Office of Compliance & Ethics
General Compliance Training

2017 JHS Annual Mandatory Education
Instructions

• This presentation is an annual update of the Office of Compliance and Ethics (OCE) training, which is designed for all employees, physicians, contractors, vendors, students, and volunteers of the Public Health Trust/Jackson Health System.

• In order to receive credit for this training you must:
  – Review all of the presentation materials
  – Score an 80% or better on the test

• If you have any questions, please contact the Office of Compliance and Ethics at (305) 585-2902.
Training Objectives / Roadmap

• Understanding Compliance
  – Understand the fundamentals of Compliance
  – Know the framework for the Compliance and Ethics program

• Compliance Benefits
  – Understand the benefits of an effective compliance program

• Spotting Compliance Issues
  – Understand some of the important laws that regulate health care activities

• Disciplinary Actions
  – Know what happens if you do not follow the laws and policies

• Reporting Compliance Issues
  – Know how to report Compliance and Ethics issues

• CMS Required Training
What is Compliance?

- Being aware of legal and ethical responsibilities
  - Abiding by all laws, regulations, JHS policies, and our Code of Conduct
  - Promoting ethical behavior
  - Recognizing areas of vulnerability
  - Reporting concerns or suspicious / improper activities
Seven Elements of an Effective Compliance Program

• Compliance Leadership
• Standards and Policies
• Training and Education
• Process for Reporting Compliance Issues
• Auditing and Monitoring

• Responding to Reports
• Enforcing Standards Through Disciplinary Guidelines
Benefits of Effective Compliance Programs

- Demonstrates commitment to honest and responsible conduct
- Increases the likelihood of preventing, identifying, and correcting unlawful behavior
- Avoids the potential for fraud, waste, and abuse
- Improves claim payment rate and reduces billing errors
- Encourages employees to report potential issues
- Early detection and reporting minimizes financial losses
- Promotes patient safety and ensures delivery of high quality care
Spotting Compliance Issues

- Stark Law
- Anti-Kickback Statute
- Patient Inducement
- False Claims Act
- Fraud, Waste, & Abuse
- EMTALA
- Conflict of Interest
- HIPAA
The Stark Law

The Stark Law says that if a medical facility (such as a hospital) has a financial relationship with a physician or a family member of the physician, then that physician may not refer patients to the facility for designated health services (including inpatient and outpatient hospital services), and the hospital may not bill for such services, unless an exception to the law is met. This prevents the physician from receiving money for referring patients, and ensures that the physician acts in the patient’s best interest, not their own.
The Anti-Kickback Statute

The Anti-Kickback Statute says you may not knowingly offer, pay, seek, or receive anything of value in return for, or to induce the referral of, items or services.

This means we may not give or receive anything of value in exchange for referrals to our business (e.g. patient services) or someone else’s business (e.g. a supply vendor).

Unlike the Stark Law, this law applies to everyone, not just physicians.
Patient Inducement

Federal law states that healthcare providers cannot influence a person’s choice of where to receive care by giving or offering the person anything of value that is likely to influence their choice of healthcare provider.

Giving or offering something to someone means providing the item for free or charging less than fair market value.

Examples of inappropriate inducement include giving or offering: cash (e.g. cash value or in-kind), items (e.g. prizes, gifts, or giveaways), services (e.g. transportation), or waivers of copayments or deductible amounts.
The False Claims Act

The False Claims Act applies to fraud involving federal and state health care programs like Medicare and Medicaid.

Any person who knowingly presents, or causes to be presented, a false or fraudulent claim may be held liable.

We have a responsibility to ensure that we bill accurately for the care we provide. All claims or bills must be supported by complete and accurate documentation.
Fraud, Waste, and Abuse

Fraud, waste, and abuse (FWA) all result in unnecessary or inappropriate costs to federal healthcare programs. Waste is unnecessary costs as a result of improper management, practices, or controls. Abuse is excessive or improper use of government resources. Fraud is obtaining something of value through intentional misrepresentation or hiding material facts. Each of us must know how to recognize, prevent, and report FWA within our network so that federal funds can be available to pay for care that our patients need.

This topic is covered in greater detail in the Office of Compliance and Ethics - Fraud, Waste, and Abuse learning module.
EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with Emergency Departments to provide a medical screening examination to any person asking for medical care, regardless of the person’s ability to pay. The purpose of the examination is to determine if the person has an emergency medical condition, which includes active labor. If the person has an emergency medical condition, then the hospital must stabilize the person to the best of its ability before it can consider transferring the patient. The screening and stabilization must occur without being delayed by inquiries into the patient’s insurance or financial status.
Conflicts of Interest

• A Conflict of Interest is any circumstance where a JHS Associate (or their family member) has a financial or personal interest in the outcome of a decision over which the associate has control or influence.

