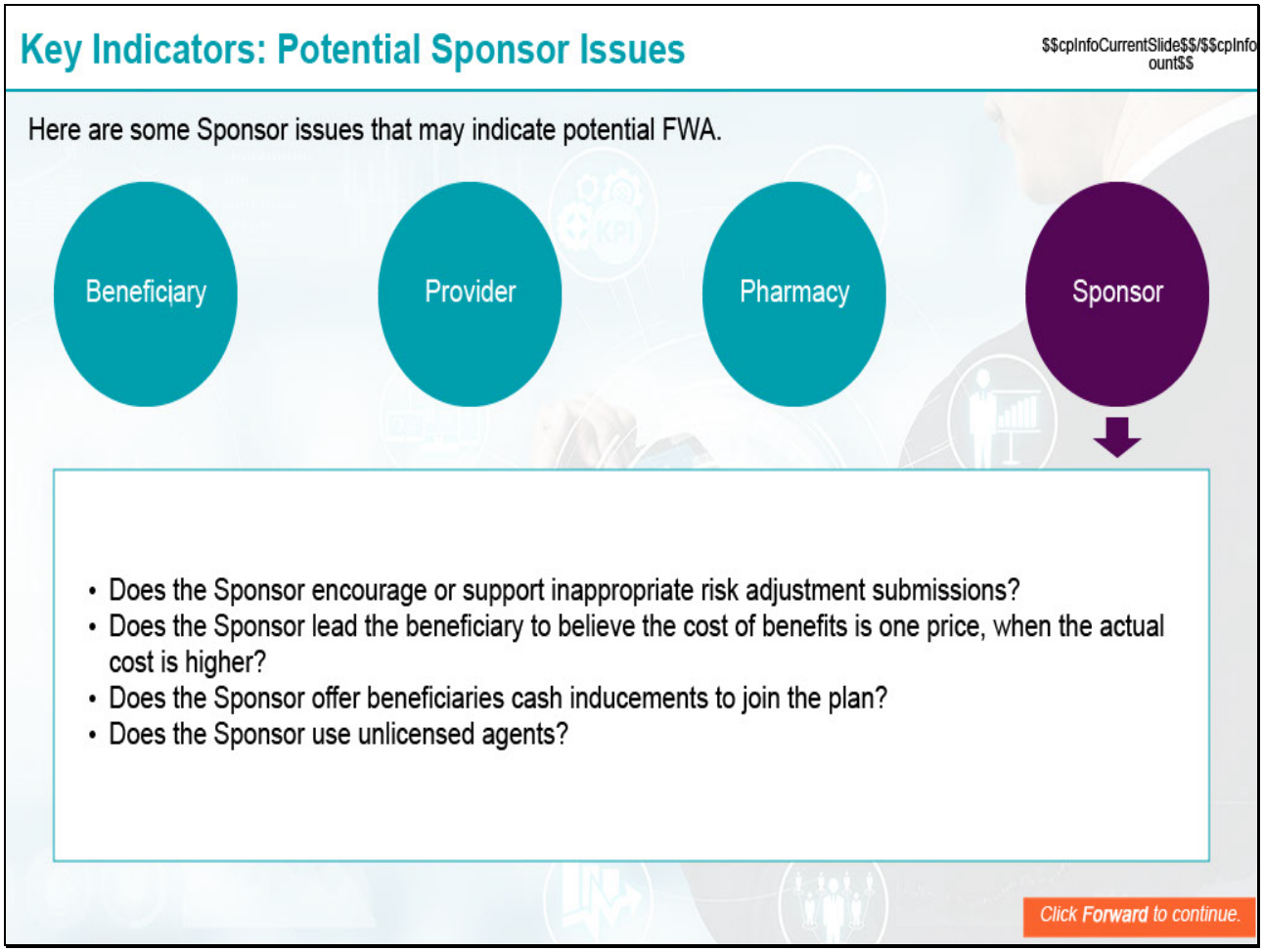
Are Pharmacy Benefit Managers (PBMs) billed for unfilled or never picked up prescriptions?

Are proper provisions made if the entire prescription cannot be filled?

For example, there should not be additional dispensing fees for split prescriptions.

Do you see prescriptions being altered? For example, change in quantities or Dispense As Written?

Slide 34



Slide notes

Finally, here are some Sponsor issues that may indicate potential FWA.

Does the Sponsor encourage or support inappropriate risk adjustment submissions?

Does the Sponsor lead the beneficiary to believe the cost of benefits is one price, when the actual cost is higher?

Does the Sponsor offer beneficiaries cash inducements to join the plan?

Does the Sponsor use unlicensed agents?

Slide 35

Slide notes

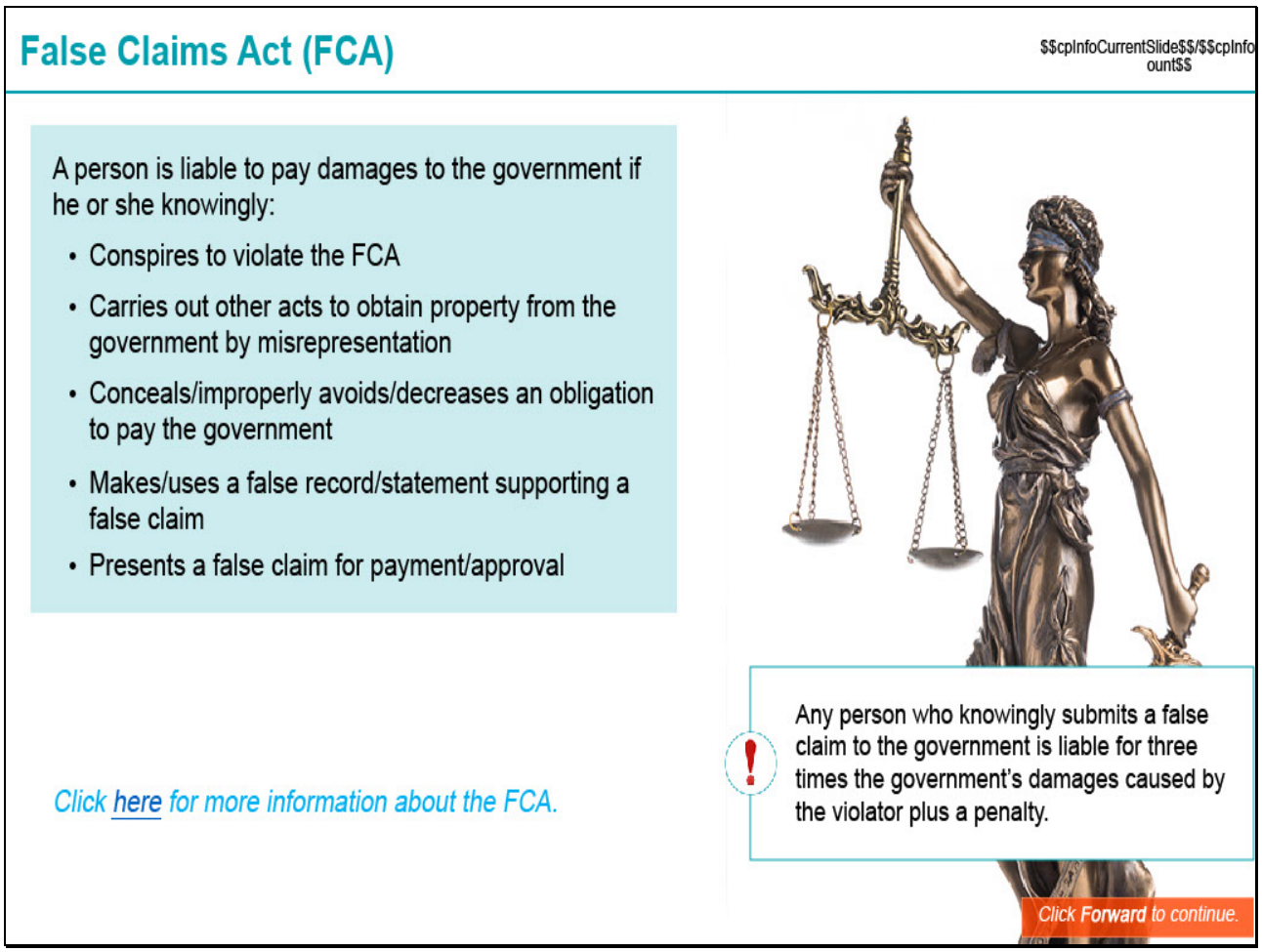
In order to understand how to detect FWA, you need to know the law.

The following slides provide high-level information about applicable laws, including the False Claims Act (FCA); the Criminal Health Care Fraud Statute; the Anti-Kickback Statute; the Stark Law, also known as the Physician Self-Referral Law; the Civil Monetary Penalties (CMP) Law; exclusion from all federal health care programs; and the Health Insurance Portability and Accountability Act, HIPAA.

For details about other specific laws and regulations, such as safe harbor provisions, consult the applicable statute and regulations.

Let’s take a closer look at each of these laws.

Slide 36



Slide notes

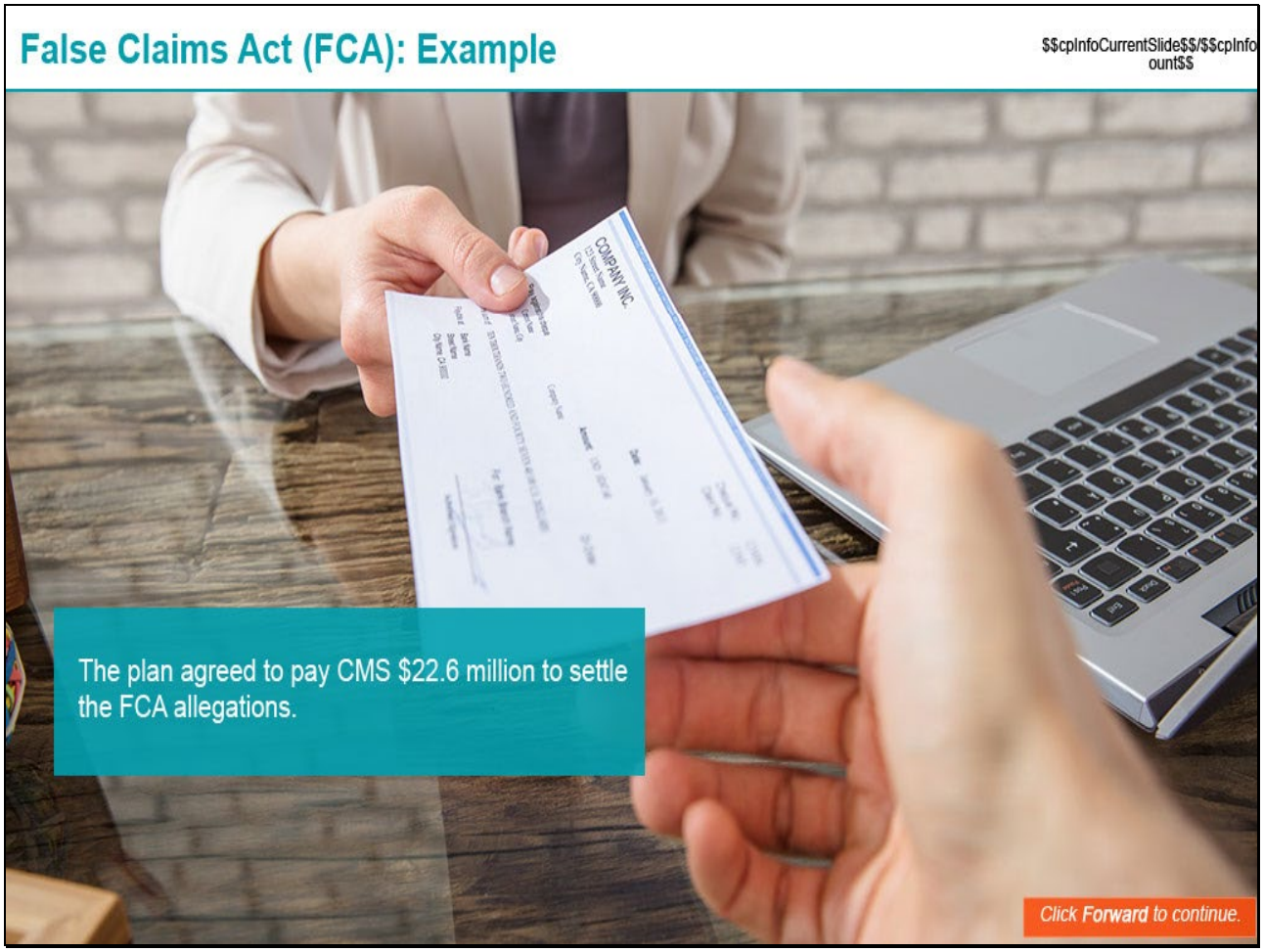
The civil provisions of the FCA make a person liable to pay damages to the government if he or she knowingly conspires to violate the FCA, carries out other acts to obtain property from the government by misrepresentation, conceals or improperly avoids or decreases an obligation to pay the government, makes or uses a false record or statement supporting a false claim, or presents a false claim for payment or approval.

Any person who knowingly submits a false claim to the government is liable for three times the government's damages caused by the violator plus a penalty.

Click the link on your screen to view more information about the FCA.

Click the Forward button to look at an example of the FCA law.

Slide 37



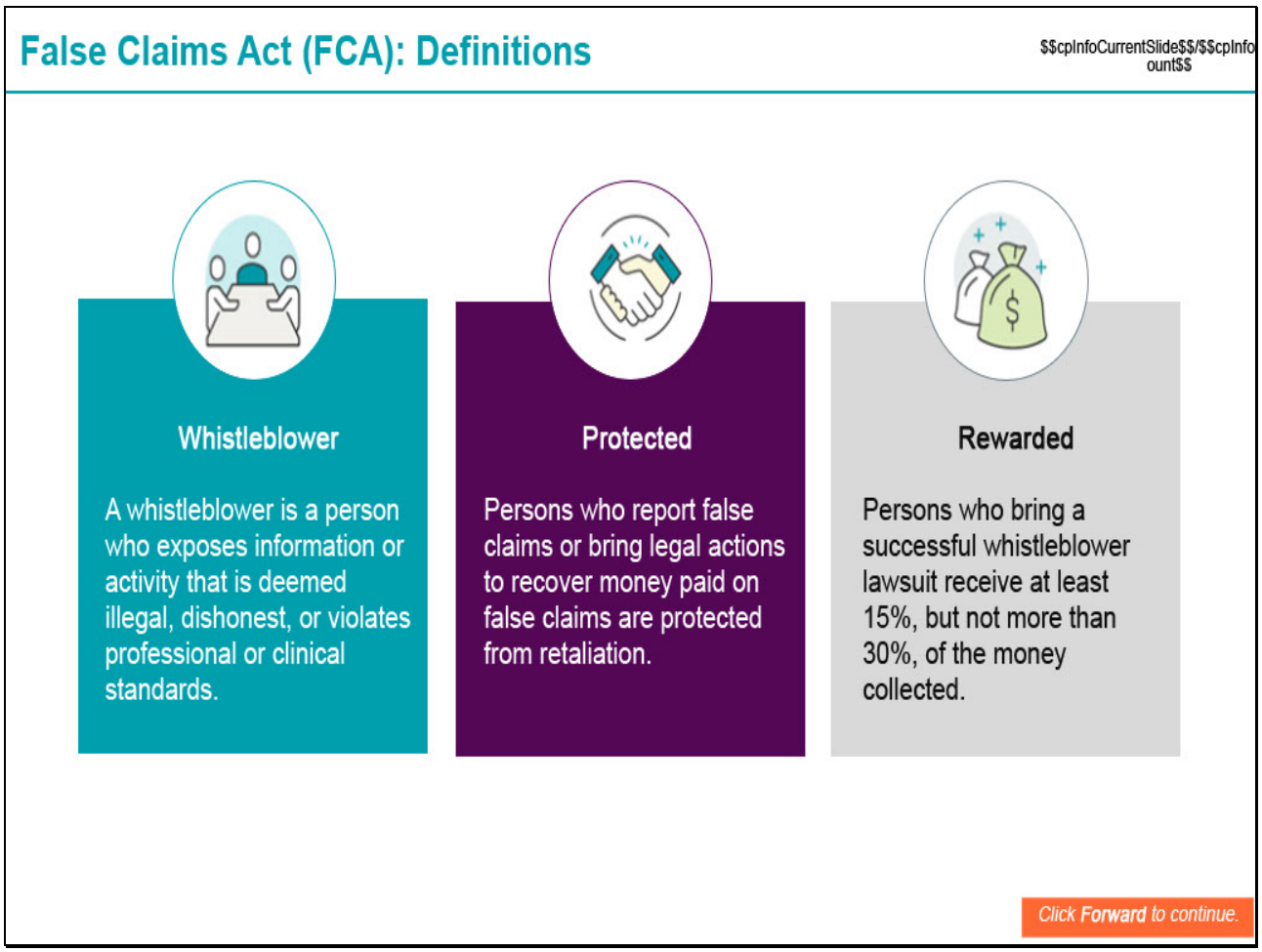
Slide notes

A Medicare Part C plan in Florida hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS.

