GENERAL COMPLIANCE & FWA TRAINING FOR ASH CONTRACTED PROVIDERS & THEIR EMPLOYEES

Training Objectives

- Understand why you need General Compliance & Fraud, Waste and Abuse (FWA) Training
- Recognize how a compliance program operates & how to report suspected non-compliance
- Learn about FWA and your role in the fight against FWA & how to report suspected FWA
- ASH's Compliance & Anti-Fraud Program
- Consequences for Non-Compliance

Why do I need this training?

ASH contracts with Medicare Advantage Organizations, Medicaid Managed Care Plans and Qualified Health Plan (QHP) Issuers to provide specialty health benefits to their members. Because these programs are paid for with federal and/or state tax dollars there are specific compliance requirements that ASH and its downstream entities must meet. One of those requirements is training on general compliance and FWA.

Since ASH's contracted providers* are considered downstream entities as defined by the Centers of Medicare and Medicaid Services (CMS), ASH is required to ensure that contracted providers and their employees who are involved in the administration or delivery of Medicare Part C, Medicaid and/or QHP benefits are trained on general compliance and FWA.

Furthermore, every year, billions of dollars are improperly spent because of FWA. It affects everyone – **including you**. This training will help you detect, correct, and prevent non-compliance and FWA.

*Contracted providers includes all contracted practitioners, contracted providers, credentialed practitioners and contracted virtual providers

A note about this training

This training was developed based on the CMS General Compliance and Fraud, Waste and Abuse Trainings. The training also includes ASH-specific information and applies to **all ASH lines of business**.

Please note that the training may contain references, statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take place of either the written law or regulations. We encourage you to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Remember, we all have a responsibility to know the compliance program and FWA laws/regulations that need to be followed, including those specific to government programs.

COMPLIANCE PROGRAM

Compliance Program Requirements

The CMS requires Medicare Advantage Organizations to implement and maintain an effective compliance program for its Medicare Parts C and D business.

To support this requirement, ASH, as a first-tier entity or delegated entity of several Medicare Advantage Organizations, has implemented a compliance program based on the CMS requirements **for all its lines of business** that:

- Articulates and demonstrates ASH's commitment to legal and ethical conduct
- Provides guidance on how to handle compliance questions and concerns
- Provides guidance on how to identify and report compliance violations

As a provider of services to members, including Medicare members, your organization should consider creating and implementing its own compliance program. Your agreement with ASH requires that you adhere to ASH's Compliance Program.

This training covers all the elements that a compliance program must include and that are reflected in ASH's Compliance Program.

What is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance and must:

- Prevent, detect, and correct non-compliance
- Be fully implemented and tailored to an organization's unique operations and circumstances
- Have adequate resources
- Promote the organization's Standards or Code of Conduct
- Establish clear lines of communication for reporting non-compliance

An effective compliance program is essential to prevent, detect, and correct noncompliance as well as fraud, waste, and abuse (FWA). It must, at a minimum, also include the seven core compliance program requirements.

What Are The Seven Core Compliance Requirements?

1. **Written Policies, Procedures, and Standards of Conduct**
   - These articulate the commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.
     - ASH has developed a Code of Conduct to meet this requirement which is available for review on the ASHLink® Web site.
2. **Compliance Officer, Compliance Committee, and High-Level Oversight**
   - There must be a designated 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. Senior management and governing body must be engaged and exercise reasonable oversight of the compliance program.
     - ASH has a Compliance Officer; a Corporate Compliance Committee also reviews compliance issues for impact on ASH's programs.
3. **Effective Training and Education**
   - This covers the elements of the compliance plan as well as preventing, detecting, and reporting FWA. The training and education are to be tailored for their different employees and their responsibilities and job functions.
     - ASH has a training program—this training is part of that program.

What Are The Seven Core Compliance Requirements?