• All employees should avoid Conflicts of Interest to prevent fraud, corruption, or questionable business relationships or conduct.

• This topic is covered in greater detail in the Office of Compliance and Ethics - Conflict of Interest learning module.
HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) says that health care providers must safeguard the privacy and security of the protected health information (PHI) of the patients that they treat.
Protected Health Information (PHI)

*PHI is any information that could reveal the identity of, or link to, a patient.*

- Names
- All geographic identifiers
- All elements of dates
- Telephone numbers
- Fax numbers
- Electronic mail (e-mail) addresses
- Social Security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers (e.g. tag numbers)
- Device identifiers and serial numbers
- URL numbers
- IP address numbers
- Biometric identifiers, including finger and voice prints
- Full face photographic images
- **ANY OTHER** unique identifying number, characteristic or code
Access to and Use of PHI

HIPAA states that a patient’s PHI may only be accessed or used on a need-to-know basis. You may only access or use PHI if you are engaged in one of three allowable purposes:

1) A patient’s medical treatment or care,
2) Patient billing, coding, insurance, or finances, or
3) Hospital operations (e.g. transferring a patient from one unit to the next).

Accessing a patient record or PHI for any other use or reason is strictly prohibited. Also be aware that it is against JHS policy for you to look at your own medical record. Should you desire a copy of your medical record, you may access it through the patient portal or request a copy from the Health Information Management department.
The Minimum Necessary Rule states that health care providers must limit the use and disclosure of PHI. When you are using PHI to accomplish one of the three allowable purposes we just discussed, you must access and use the least amount of PHI necessary to accomplish that purpose.
Practical Considerations

• **Social Media:** Never share PHI on any form of social media (Facebook, YouTube, Instagram, Twitter, Snapchat, etc.)

• **News Media:** Never share PHI with any member of the news media. These requests should always be referred directly to the Department of External Affairs.
Practical Considerations Continued

- **Email Use:** When using email, always use your JHS work email, and never use a personal email address.
  - Internal emails (to/from a JHS or University of Miami email address) are automatically encrypted and secure.
  - If you have to send PHI outside the system (to a non-JHS or non-University of Miami email address), type the email as you normally would, and then enter the word “secure” in the subject line. This will ensure only your recipients can access it.
  - Most people put “secure” at the beginning of the subject in brackets so, as an example, your subject line might look like this: “[Secure] Regarding Patient Xyz’s Treatment”
Safeguarding PHI

• Never leave desktop computers unlocked and unattended
  – Turning off a screen or monitor is not sufficient to protect PHI

• Never leave electronic devices unattended
  – USBs, laptops and tablets or any other mobile device

• Never leave paper medical records or other records containing PHI unattended

• Do not hand out PHI without verifying that the information is being given to the correct patient, especially when discharging patients. Always confirm that every page of discharge instructions given to a patient belongs to that patient.
Excluded Parties

The Office of Inspector General has the authority to exclude persons or entities (e.g. hospitals) from participating in federally funded healthcare programs, like Medicare and Medicaid. When a party is excluded from a federal healthcare program, the federal government will no longer pay for any item or service provided, ordered, or prescribed by that person or entity.
Disciplinary Actions

• Employees who violate any laws, regulations, or JHS policies including the Code of Conduct, will be disciplined according to JHS Policy No. 305 - Corrective Action.

• Violations can result in termination of employment with the Jackson Health System.

• If you break any federal or state laws or regulations, the government may decide to charge you personally.
Non-Retaliation

• Everyone should feel comfortable asking questions and reporting concerns about situations or practices that they believe could place themselves and / or JHS “at risk.”

• To ensure that our employees feel safe reporting potential compliance issues, JHS has a strict no retaliation/retribution policy. This policy states that you cannot and will not be punished for reporting compliance issues in good faith.
Reporting Issues to Compliance

HOTLINE (800) 684-6457

• Reporting to Compliance
  – Employees are required to report suspicious or improper behavior. If you know about something, you must report it.
  – You should report any potential compliance issue promptly (when you first become aware of it).
  – Issues may be reported to:
    • Your Supervisor or Manager
    • The Hospital Compliance Officer of your facility
    • The Compliance Hotline

• Compliance Hotline
  – You may report anonymously if you choose
  – Managed by an independent vendor
  – A live person will answer your call 24/7
  – Please provide as many details as possible
Centers for Medicare and Medicaid Services

Mandatory Slides Follow
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Medicare Parts C and D General Compliance Training
Web-Based Training Course
Introduction

- The Medicare Parts C and D General Compliance Training course is brought to you by the Medicare Learning Network®, a registered trademark of the U.S. Department of Health & Human Services (HHS)
This Web-Based Training (WBT) course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the WBT for your reference.