The plan was informed by the vendor that certain diagnosis codes previously submitted to CMS were undocumented or unsupported, and yet the plan failed to report these unsupported codes to CMS.

The plan agreed to pay CMS $22.6 million to settle the FCA allegations.

Slide 38



Slide notes

Let’s review some definitions applicable to the civil FCA.

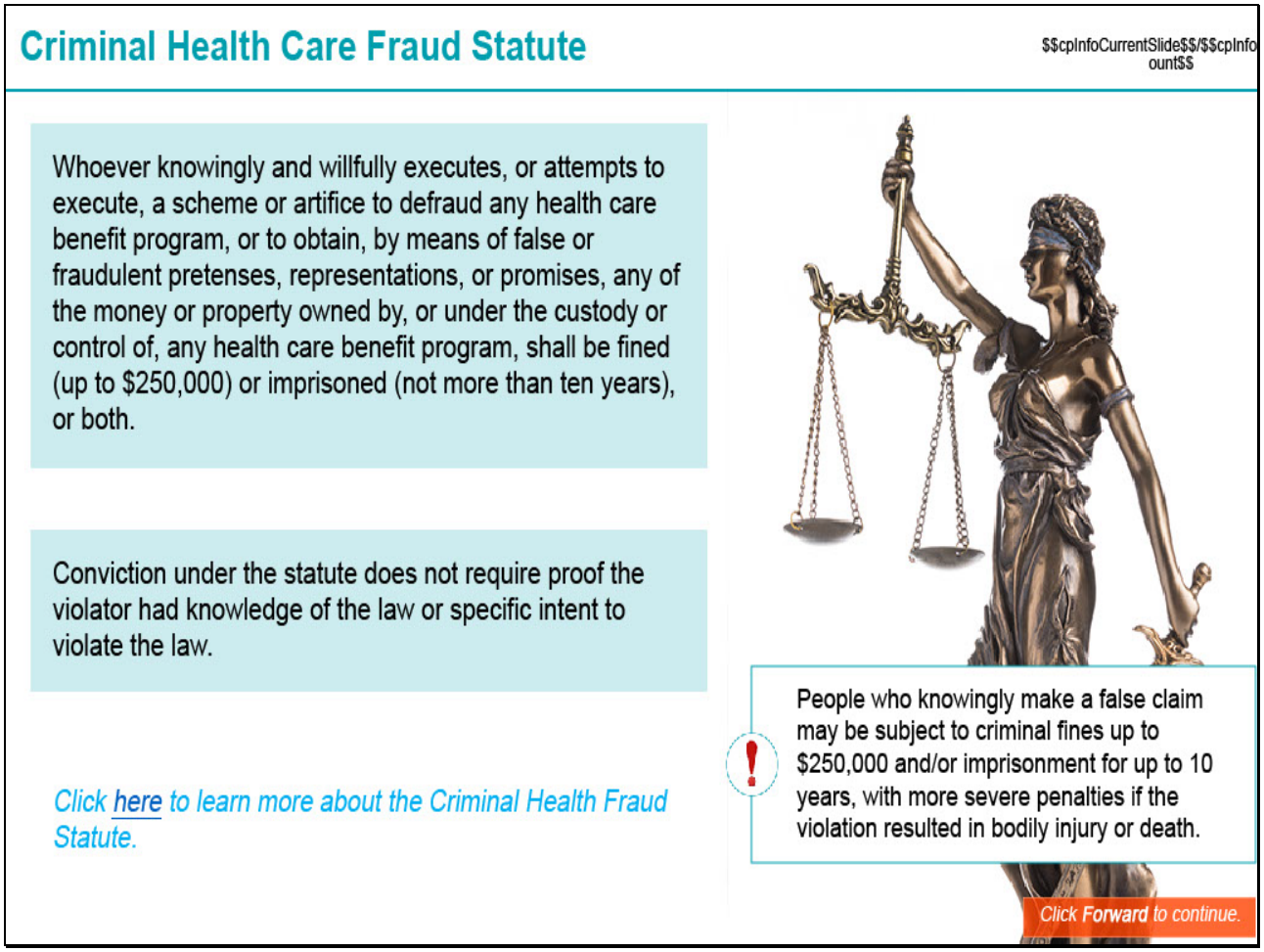
A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected means persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded means persons who bring a successful whistleblower lawsuit receive financial compensation, usually between 15-30% of the money collected.

Click the Forward button to learn about the Criminal Health Care Fraud Statute.

Slide 39



Slide notes

The Criminal Health Care Fraud Statute states that “Whoever knowingly and willfully executes, or attempts 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, shall be fined (up to $250,000) or imprisoned not more than 20 years, or both.”

Conviction under the statute does not require proof the violator knew the law or had specific intent to violate the law.

If the violation results in serious bodily injury, such person shall be fined under this title or imprisoned for any term of years or for life, or both. and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

Click the link on your screen to learn more about the Criminal Health Care Fraud Statute.

Click the Forward button to look at an example of the Criminal Health Care Fraud Statute.

Slide 40

Slide notes

Minal Patel, the owner of LabSolutions LLC, was recently sentenced to 27 years in prison and ordered to forfeit over $187 million related to health care fraud.

This included a Ferrari Spider sportscar, a Range Rover, real estate properties, and $30 million dollars in personal and corporate bank accounts.

The owner conspired to target Medicare members with false information, misleading them into signing up for expensive cancer genetic testing.

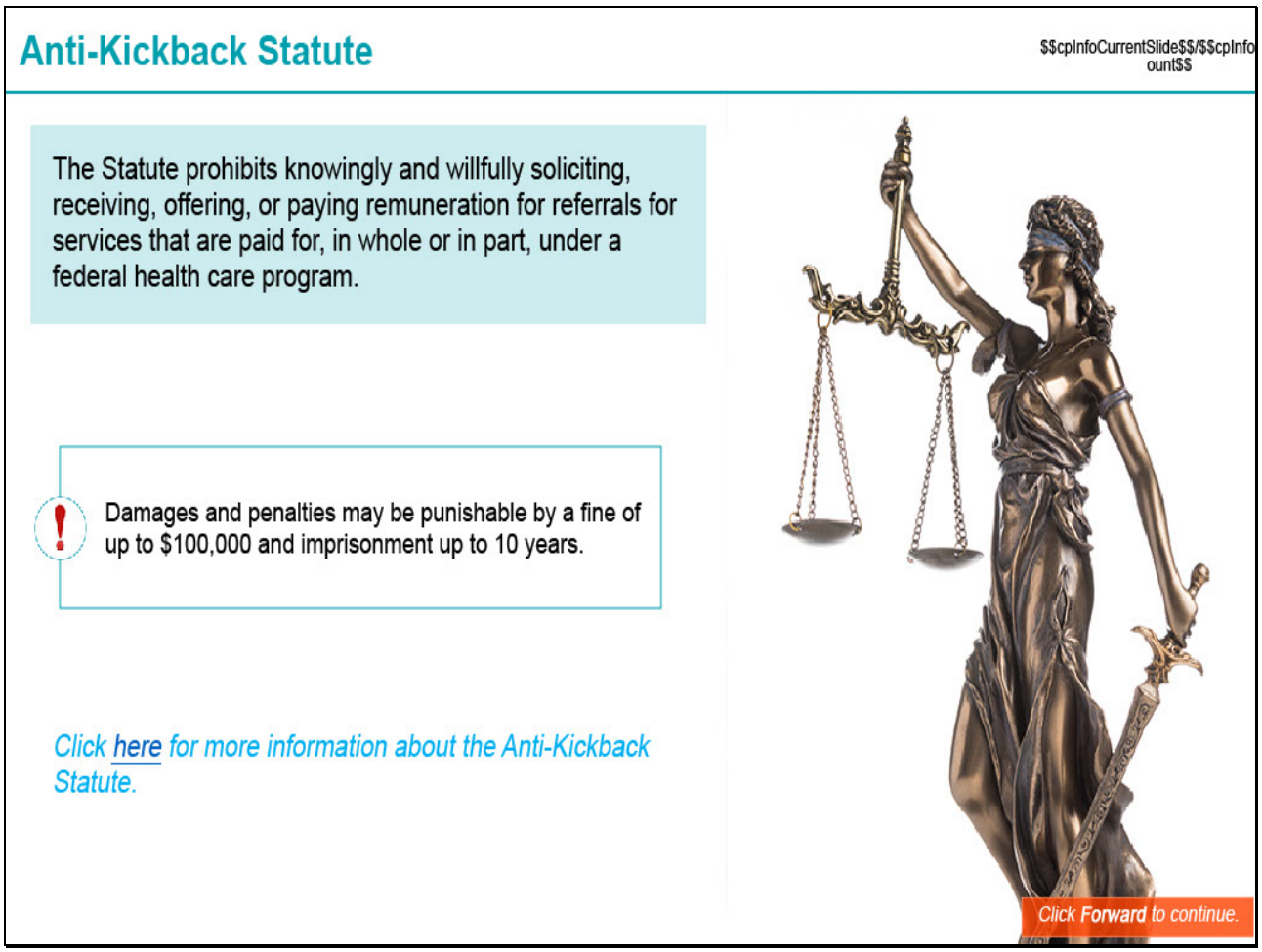
Once members agreed to the test, Patel paid kickbacks to patient brokers who provided signed doctors' orders authorizing the tests.

The patient brokers were then required to sign bogus contracts that erroneously stated the brokers were conducting advertising services for the lab company.

From July 2016 through August 2019, Medicare paid over $187 million for these unnecessary genetic tests.

Click the Forward button to learn about the Anti-Kickback Statute.

Slide 41



Slide notes

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 for, in whole or in part, under a federal health care program (including the Medicare program).

Damages and penalties may be punishable by a fine of up to $100,000 and imprisonment up to 10 years.

Click the link on your screen to view more information about the Anti-Kickback Statute.

Click the Forward button to look at an example of the Anti-Kickback Statute.

Slide 42

Slide notes

A Massachusetts-based web development firm agreed to an $18.25 million settlement to resolve claims that it paid kickbacks to promote sales of its Electronic Health Record (EHR) product.

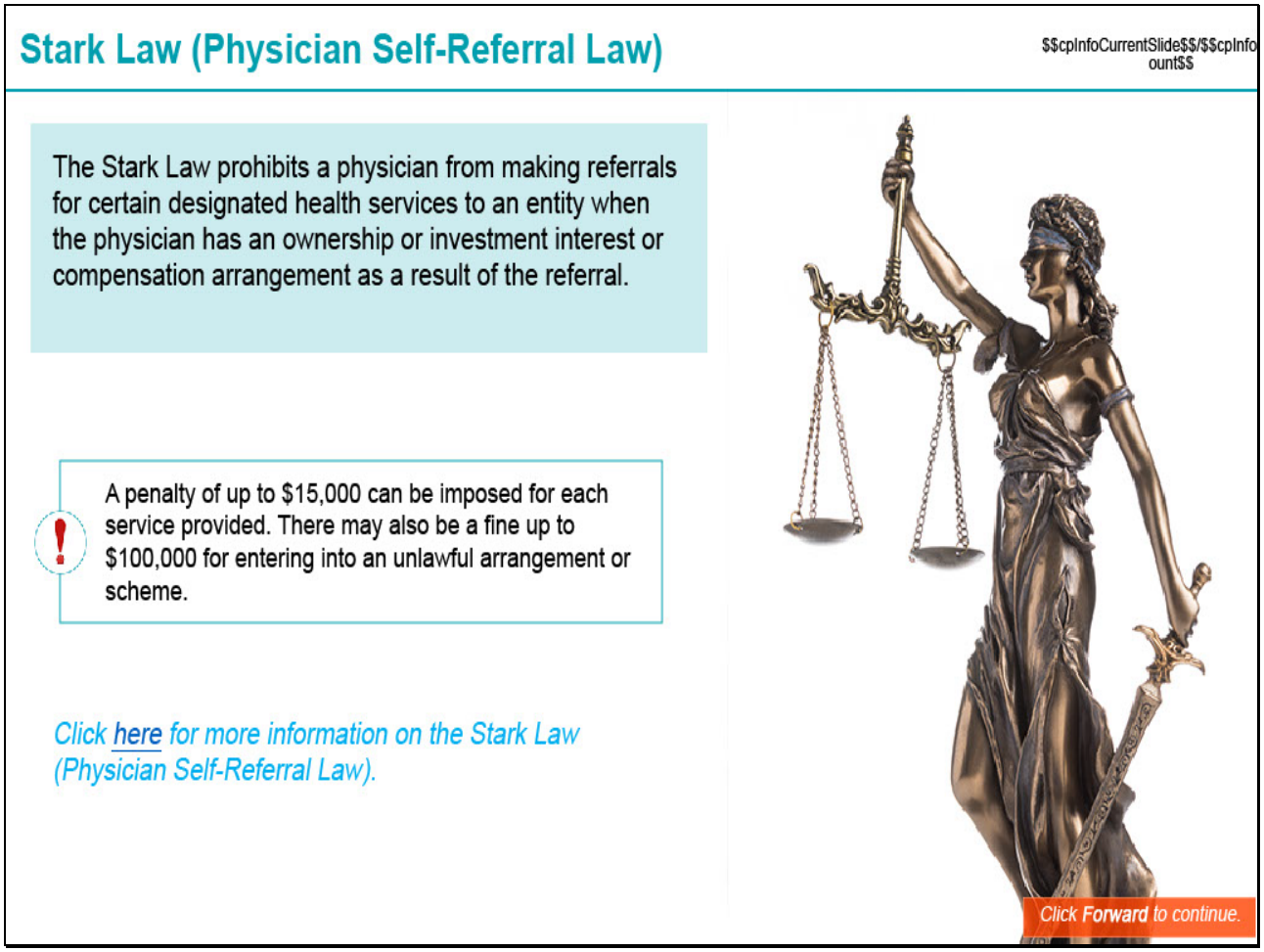
One allegation stated that the firm used unlawful marketing techniques to promote its EHR product including inviting prospective customers to all-inclusive, all-expense-paid sporting, entertainment, and recreational events with travel and luxury accommodations.

The second allegation was that the firm paid illegal bribes of around $3,000 to its customers for “lead generation” regardless of whether they generated leads for the firm.

Finally, the firm allegedly targeted other companies that were discontinuing their health information technology products and offered to pay them for successful customer referrals to its product.

Click the Forward button to learn about the Stark Law.

Slide 43



Slide notes

The Stark Law, also referred to as the Physician Self-Referral law, prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of the physician's family) has an ownership or investment interest or compensation arrangement as a result of the referral.

Medicare claims tainted by an arrangement that does not comply with the Stark Law are not payable.

A penalty of up to $15,000 can be imposed for each service provided.

There may also be a fine up to $100,000 for entering into an unlawful arrangement or scheme.

Click the link on your screen for more information on the Stark Law (Physician Self-Referral Law).