4. **Effective Lines of Communication**
   - Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith compliance issues reporting.
     - ASH maintains hotlines and emails for you to report compliance issues in good faith—please see pages 16, 38 and 39 of this training.
5. **Well-Publicized Disciplinary Standards**
   - Enforce standards through well-publicized disciplinary guidelines.
     - ASH publicizes its disciplinary guidelines. For contracted providers this is addressed in the agreement with ASH and in the Operations Manual.
6. **Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks**
   - Conduct routine monitoring and auditing to evaluate compliance with requirements as well as the overall effectiveness of the compliance program.
     - ASH does engage in monitoring and auditing of our contracted providers to confirm compliance.
7. **Procedures and System for Prompt Response to Compliance Issues**
   - Use effective measures to respond promptly to non-compliance and undertake appropriate corrective action
     - ASH is committed to correcting non-compliance promptly with necessary actions.

Ethics: Do the Right Thing!

As a downstream entity of ASH, you must conduct yourself in an ethical and legal manner. **It's all about doing the right thing!**

How Do You Know What is Expected of You?

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

- ASH's Code of Conduct and Ethics Program states compliance expectations, operational principles and values and outlines how to report suspected non-compliance. As outlined in your Provider Services Agreement, you are required to abide by ASH's Code of Conduct & Ethics Program. A copy of ASH's Code of Conduct & Ethics Program is readily available on ASHLink.

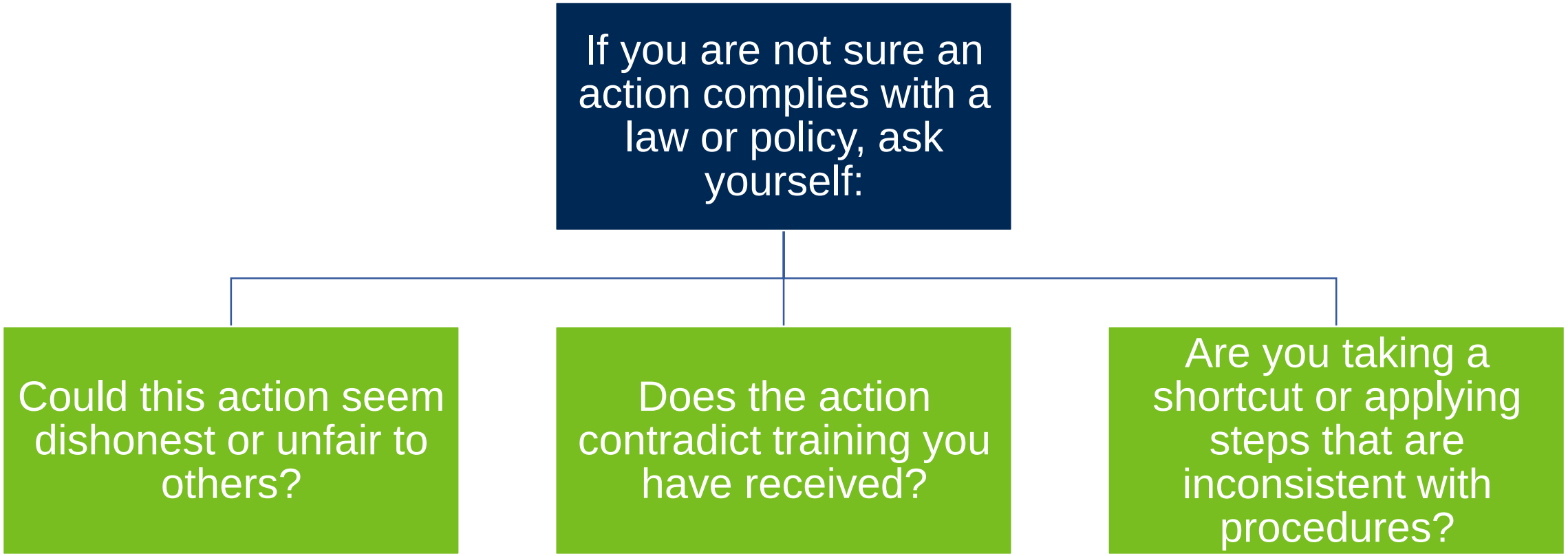
- As a reminder, reporting Code of Conduct violations and suspected non-compliance is everyone's responsibility.

What is Non-Compliance

Noncompliance is conduct that does not conform to the law, health care program requirements or to ASH's policies and procedures. Below are examples of high-risk areas identified by CMS:

- Agent/broker/delegate misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Member notices
- Conflicts of interest
- Claims and Utilization Management processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- Ethics
- Oversight and monitoring of downstream entities
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care
- IT System access and safeguards
- Claims and Utilization Management documentation manipulation

Questions to Consider



Know the Consequences of Non-Compliance

- Failure to follow requirements can lead to serious consequences, including:
  - Mandatory training or re-training
  - Corrective Action Plan (CAP) under your contract with ASH
  - Contract termination
  - Criminal penalties
  - Exclusion from participating in all State and/or Federal health care programs
  - Civil monetary penalties

Non-Compliance Affects Everybody

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

Harm to members, such as:

- delayed services,
- denial of benefits
- difficulty in using providers of choice; and
- other hurdles to care.

Less money for everyone due to:

- high insurance copayments
- higher premiums
- lower benefits for individuals and employers; and
- lower profits

Reporting Potential Non-Compliance

Reporting potential Code of Conduct violations and suspected non-compliance is everyone's responsibility. Below are the various methods of reporting. Remember, reports of suspected non-compliance are confidential and can be made anonymously.

Email:	ethicsandintegrity@ashn.com
Hotline:	866.998.2746
Write:	American Specialty Health Attn: ASH Compliance Officer P.O. Box 509001 San Diego, CA 92150-9002

Retaliation against anyone reporting issues in good faith is strictly prohibited!

What Happens After Non-Compliance is Detected?

Once non-compliance is detected and corrected, steps should be taken to ensure that:

- No reoccurrence of the same non-compliance
- Ongoing compliance with federal and state requirements
- Efficient and effective internal controls
- Protected members

ASH monitors activities with regular reviews to confirm ongoing compliance and ensures that corrective actions are implemented and effective.

As a downstream entity of ASH, you must also take steps to correct non-compliance identified and take steps to ensure ongoing compliance and that the non-compliance does not reoccur.

Key REMINDER:
Compliance is **Everyone's** Responsibility

PREVENT

Operate within ASH's ethical expectations and policy requirements to **prevent** noncompliance!

DETECT AND REPORT

If you **detect** potential noncompliance, **report** it!

CORRECT

Correct noncompliance to protect members and to promote quality and efficiency!

WHAT IS FRAUD, WASTE & ABUSE

What is FWA?

- **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 of fraudulent pretenses, representations, or promises, any of the money or property owned by, under the custody or control of, any health care benefit program. This most commonly involves a false statement or a misrepresentation or deliberate omission that is critical to the determination of benefits.

- **Waste** includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be cause by criminally negligent actions but rather by the misuse of resources.

- **Abuse** includes actions that may, directly or indirectly, result in unnecessary costs. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of FWA

Examples of possible fraud:

Knowingly billing for services not rendered, including billing for appointments that the patient failed to show up for

Knowingly altering claims forms, medical records, or receipt to obtain a higher payment

Knowingly billing for services that were medically unnecessary

Examples of possible waste:

Conducting excessive office visits

Ordering excessive tests or x-rays

Examples of possible abuse:

Unknowingly billing for unnecessary medical services

Unknowingly charging excessively for services

Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Differences Among FWA

One of the primary distinctions between fraud, waste, and abuse 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 cost but **does not require the same intent and knowledge**.

Understanding FWA

To detect potential instances of FWA, you need to know the applicable laws. The following pages provide high-level information about the following laws.

- False Claims Act
- Health Care Fraud Statute / Criminal Fraud
- Anti-Kickback Statute
- Stark Statute (Physician Self-Referral Law);
- Exclusion from Federal health care programs
- Health Insurance Portability and Accountability Act (HIPAA)

*This is not an exhaustive list of all laws that are applicable to FWA.

False Claims Act

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

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

Example

A physician who submits a bill to Medicare for medical services that they know has not been provided.

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.

Whistleblowers

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards. A person who reports false claims or bring legal actions to recover money paid on false claims are ***protected from retaliation*****.** A person who brings a successful whistleblower lawsuit is **rewarded** by receiving at least 15 percent, but not more than 30 percent, of the money collected.

State Laws

In most states it is a crime to obtain something (e.g., such as a Medicaid payment or benefit) based on false information. In addition to the federal law, several states have adopted similar laws allowing individuals to file a lawsuit in state court for false claims that were filed with the state for payment, such as the Medicaid program.