Click the Forward button to look at an example of the Stark Law.

Slide 44 - Slide 44

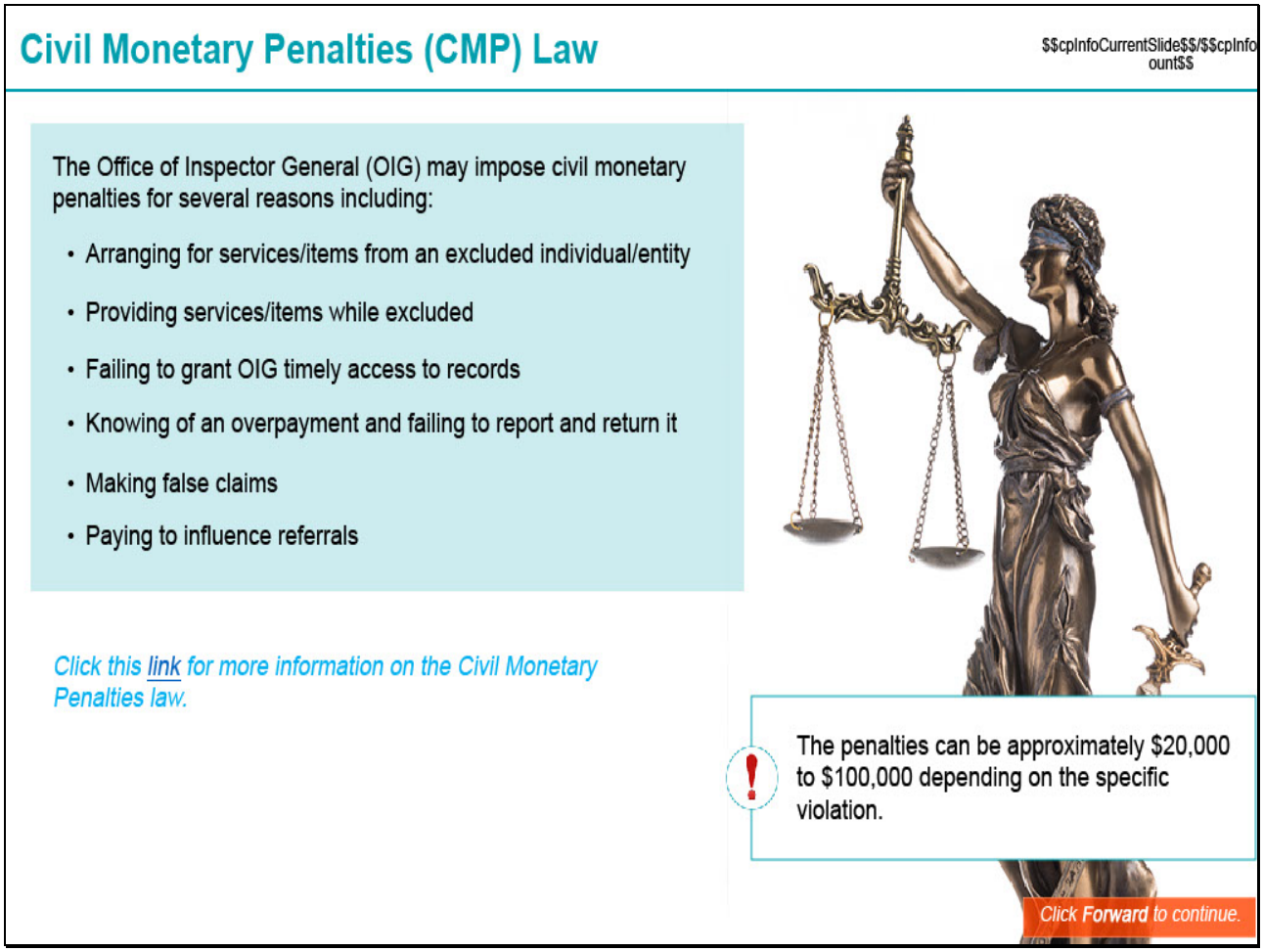
Slide notes

An Indiana hospital paid $3.6 million to resolve allegations that it paid kickbacks to two doctors in exchange for patient referrals.

Allegations state that the hospital, under the direction of its management organization, provided personal loans to two physicians without requiring repayment for more than two years after the loans had matured in an attempt to boost referrals of patients from the two providers.

Click the Forward button to learn about the Civil Monetary Penalties (CMP) Law.

Slide 45



Slide notes

The Office of Inspector General (OIG) may impose civil monetary penalties for several 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.

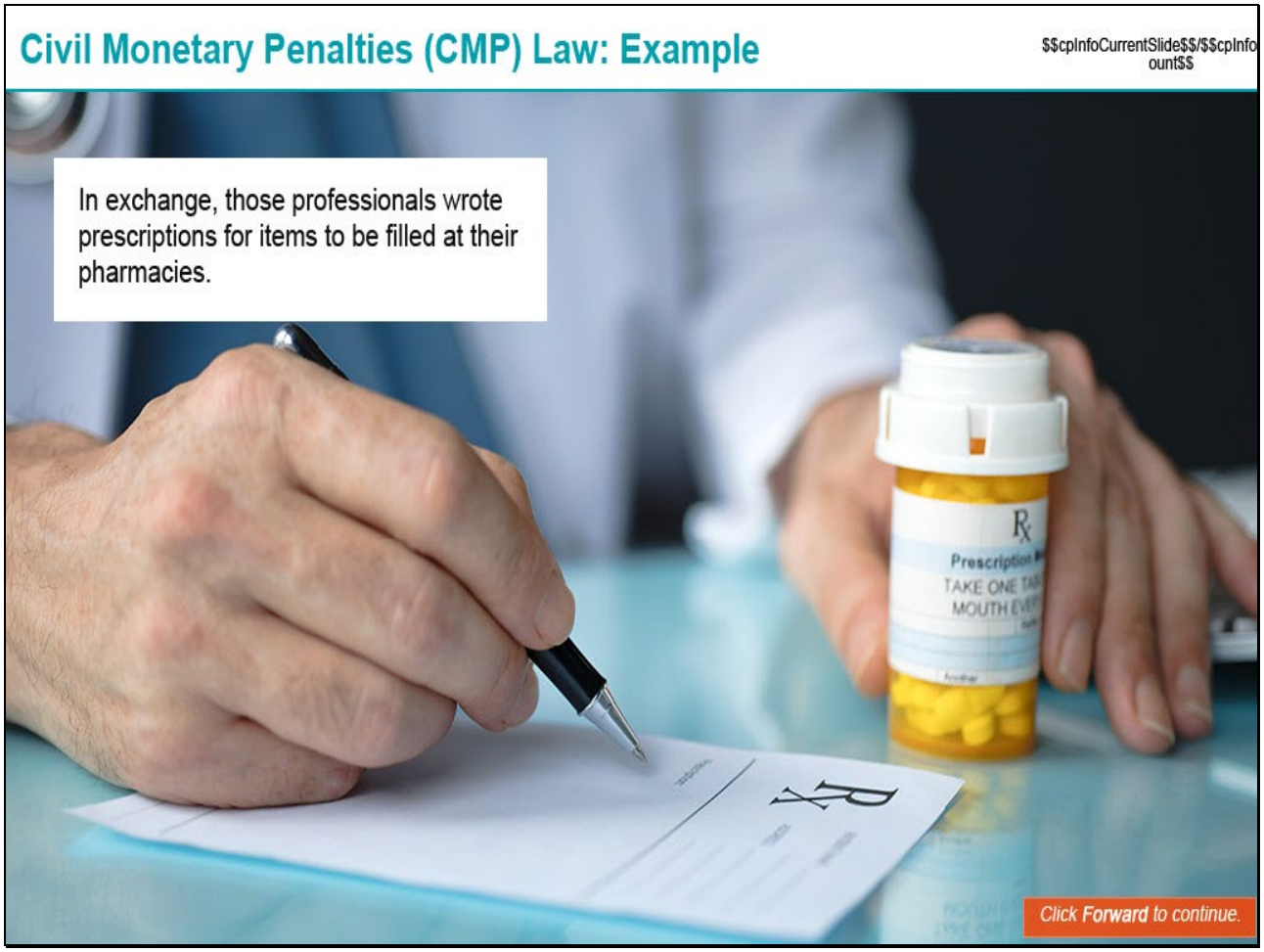
The penalties can be approximately $20,000 to $100,000 depending on the specific violation.

Violators are also subject to three times the amount:

Claimed for each service or item or of remuneration offered, paid, solicited, or received.

Click the link on your screen for more information on the Civil Monetary Penalties law.

Slide 46

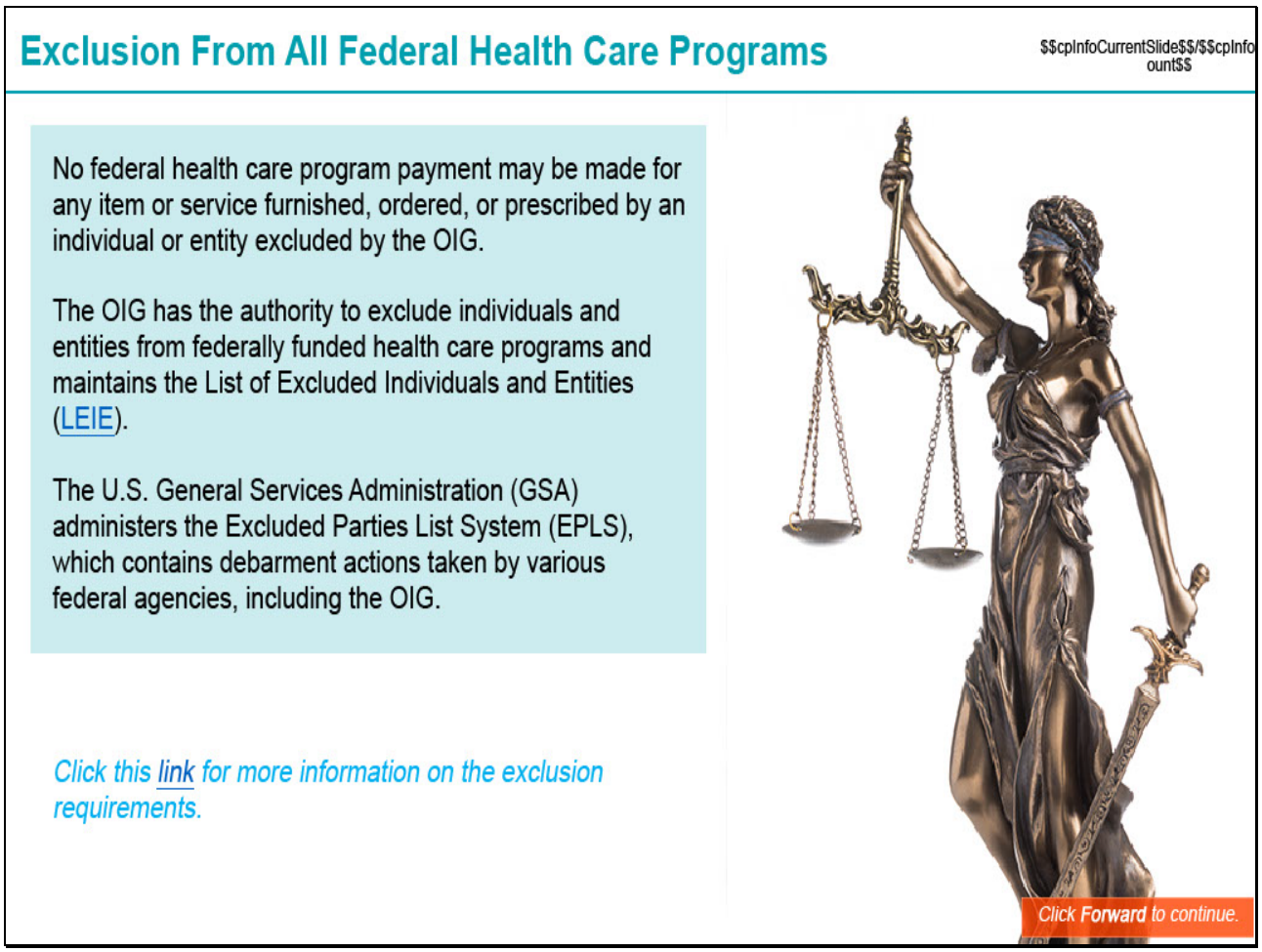


Slide notes

In Puerto Rico, a major retail pharmacy paid $512,000 to settle allegations that it paid remuneration to health care professionals in the form of discounts on retail purchases at their stores when those professionals wrote prescriptions for items to be filled at their pharmacies.

Click the Forward button to learn about the Exclusion law.

Slide 47



Slide notes

No federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG.

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

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various federal agencies, including the OIG.

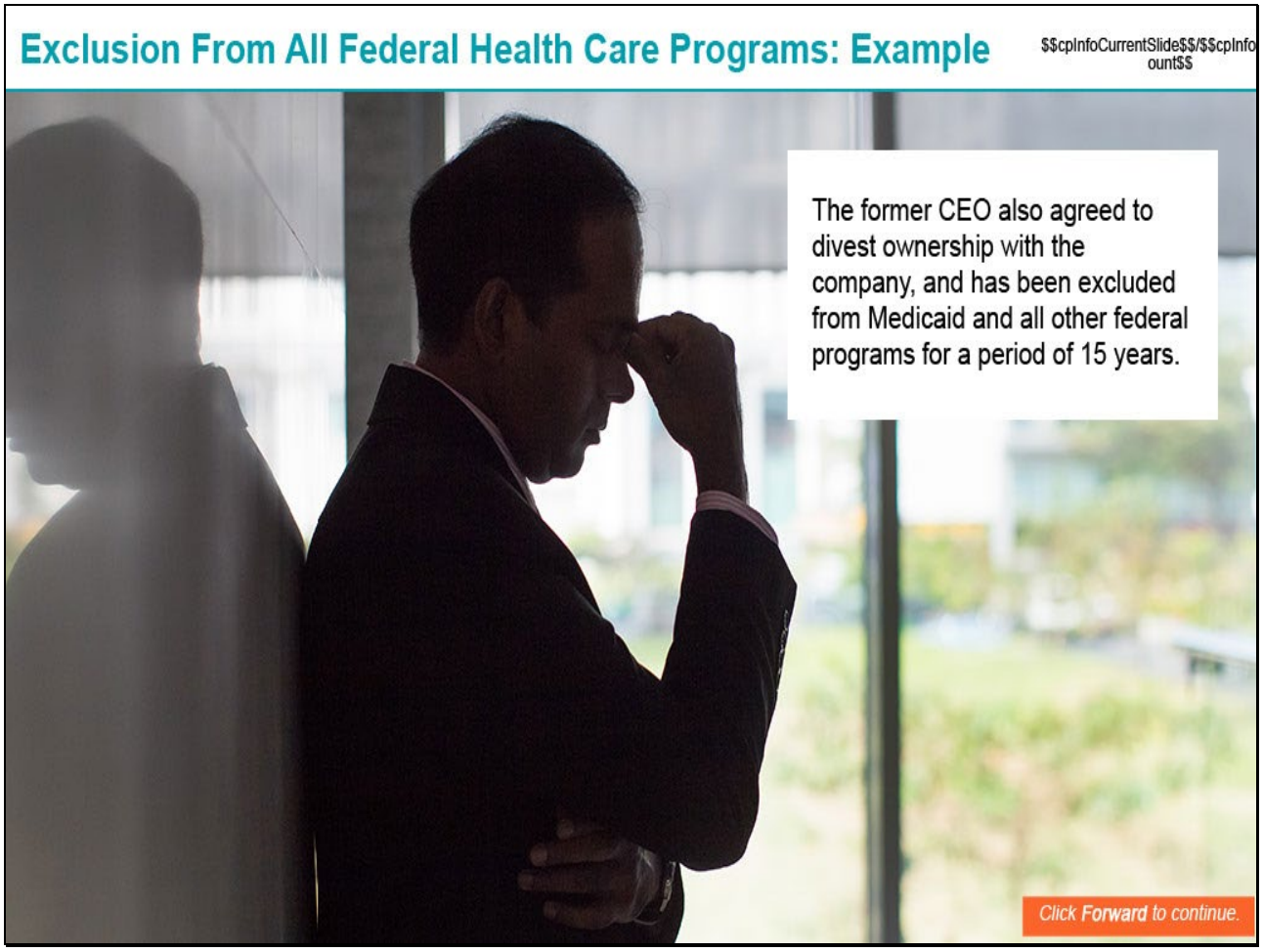
You may access the EPLS on the System for Award Management (SAM) website.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same.