Health Care Fraud Statute / Criminal Fraud

Knowingly and willfully executing or attempting to execute, a scheme or artifice to defraud any health care benefit program. Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

Example

A provider who submits a bill to Medicare for medical services that they know has not been provided.

Criminal Fraud Damages and Penalties

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

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 Federal health care program (including the Medicare Program).

Example

A clinic pays a provider a referral fee or other compensation for referring patients to their clinic.

Damages and Penalties

Violations are punishable by:

- A fine up to $25,000
- Imprisonment up to 5 years

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits physicians from referring Medicare patients to an entity with which the physician or a physician's immediate family member has a financial relationship (e.g. ownership, investment, or compensation arrangement), unless an exception applies.

Example
A physician who refers a member to a rehabilitation facility that his/her brother owns.

Damages and Penalties
Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around $24,250 can be imposed for each service provided. There may also be around a $161,000 fine for entering into an unlawful arrangement or scheme.

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil 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 and failing to report and return an overpayment
- Making false claims
- 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

Exclusion from Government Programs

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 federally funded programs. Reasons for exclusions include conviction of fraud or abuse, default on federal student loans, controlled substance violations and licensing board actions.

ASH requires its downstream entities to check all employees involved in the administration or delivery of Medicare, Medicaid and/or QHP benefits against the federal exclusion lists maintained by the Office of Inspector General (OIG) and U.S. General Services Administration (GSA). In addition, some State Medicaid agencies maintain their own exclusion lists. ASH also requires its downstream entities to check all available State Medicaid exclusion lists in addition to the lists maintained by the OIG and GSA as the lists may not be the same. All checks must be done prior to hire and monthly thereafter. Please refer to the Exclusion Check Guide that is readily available on ASHLink.com for a full listing of exclusion lists that must be checked.

Example

A provider pled guilty to one felony count of criminal fraud related to billing for services not rendered. The Provider was excluded by the OIG based upon the provider's guilty plea.

REMEMBER: You must maintain records of exclusion checks for 10 years from the final date of the final contract period of the contract entered into between ASH and the contracted provider.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter 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
An employee of a health insurer pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain.

Per your Provider Services Agreement and Operations Manual, you are required to abide by confidentiality and HIPAA requirements.

Indicators of Potential FWA

Now let’s review some key indicators to help you recognize the signs of someone committing FWA. The following page presents potential FWA issues and provides questions to ask yourself about different areas, depending on your role in delivering Medicare Parts C, Medicaid and/or QHP benefits to members.

Key Indicators: Potential Issues

Provider Issues

- Does the provider bill the health plan for services not provided?
- Is the provider performing medically unnecessary or excessive services for the member?
- Is the provider's diagnosis for the member supported in the medical record?
- Is a non-contracted provider using a contracted provider's TIN to gain benefits and/or avoid medical necessity review?
- Is there a lack of supporting documentation for the services under review?
- Is the provider billing for a higher level of service than what was actually rendered?
- Is the provider billing non-covered services as covered services?

Member Issues

- Does the medical record look altered or possibly forged?
- Does the member's medical history support the services requested?
- Is the person receiving the medical service the member (identify theft)?

YOUR ROLE IN THE FIGHT AGAINST FWA:

PREVENT, REPORT & CORRECT

What Are Your Responsibilities?

You play a vital part in preventing, detecting, and reporting potential FWA, as well as noncompliance:

- **FIRST,** you must **comply** with all applicable statutory, regulatory, and other regulatory requirements.
- **SECOND,** you have a **duty** to report any compliance concerns and suspected or actual violations of which you may be aware.
- **THIRD,** you have a duty to **conduct** yourself in a manner that aligns with ASH's Code of Conduct which articulates a commitment to standards of conduct and ethical rules of behavior.

How Do You Prevent FWA?

- Look for suspicious activity – and always act ethically
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, and regulations
- Verify all received information

Report FWA

Everyone must report suspected FWA. Our Code of Conduct & Ethics Program clearly states our affirmative obligation to report noncompliance and unethical behavior, including suspected fraud, waste and abuse.

- **Whistleblower Protections:** retaliation is prohibited when you report a concern in good faith.
- FWA referrals are **confidential** and can be made anonymously.
- Even when you're not sure whether something is fraud, waste or abuse, you should report your concerns so the issue can be investigated, and appropriate action taken.