Click the link on your screen for more information on the exclusion requirements.

Click the Forward button to look at an example of this.

Slide 48



Slide notes

A New York City substance abuse treatment facility and its owner reached a $6 million settlement in December 2020 resolving charges that the center provided kickbacks and used fraudulent means to enroll patients into their treatment center to bill Medicaid.

Allegations state that the center targeted homeless individuals, bribing them with food, cash, and other goods to entice them into enrolling in the center's treatment program.

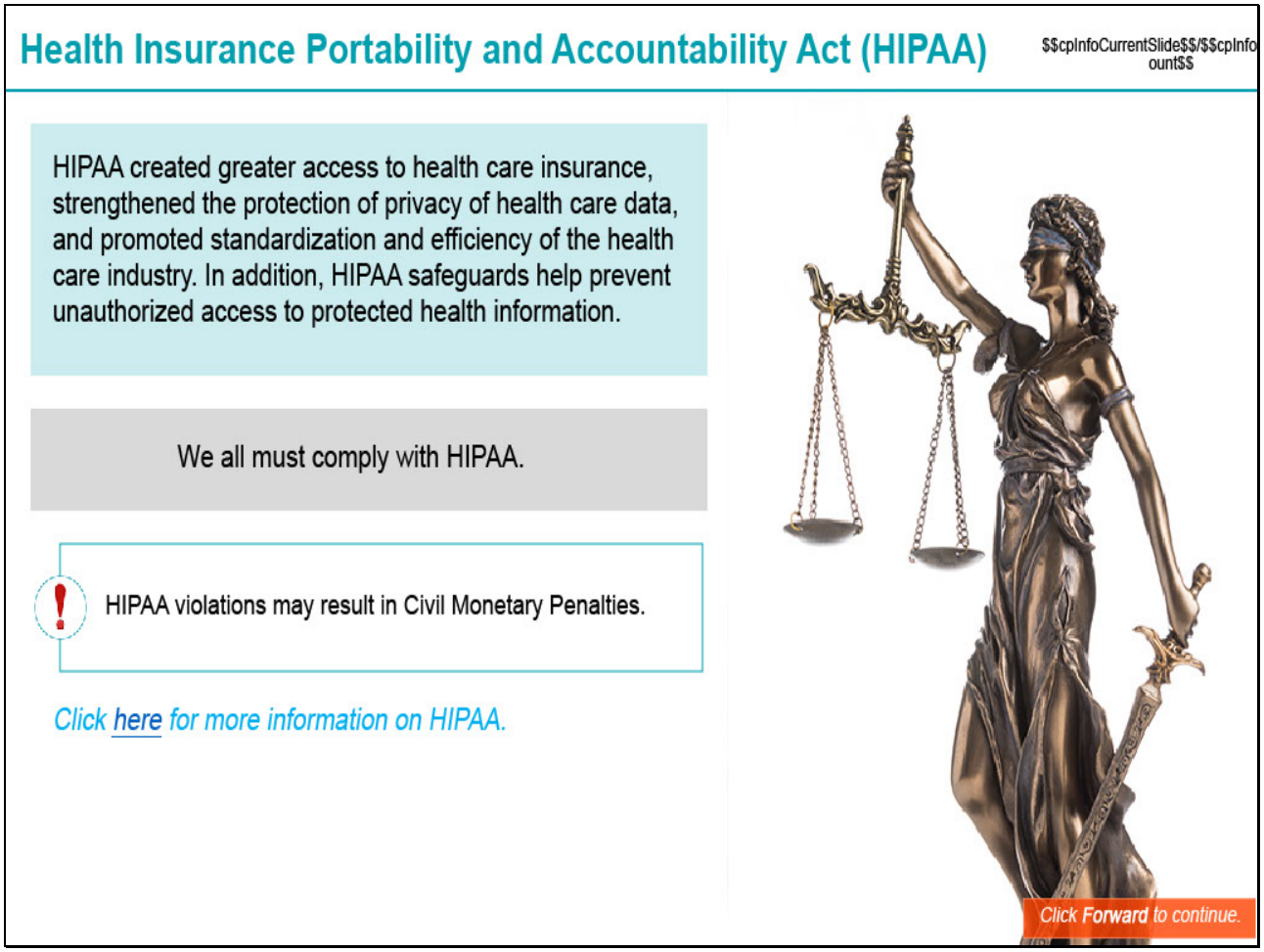
A second allegation states that the center created sham employment for a woman tasked with referring patients to the center's programs.

Finally, the lawsuit states that the center used photocopied physicians' signatures on its admission forms to give the appearance that its new patients were being evaluated by qualified health professionals.

Of the $6 million settlement, half of those funds were charged to the former CEO and primary owner personally.

The former CEO also agreed to divest ownership with the company and has been excluded from Medicaid and all other federal programs for a period of 15 years.

Slide 49



Slide notes

The Health Insurance Portability and Accountability Act created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency of the health care industry.

HIPAA safeguards also help prevent unauthorized access to protected health information.

As individuals with access to protected health information, we must all comply with HIPAA.

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

Click the link on your screen to visit the HIPAA webpage.

Click the Forward button to look at an example of HIPAA.

Slide 50

Slide notes

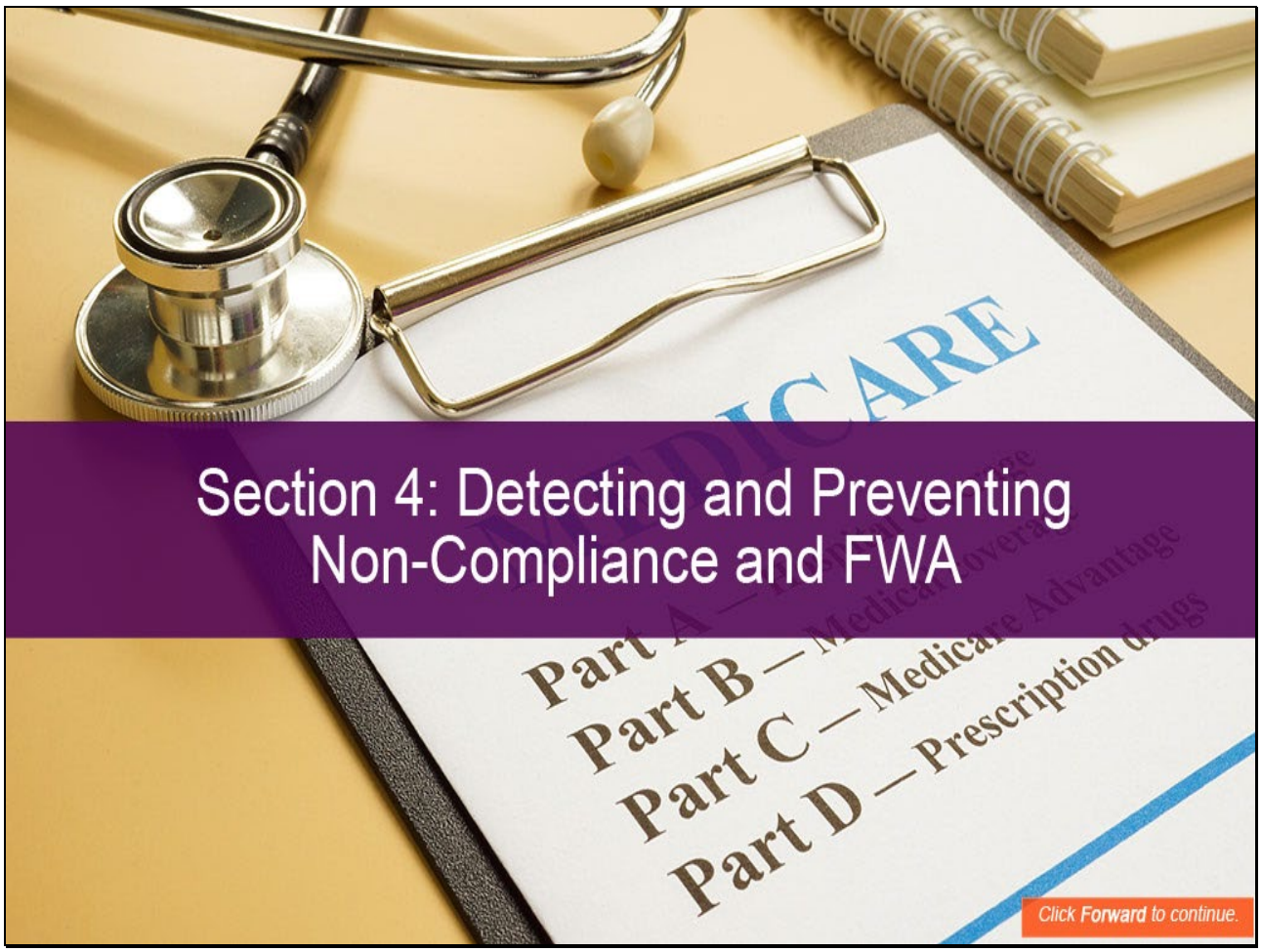
An Arizona man, Rico Prunty, was recently sentenced to 54 months in prison and ordered to pay approximately $132,000 in restitution after pleading guilty to aggravated identity theft.

Prunty used his employment at an Arizona medical facility as an opportunity to unlawfully access medical intake forms to obtain patients' individually identifiable information.

He then provided this information to co-conspirators in Indiana who used the stolen information to open new credit card accounts and access existing credit card accounts without patients' knowledge.

Between July 2014 and May 2017, Prunty accessed nearly 500 patient files.

Slide 51

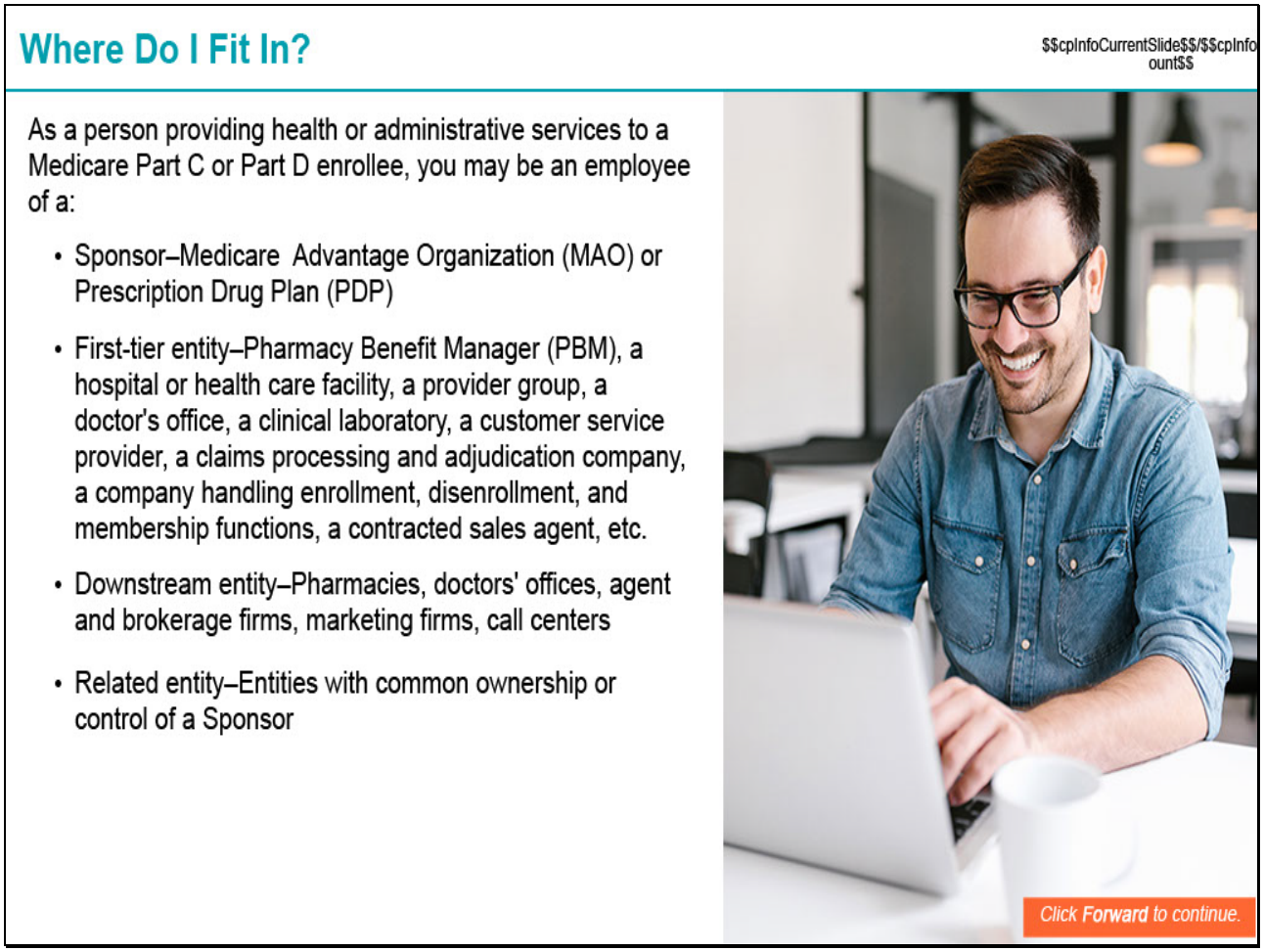


Slide notes

Section 4: Detecting and Preventing Non-Compliance and FWA

This section will cover your role and responsibilities in preventing, reporting, and correcting non-compliance and FWA.

Slide 52



Slide notes

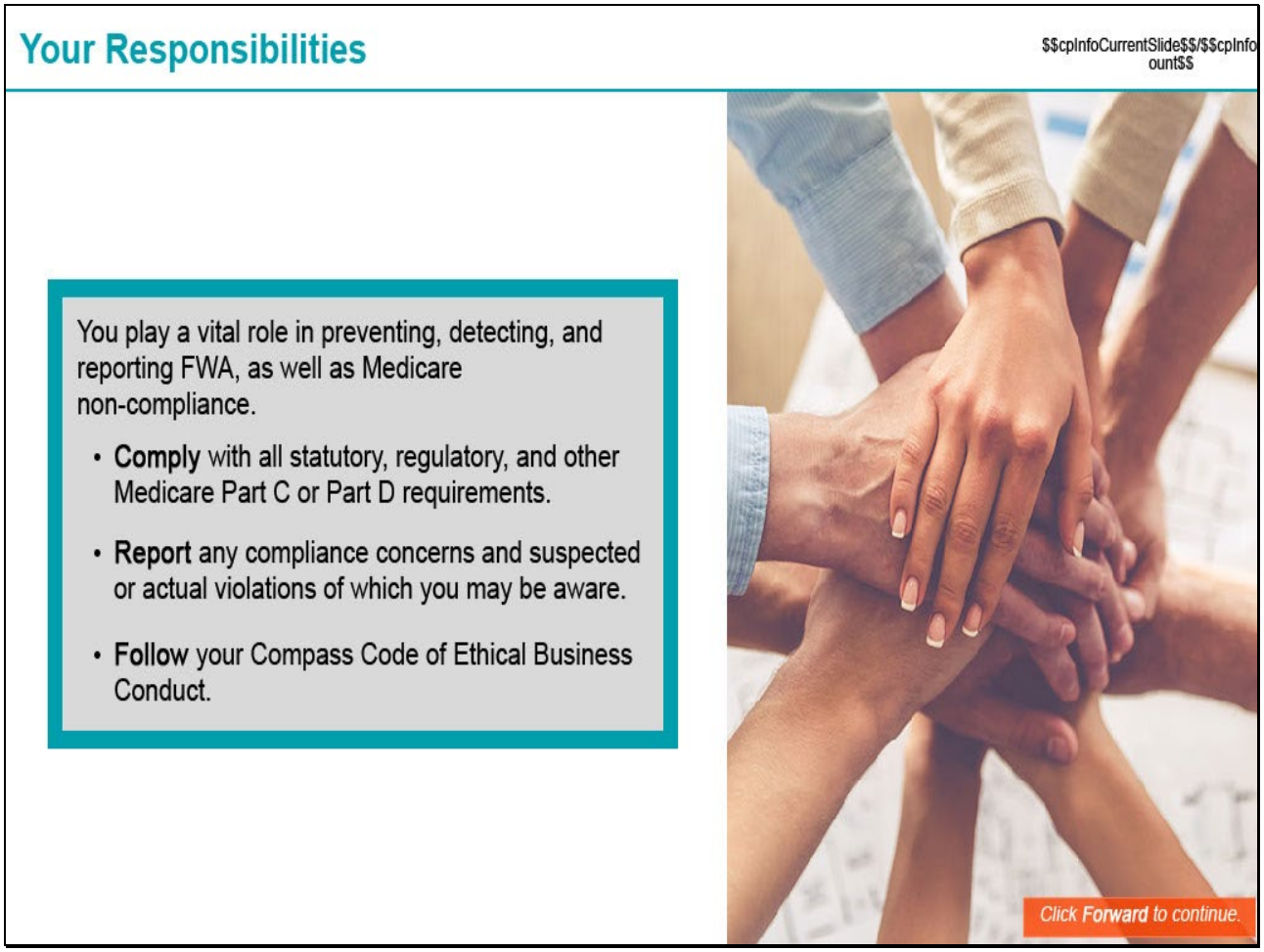
As a person providing health or administrative services to a Medicare Part C or Part D enrollee, you are likely to be an employee of a Sponsor that is a Medicare Advantage Organization (MAO) or a Prescription Drug Plan (PDP).

You may be an employee of a first-tier entity, such as a Pharmacy Benefit Manager (PBM), a hospital or health care facility, a provider group, a doctor’s office, a clinical laboratory, a customer service provider, a claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, or a contracted sales agent.

You may even be an employee of a downstream entity that includes pharmacies, doctor’s offices, firms providing agent and broker services, marketing firms, and call centers or a related entity that includes entities with common ownership or control of a Sponsor.

Click the Forward button to learn about your responsibilities.

Slide 53



Slide notes

You play a vital role in preventing, detecting, and reporting FWA, as well as Medicare non-compliance.

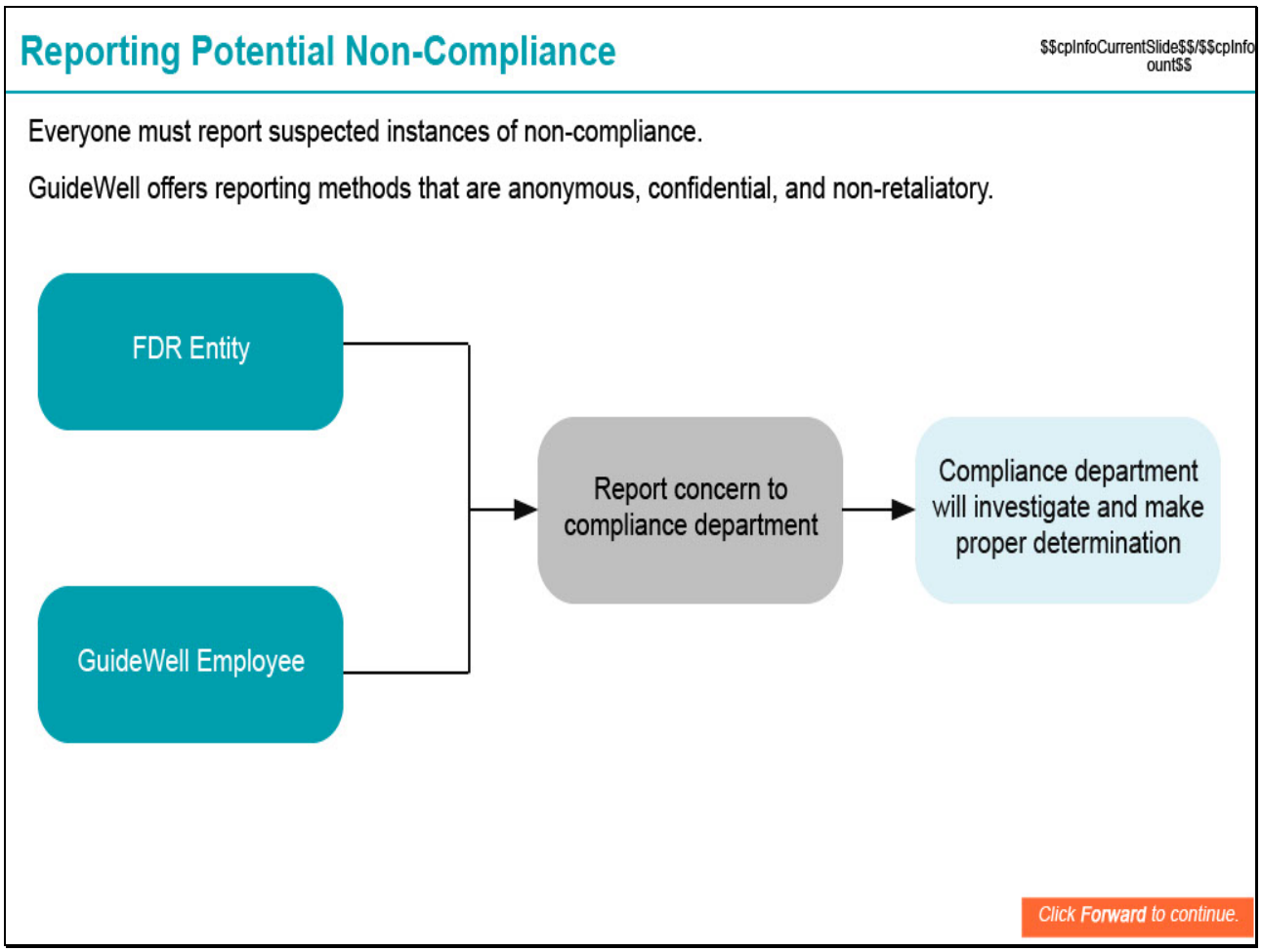
Firstly, you must comply with all statutory, regulatory, and other Medicare Part C or Part D requirements, including following the GuideWell compliance program.

Secondly, you have a duty to the Medicare program to report any compliance concerns and suspected or actual violations of which you may be aware.

And finally, you have a duty to follow your Compass Code of Ethical Business Conduct that articulates your and GuideWell's commitment to standards of conduct and ethical rules of behavior.

Click the Forward button to learn how to report non-compliance.

Slide 54



Slide notes

Everyone must report suspected instances of non-compliance.

The Compass Code of Conduct clearly states this obligation.

When you report suspected non-compliance, GuideWell cannot retaliate against you.

GuideWell offers reporting methods that are anonymous, confidential, and non-retaliatory.

If you are an FDR or a GuideWell employee, you can report your concern to the compliance department online by using the link displayed on your screen or by phone.

GuideWell's compliance department will investigate and make the proper determination.

Click the Forward button to learn how to report FWA.

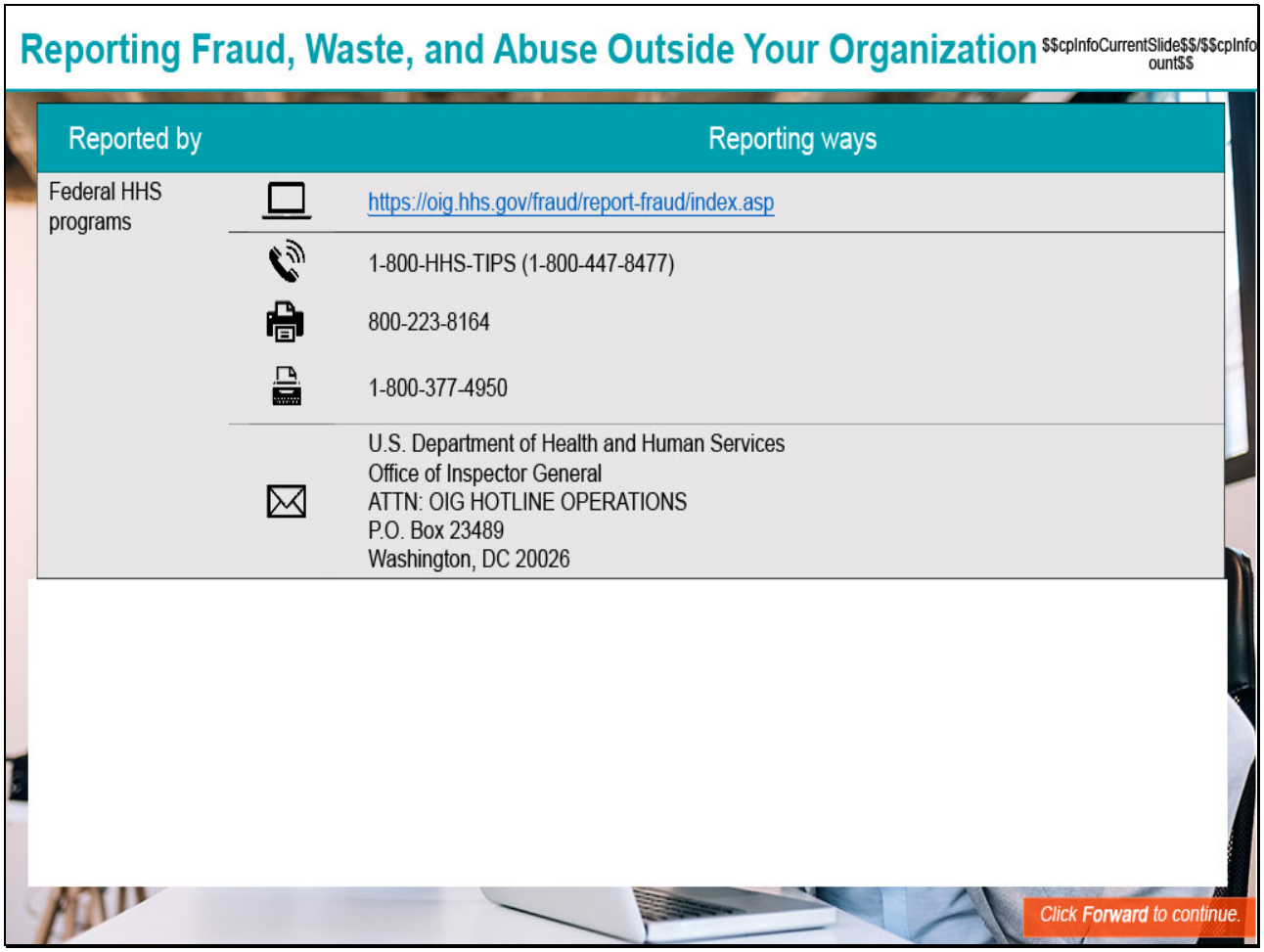
Slide 55

Slide notes

If you suspect fraud, waste, or abuse involving providers, agents, beneficiaries, or other people who are not our employees, you have a responsibility to report the situation.

The easiest way to submit a report is to use the online fraud, waste and abuse report form. Other ways of reporting include: calling the GuideWell fraud hotline, emailing the Special Investigation Unit (SIU), or writing to GuideWell's Special Investigation Unit.

Slide 56



Slide notes

Sometimes, it may be necessary for GuideWell to report fraudulent conduct outside of the organization to the OIG, the U.S. Department of Justice, or CMS.

Individuals or entities that wish to voluntarily disclose self-discovered potential fraud to the OIG may do so under the Self-Disclosure Protocol (SDP).

Self-disclosure gives people the opportunity to avoid the costs and disruptions associated with a government-directed investigation and civil or administrative proceedings.

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.

To report suspected cases of fraud, waste, or abuse in Federal HHS programs, use the online OIG Hotline form.

You may also call, mail, or fax HHS using the information provided on your screen.

For Medicare Parts C and D, contact the National Benefit Integrity Medicare Prescription Drug Integrity Contractor.

For all other federal health care programs, contact the CMS Hotline or the Medicare beneficiary website.

Click the Forward button to continue.

Slide 57

Slide notes

Non-compliance and FWA must be investigated immediately and corrected promptly.

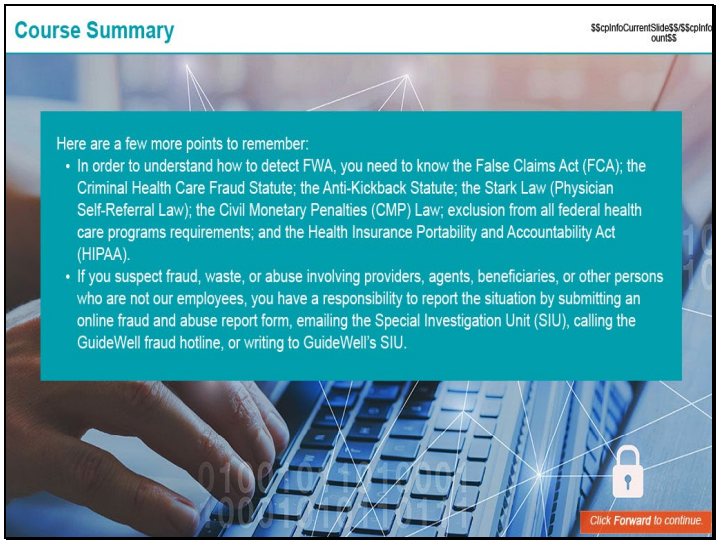
Ask your compliance department about the development process for the corrective action plan.

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 Sponsor's employee or FDR's employee; include consequences for failure to satisfactorily complete the corrective action; and finally, monitor corrective actions continuously to ensure effectiveness.

Monitoring should ensure no recurrence of the same non-compliance or FWA, ongoing compliance with CMS requirements, efficient and effective internal controls, and protected enrollees.

Slide 58



Slide notes

Here is a recap of what you learned:

Medicare is a federal health insurance program that is part of the Social Security Act and is strictly regulated by CMS.

An effective compliance program must articulate and demonstrate an organization’s 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.

At a minimum, an effective compliance program includes seven core requirements.

Non-compliance is conduct that does not conform to the law, federal health care program requirements, or an organization’s ethical and business policies.