Details to Include When Reporting FWA

- While reporting suspected FWA, please include the following information.
- Contact information for the source of information, suspect, and witnesses
- What was the event that triggered the suspicion of FWA
- When did the event occur (e.g. the date(s)/time(s))
- A narrative of the entire situation surrounding the suspected FWA, including the persons involved and the facts and circumstances surrounding the suspected FWA
- Copies, if possible, or a listing of documentation that may be relevant to the situation (e.g. claim numbers, telephone logs)
- Any other known information which may be relevant

Reporting FWA to ASH

Reports can be made directly to ASH's Special Investigations Unit via the methods below. As a reminder, FWA referrals are confidential and can be made anonymously.

ASH's Special Investigations Unit:

Email: antifraud@ashn.com

Hotline: 877.427.4722

Write: American Specialty Health
Attn: Special Investigation Unit
P.O. Box 509001
San Diego, CA 92150-9001

Reporting FWA Outside of ASH

Reports can also be made to Government authorities, such as the Office of Inspector General (OIG) or CMS via the methods below. For Medicaid or QHP business, you can report directly to the state agency overseeing the applicable program.

Individuals or entities who wish to voluntary disclose self-discovered potential fraud to the OIG may do so under the Self-Disclosure Protocol. Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation. The Self-Disclosure Online Submission can be located via the following link: https://oig.hhs.gov/compliance/self-disclosure-info/self-disclosure-protocol/

- **Office of Inspector General (OIG):**
  - Phone: 1.800.477.8477 or TTY 1.800.377.4950
  - Fax: 1.800.223.8164
  - Email: HHSTips@oig.hhs.gov
  - Online: forms.OIG.hhs.gov/hotlineoperations/index.aspx

- **Investigations Medicare Drug Integrity Contractor (I MEDIC):**
  - Phone: 1.877.772.3379

- **CMS Hotline:**
  - Phone: 1.800.633.4227 or TTY 1.877-486-2048

Correcting FWA

After a potential FWA situation has been reported and investigated, any findings will be promptly corrected. ASH's SIU will develop a plan to correct the issue. The actual plan will very, depending on the specific circumstances, but the below provides some examples of actions that may be taken:

- Conducting training
- Providing education materials
- Revising policies and procedures
- Seeking restitution
- Corrective Action Plan (CAP) under your contract with ASH
- Monitoring the results of corrective actions to ensure effectiveness

ASH’s COMPLIANCE & ANTI-FRAUD PROGRAM

ASH's Compliance & Anti-Fraud Program

ASH has established a compliance and anti-fraud program to comply with state and federal requirements and to meet generally accepted, industry standard compliance and anti-fraud program standards. ASH maintains the following documents which support ASH's compliance and anti-fraud program:

- Code of Conduct & Ethics Program
- Compliance Program
- Anti-Fraud Policy

For a copy of the above documents, please log into ASHLink, call our Contract Services department, or email ASH at ethicsandintegrity@ashn.com or antifraud@ashn.com.

As a provider of services to members in government programs (i.e. Medicare, Medicaid and/or QHP), your organization should consider creating and implementing its own compliance program to prevent, detect and correct non-compliance and FWA.

NEXT STEPS & CONSEQUENCES FOR NON-COMPLIANCE

Next Steps

At the completion of the training, contracted providers must document that all employees involved in the administration or delivery of Medicare Part C, Medicaid and/or QHP benefits have taken the training.

In addition, contracted providers must complete the annual “Attestation of Compliance and Acknowledgment of Compliance Obligations” to show compliance with various requirements including training all applicable employees on general compliance and FWA.

A copy of the sample training log and the annual attestation can be located on ASHLink.

As a reminder, all training records and attestations must be kept for at least 10 years after the final date of the applicable member benefit plan contract period.

Consequences for Non-Compliance with the Training Requirement

As outlined in your Provider Services Agreement, ASH may request a copy of the annual attestation at any time.

Failure to provide ASH with the annual attestation if requested to demonstrate compliance may result in the following actions:

THANK YOU

for participating and expanding compliance program effectiveness by ensuring you adopt the learning's into your individual compliance programs and business practices.

Last updated: 4/25/2024