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

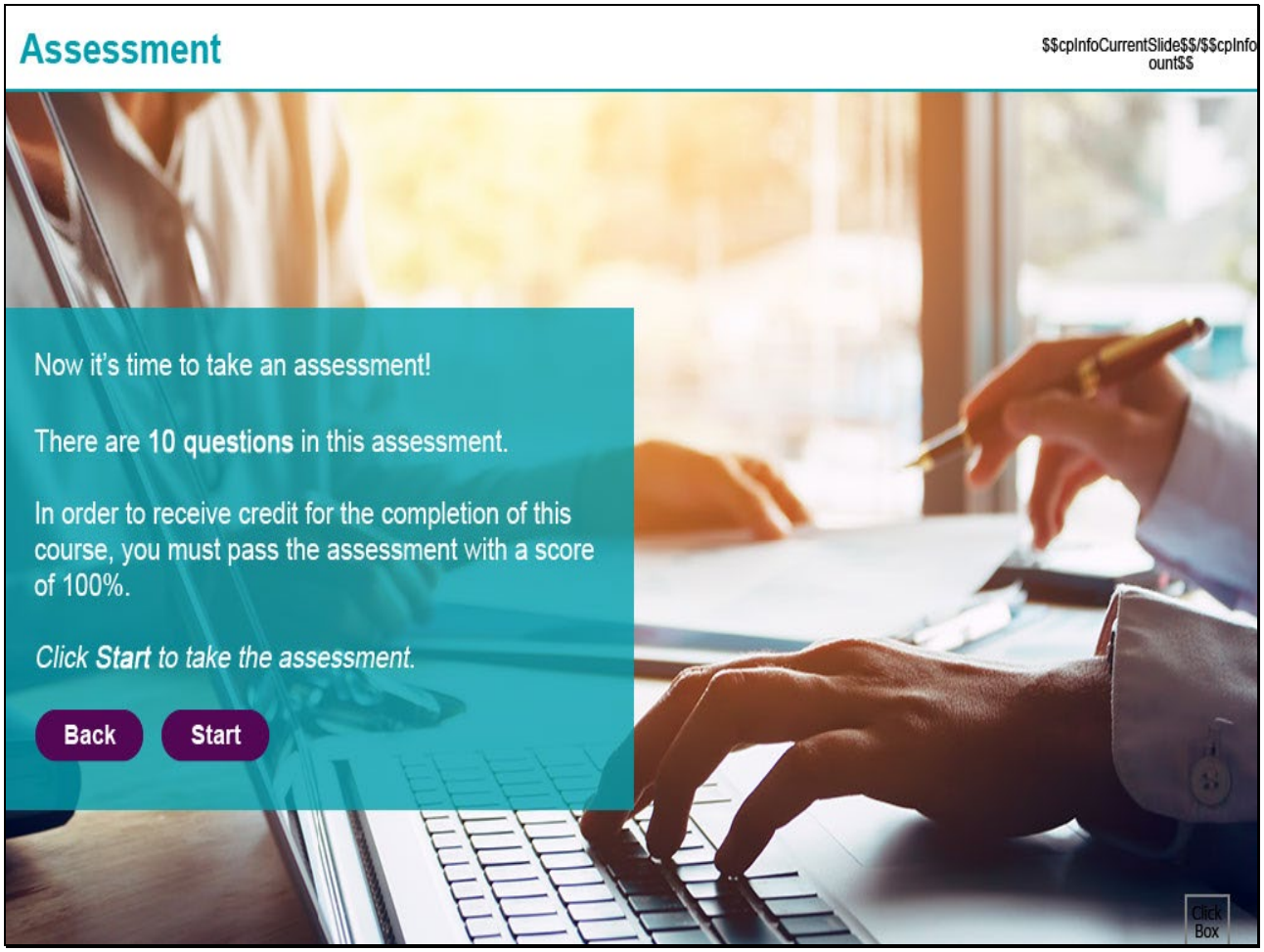
Waste and abuse includes practices that directly or indirectly result in unnecessary costs to the Medicare program.

Here are a few more points to remember:

In order to understand how to detect FWA, you need to know the False Claims Act (FCA); the Criminal Health Care Fraud Statute; the Anti-Kickback Statute; the Stark Law (Physician Self-Referral Law); the Civil Monetary Penalties (CMP) Law; exclusion from all federal health care programs requirements; and the Health Insurance Portability and Accountability Act (HIPAA).

If you suspect fraud, waste, or abuse involving providers, agents, beneficiaries, or other persons who are not our employees, you have a responsibility to report the situation by submitting an online fraud and abuse report form, emailing the Special Investigation Unit (SIU), calling the GuideWell fraud hotline, or writing to GuideWell’s SIU.

Slide 59



Slide notes

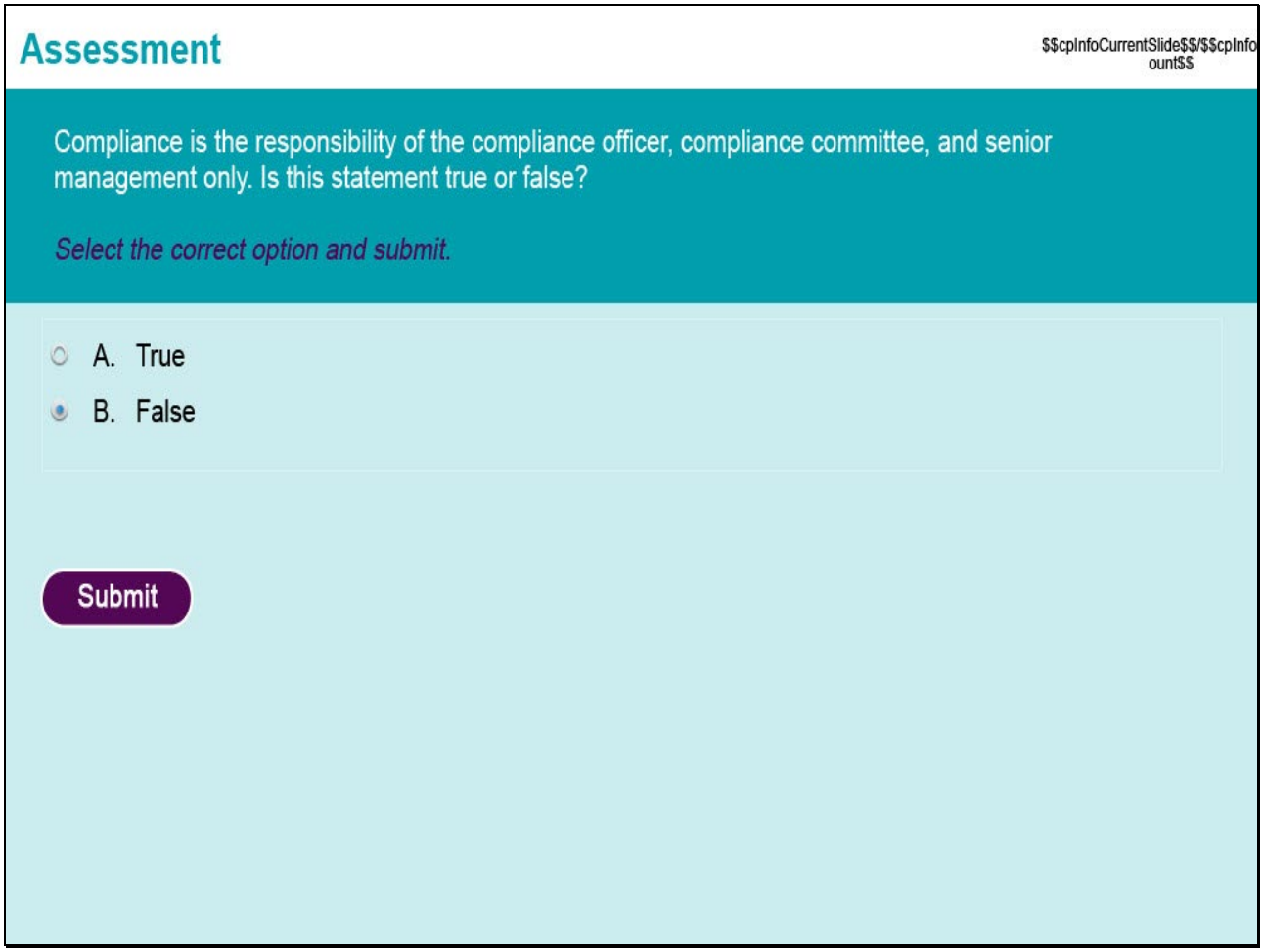
Now it's time to take an assessment.

There are 10 questions in this assessment.

In order to receive credit for the completion of this course, you must pass the assessment with a score of 100%.

Click the Start button to take the assessment.

Slide 60



Slide notes

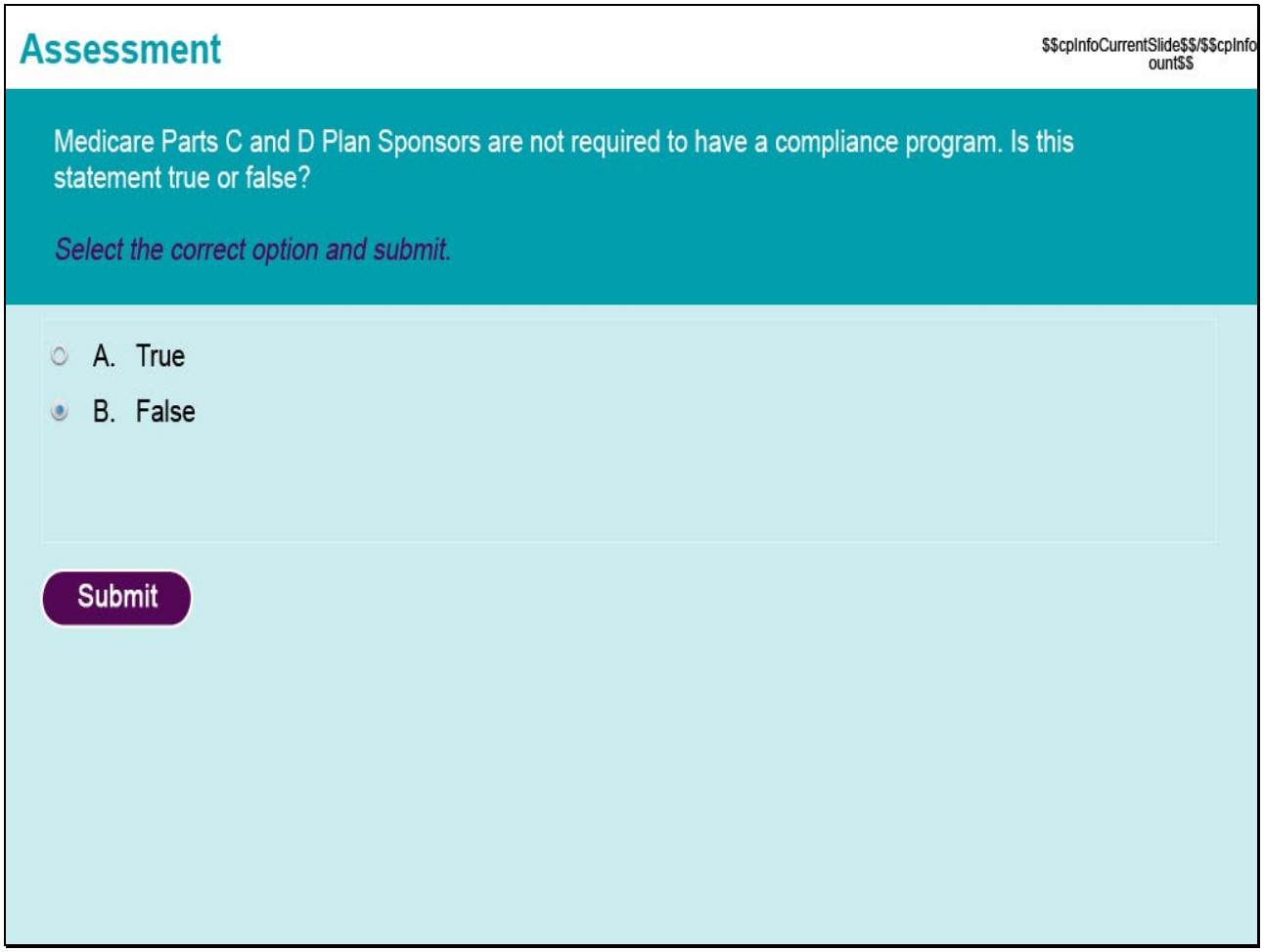
Question 1: Compliance is the responsibility of the compliance officer, compliance committee, and senior management only.

Is this statement true or false?

A. True
B. False

Select the correct option and submit.

Slide 61



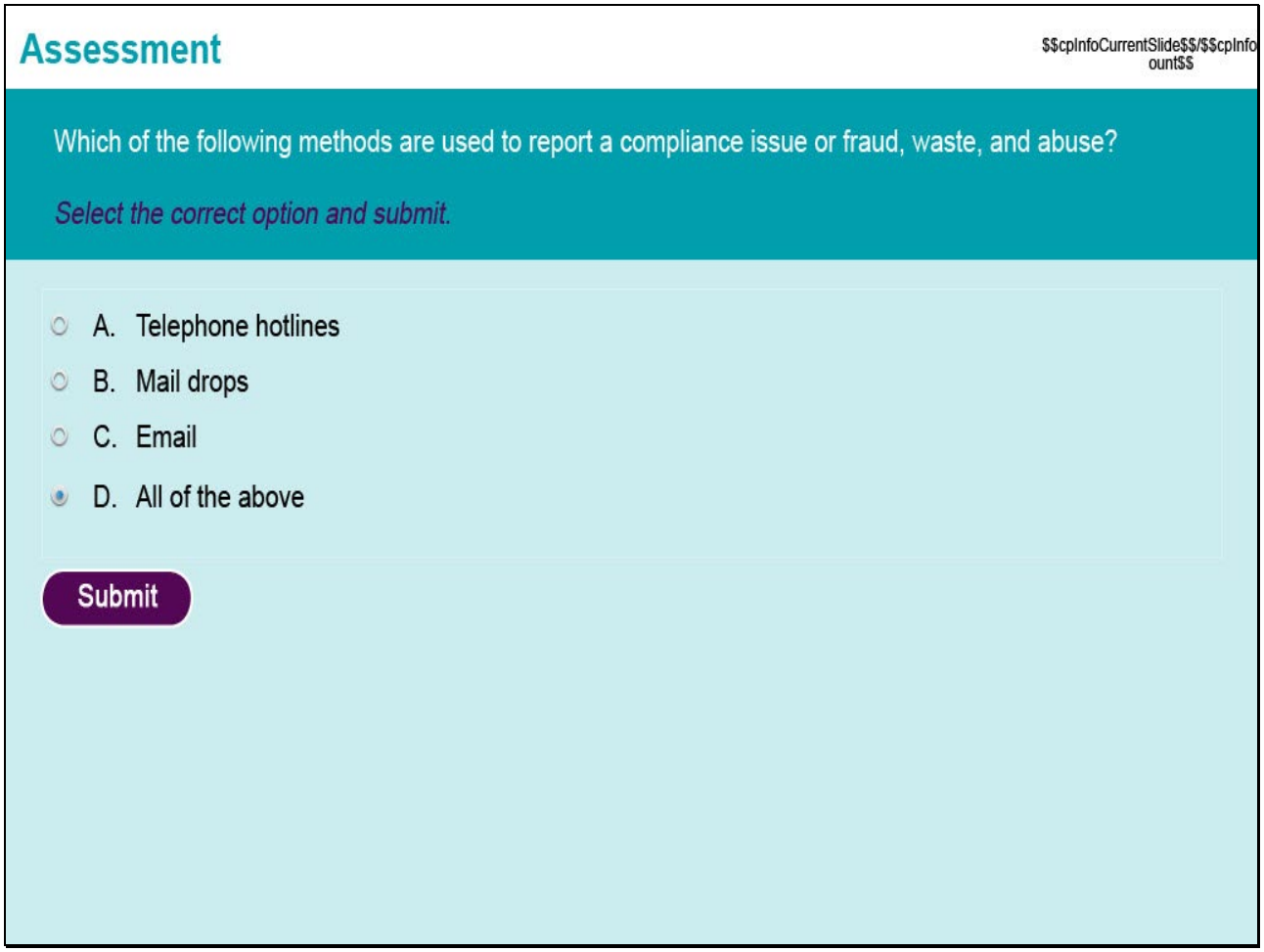
Slide notes

Question 2: Medicare Parts C and D Plan Sponsors are not required to have a compliance program. Is this statement true or false?

A. True
B. False

Select the correct option and submit.

Slide 62



Slide notes

Question 3: Which of the following methods are used to report a compliance issue or fraud, waste, and abuse?

A. Telephone hotlines

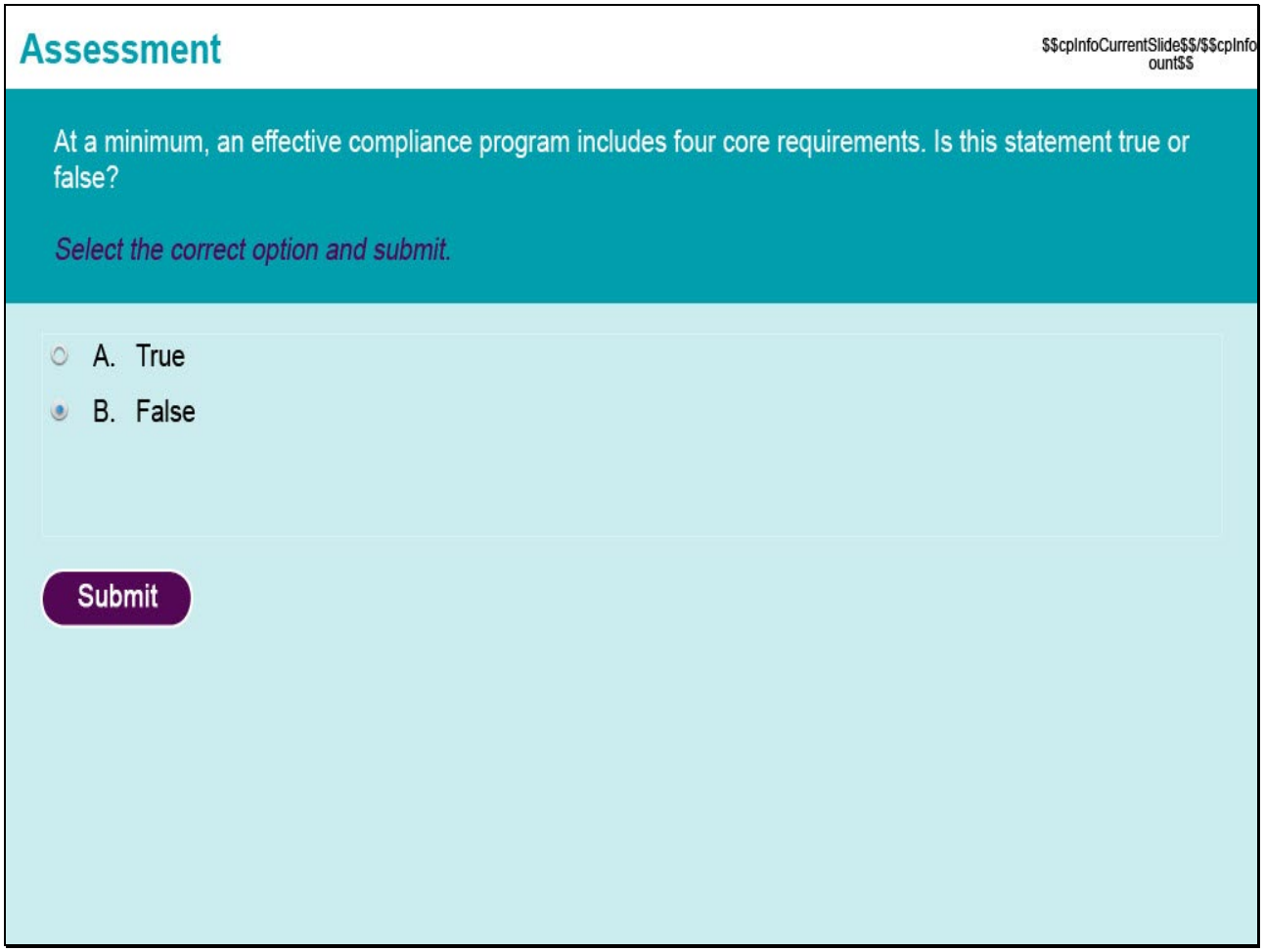
B. Mail drops

C. Email

D. All of the above

Select the correct option and submit.

Slide 63



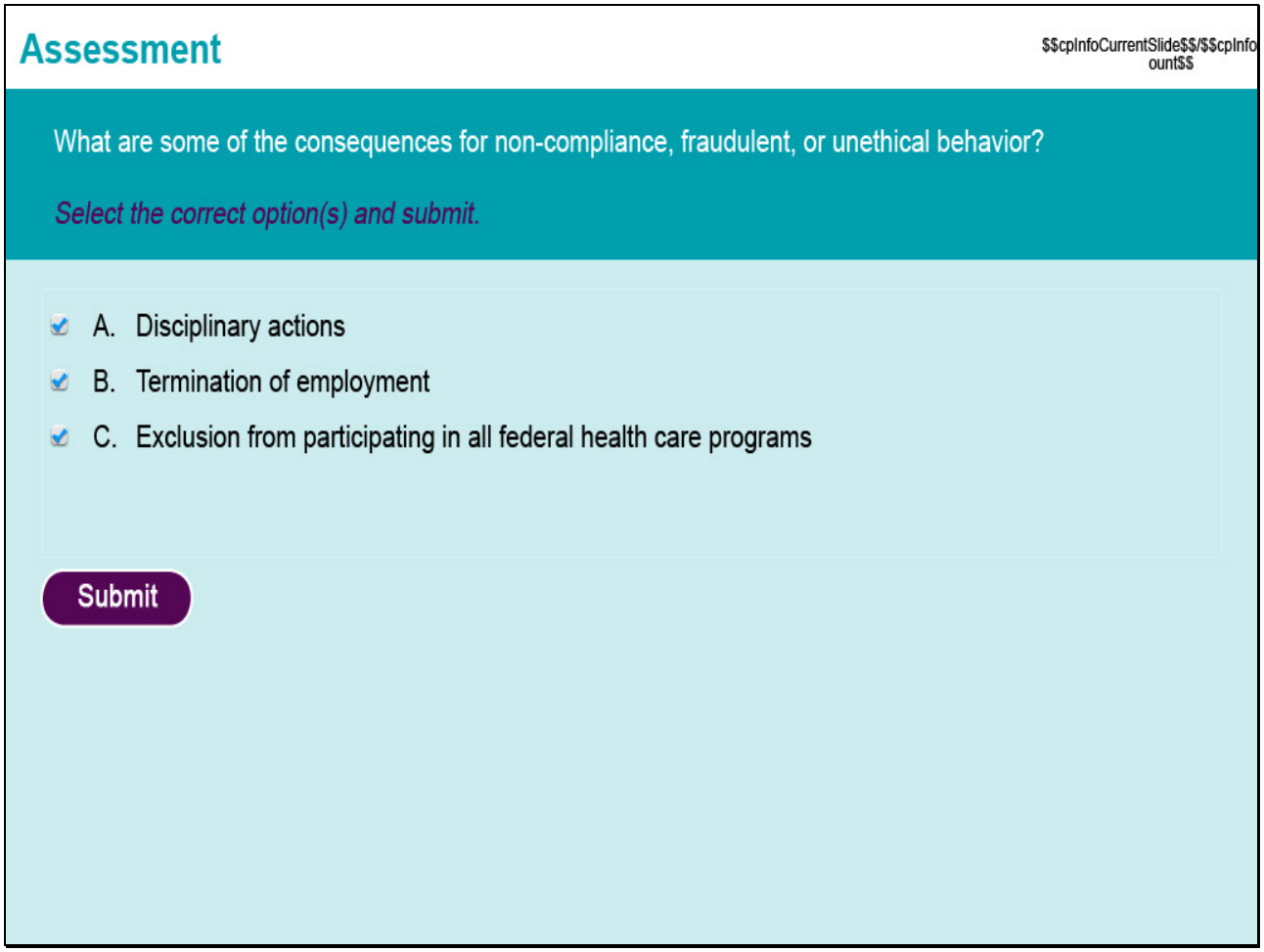
Slide notes

Question 4: At a minimum, an effective compliance program includes four core requirements. Is this statement true or false?

A. True
B. False

Select the correct option and submit.

Slide 64



Slide notes

Question 5: What are some of the consequences for non-compliance, fraudulent, or unethical behavior?

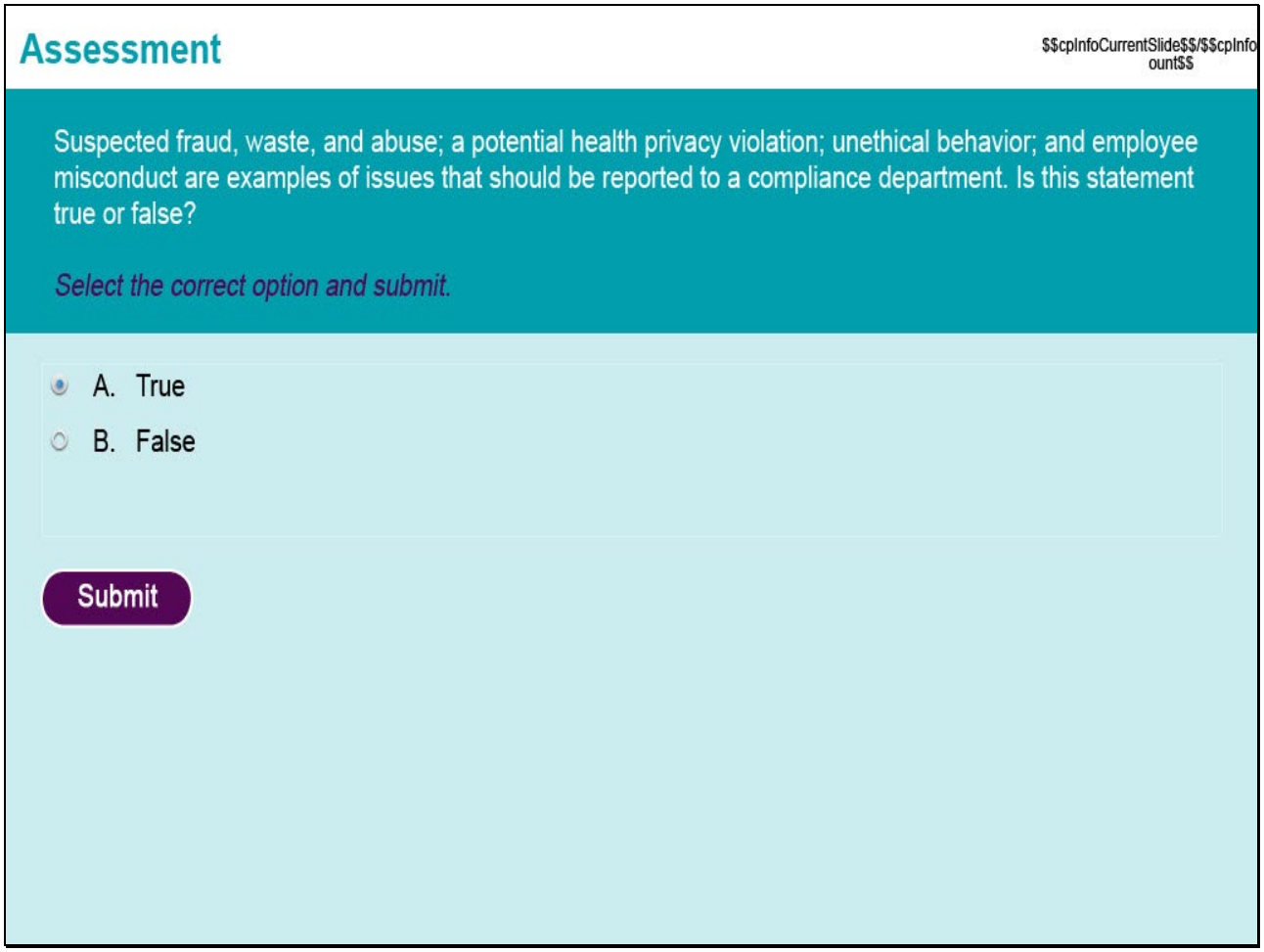
A. Disciplinary actions

B. Termination of employment

C. Exclusion from participating in all federal health care programs

Select the correct options and submit.

Slide 65



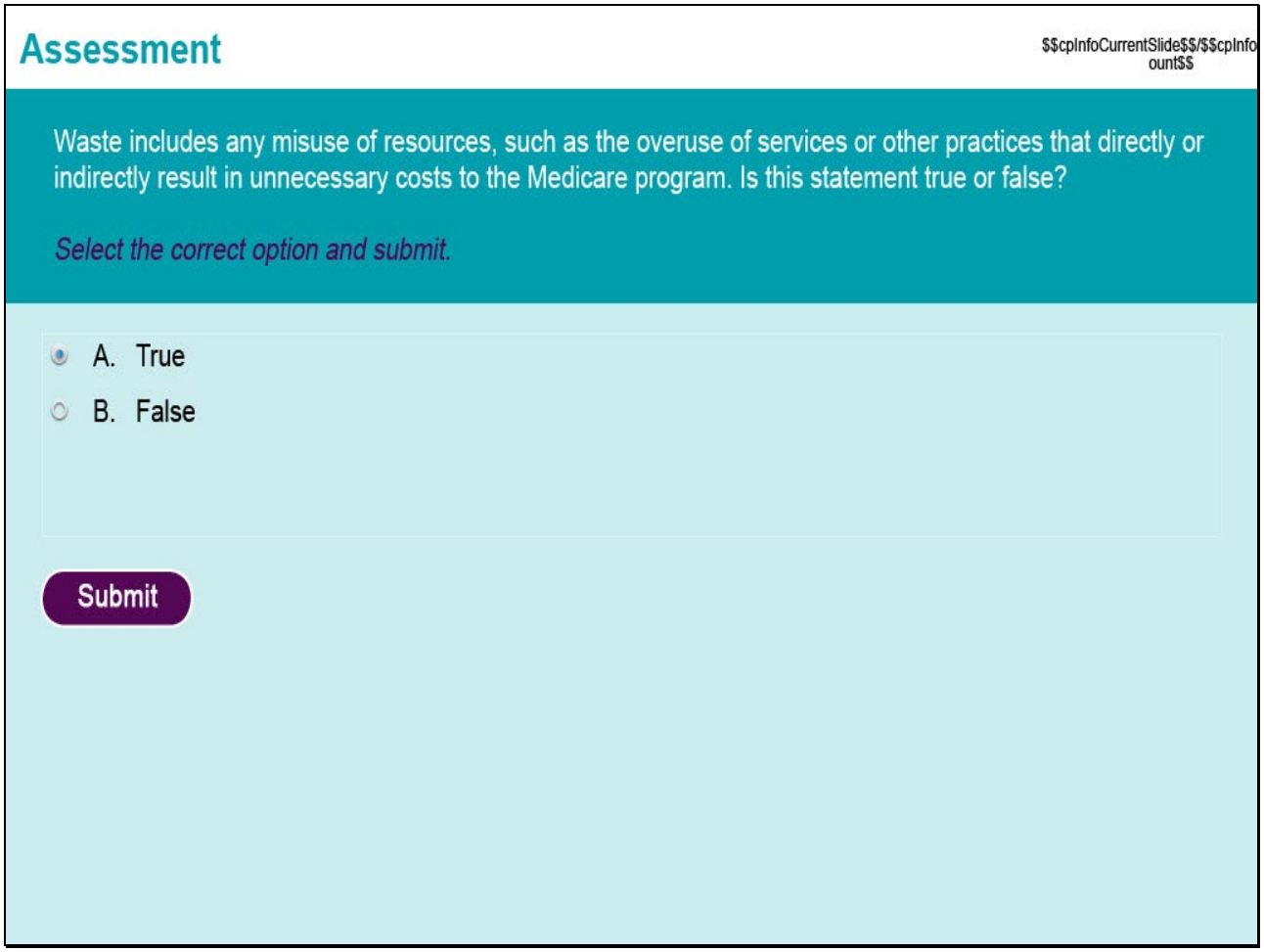
Slide notes

Question 6: Suspected fraud, waste, and abuse; a potential health privacy violation; unethical behavior; and employee misconduct are examples of issues that should be reported to a compliance department. Is this statement true or false?

A. True
B. False

Select the correct option and submit.

Slide 66



Slide notes

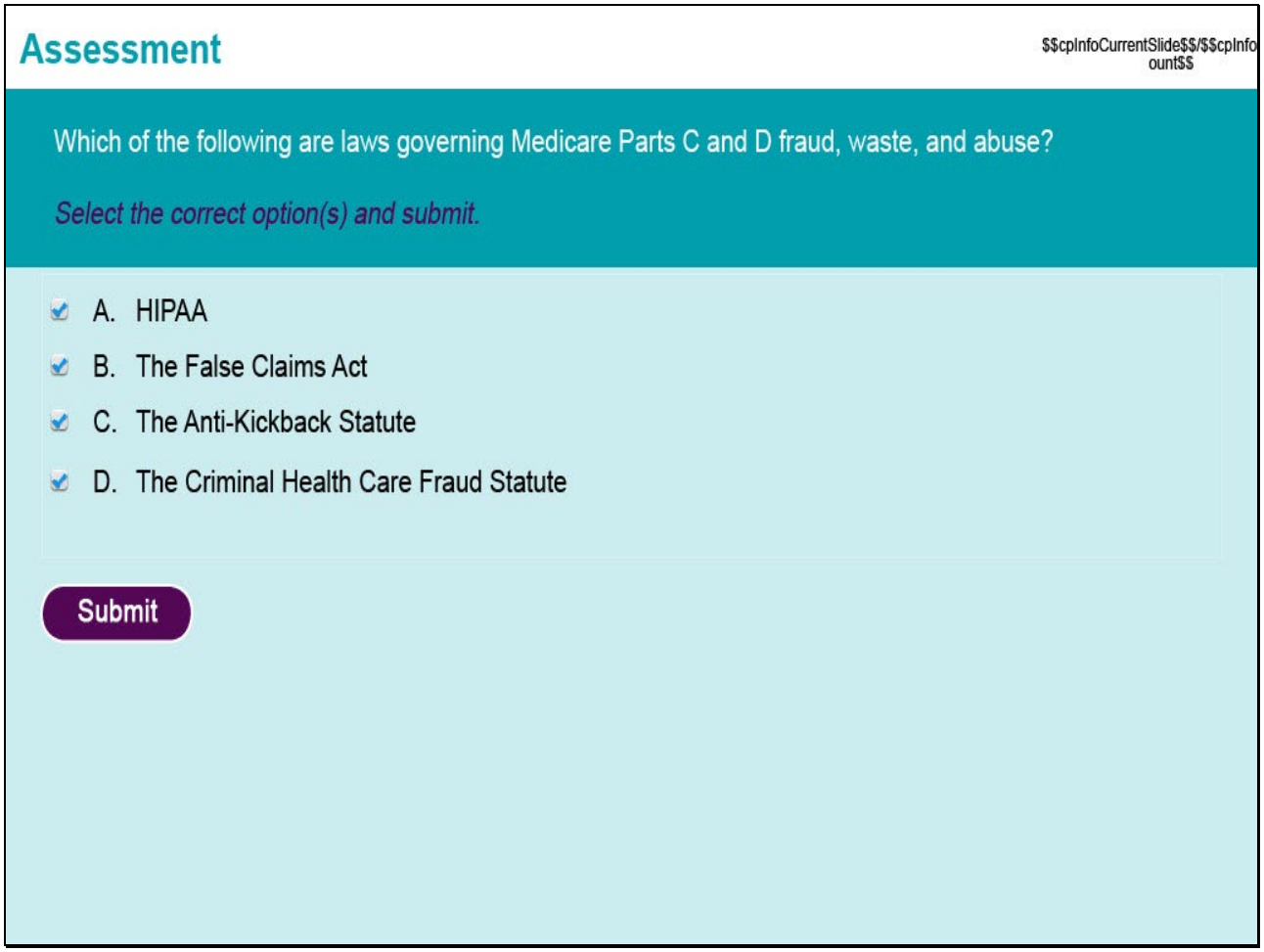
Question 7: Waste includes any misuse of resources, such as the overuse of services or other practices that directly or indirectly result in unnecessary costs to the Medicare program.

Is this statement true or false?

A. True
B. False

Select the correct option and submit.

Slide 67



Slide notes

Question 8: Which of the following are laws governing Medicare Parts C and D fraud, waste, and abuse?

A. HIPAA

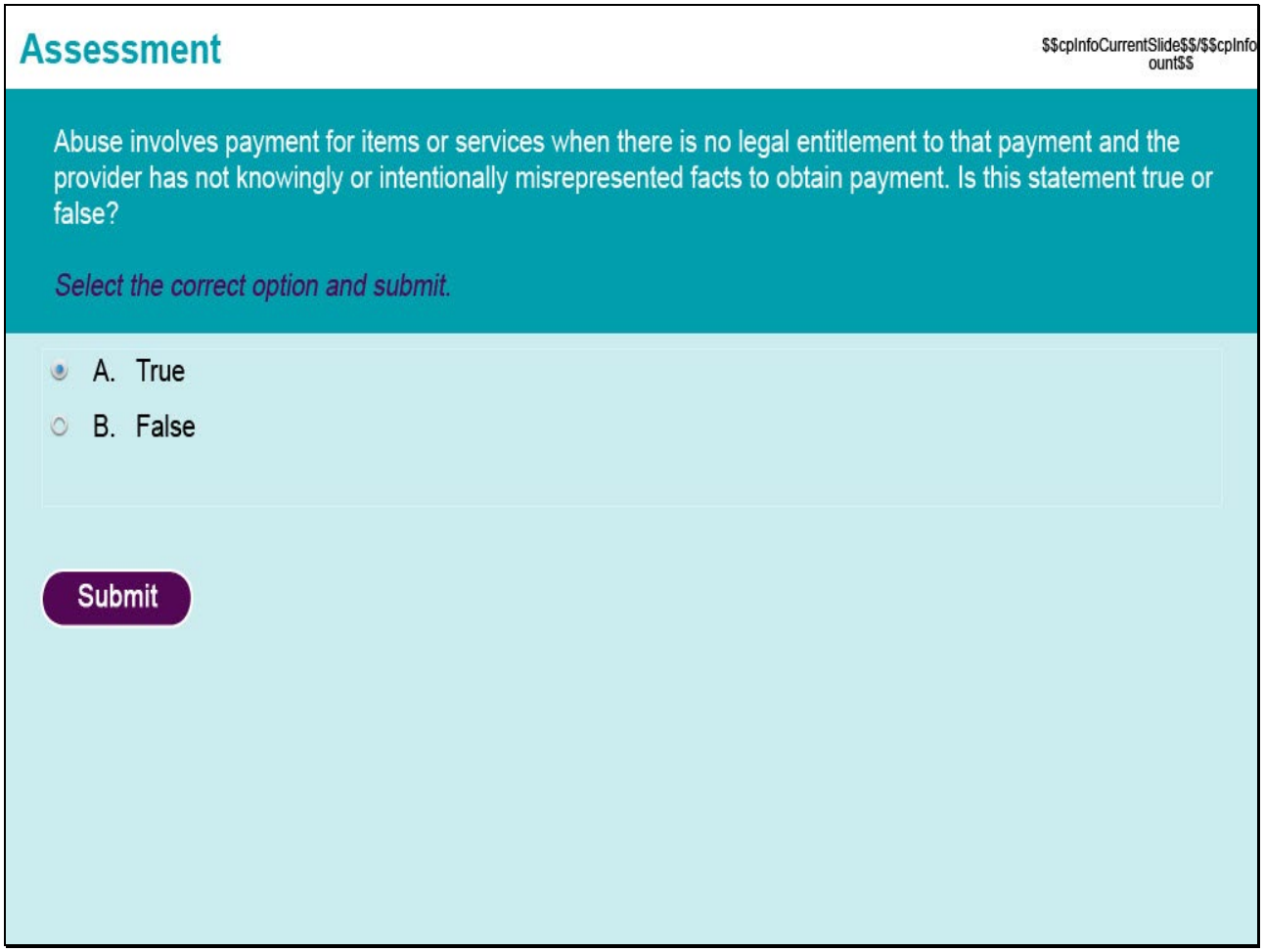
B. The False Claims Act

C. The Anti-Kickback Statute

D. The Criminal Health Care Fraud Statute

Select the correct options and submit.

Slide 68



Slide notes

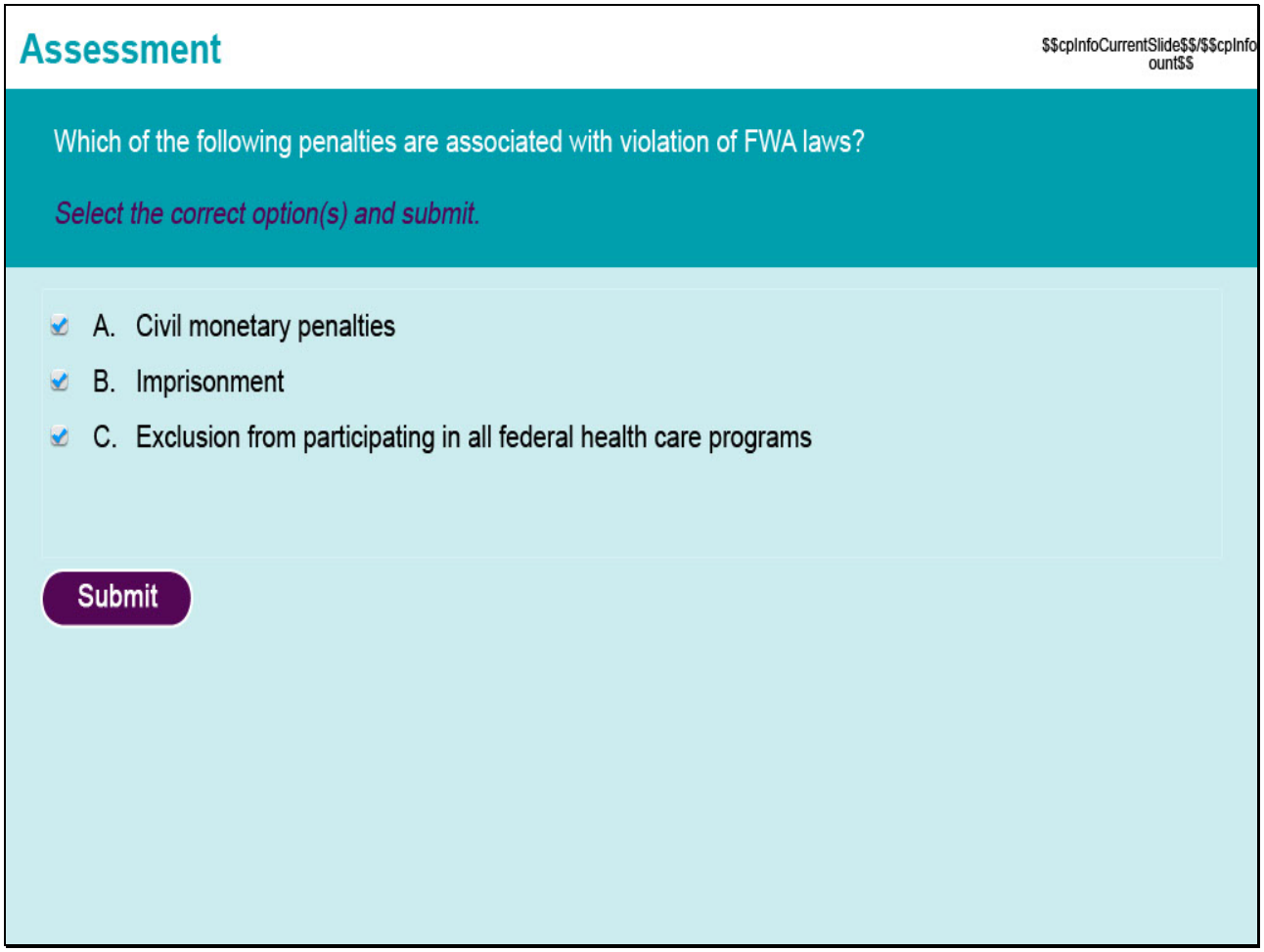
Question 9: Abuse involves payment for items or services when there is no legal entitlement to that payment

and the provider has not knowingly or intentionally misrepresented facts to obtain payment. Is this statement true or false?

A. True
B. False

Select the correct option and submit.

Slide 69



Slide notes

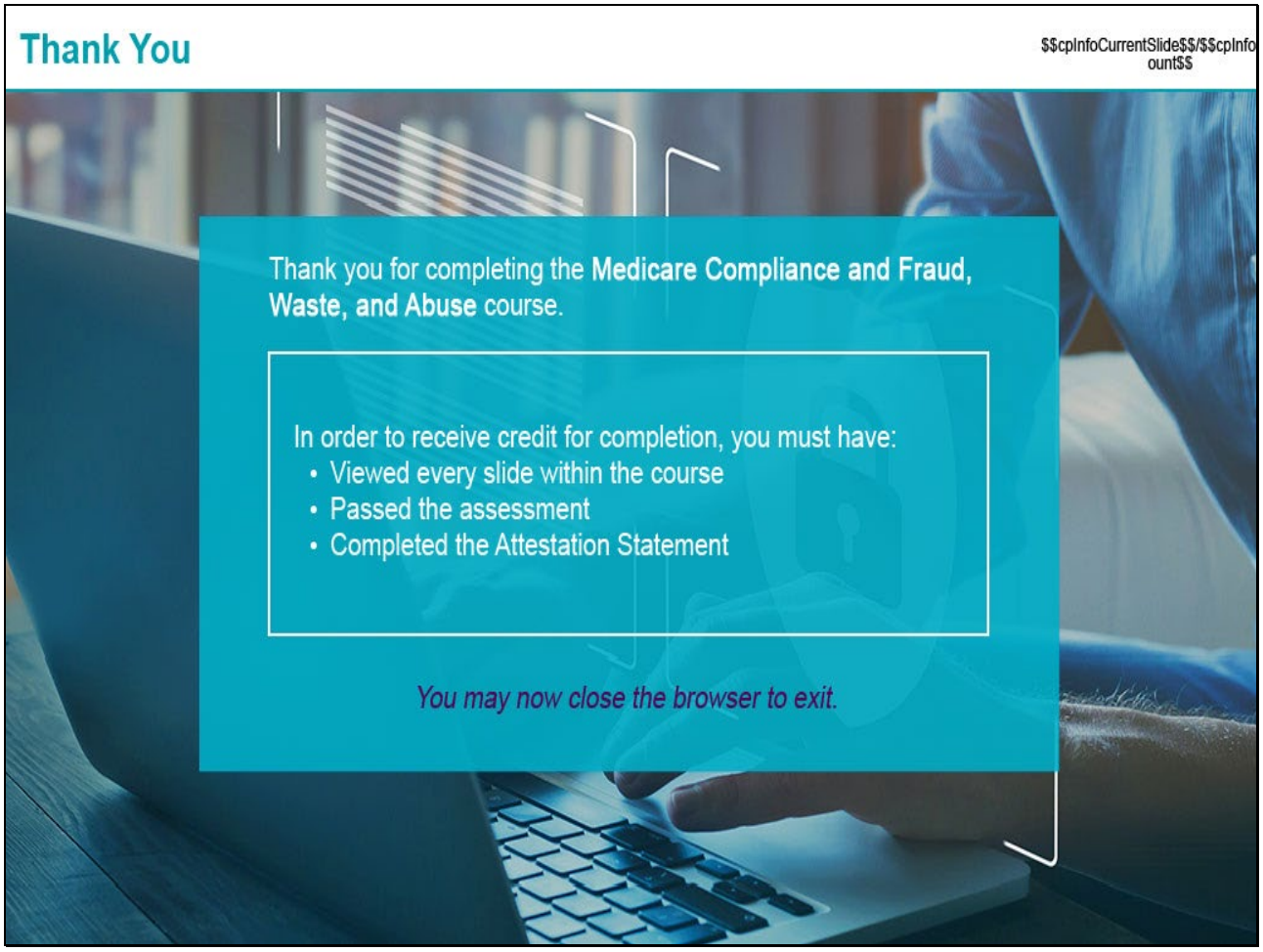
Question 10: Which of the following penalties are associated with violation of FWA laws?

A. Civil monetary penalties

B. Imprisonment

C. Exclusion from participating in all federal health care programs

Select the correct options and submit.



Slide notes

This completes the Medicare Compliance and Fraud, Waste, and Abuse course.

In order to receive credit for completion, you must have:

Viewed every slide within the course

Passed the assessment

Completed the Attestation Statement