This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Completing this training module satisfies the Medicare Parts C and D plan Sponsors annual general compliance training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi);
- 42 CFR Section 423.504(b)(4)(vi);
- Section 50.3 of the Compliance Program Guidelines (Chapter 9 of the “Medicare Prescription Drug Benefit Manual” and Chapter 21 of the “Medicare Managed Care Manual”); and
- June 17, 2015, Health Plan Management System (HPMS) memo: Update – Reducing the Burden of the Compliance Program Training Requirements. (Keep up-to-date with the most recent memos on the CMS Compliance Program Policy and Guidance website.)

While Sponsors are required to complete this training or use this module’s downloaded content to satisfy compliance training requirements, completing this training in and of itself does not ensure that a Sponsor has an “effective Compliance Program.” Sponsors are responsible for establishing and executing an effective compliance program according to the Centers for Medicare & Medicaid Services (CMS) regulations and program guidelines.

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Welcome to the Medicare Learning Network® (MLN) – Your free Medicare education and information resource!

The MLN is home for education, information, and resources for the health care professional community. The MLN provides access to the CMS Program information you need, when you need it, so you can focus more on providing care to your patients.

Serving as the umbrella for a variety of CMS education and communication activities, the MLN offers:

1. MLN Educational Products, including MLN Matters® Articles;
2. WBT Courses (many offer Continuing Education credits);
3. MLN Connects® National Provider Calls;
4. MLN Connects® Provider Association Partnerships;
5. MLN Connects® Provider eNews; and

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

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Why Do I Need Training?

• Every year billions of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone – including you. This training helps you detect, correct, and prevent FWA. You are part of the solution.

• Compliance is everyone’s responsibility. As an individual who provides health or administrative services for Medicare enrollees, your every action potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

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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 the Medicare Parts C and D benefits. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this WBT course as “Sponsors”) and the entities with which they contract to provide administrative or health care services for enrollees on behalf of the sponsor (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.

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**Course Content**
This WBT course consists of general compliance program training, a post-assessment, and a course evaluation.

Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You must use this course to satisfy general compliance training requirements.

**Course Objectives**
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.

**Lesson: Compliance Program Training**

**Introduction and Learning Objectives**
This lesson outlines effective compliance programs. It should take about 15 minutes to complete. Upon completing the lesson, you should be able to correctly:
- Recognize how a compliance program operates; and
- Recognize how compliance program violations should be reported.

**Compliance Program Requirement**
The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans. An effective compliance program should:
- 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.
Lesson: Continued

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.

For more information, refer to:
• 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi) on the Internet;
• 42 CFR Section 423.504(b)(4)(vi) on the Internet;
• “Medicare Managed Care Manual,” Chapter 21 on the CMS website; and

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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 Sponsor’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 Sponsor 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 Sponsor’s senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor’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.

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 Sponsor and First-Tier, Downstream, or Related Entity (FDR) levels.

5. Well-Publicized Disciplinary Standards  Sponsor 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 Sponsor’s and FDR’s operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

    NOTE: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor’s Medicare Parts C and D program comply with Medicare Program requirements.

7. Procedures and System for Prompt Response to Compliance Issues  The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

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Compliance Training—Sponsors and their FDRs

CMS expects that all Sponsors will apply their training requirements and “effective lines of communication” to their FDRs. Having “effective lines of communication” means that employees of the Sponsor and the Sponsor’s FDRs have several avenues to report compliance concerns.
Lesson: Continued

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.
Lesson: Continued

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.

For more information, refer to the Compliance Program Guidelines in the “Medicare Prescription Drug Benefit Manual” and “Medicare Managed Care Manual” on the CMS website.

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.

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Lesson: Continued

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 Sponsor
• Call the Medicare Compliance Officer;
• Make a report through your organization’s website; or
• Call the Compliance Hotline.

First-Tier, Downstream, or Related Entity (FDR) Employees
• Talk to a Manager or Supervisor;
• Call your Ethics/Compliance Help Line; or
• Report to the Sponsor.

Beneficiaries
• Call the Sponsor’s Compliance Hotline or Customer Service;
• Make a report through the Sponsor’s website; 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 Sponsor 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 CMS 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, Review & Knowledge Check

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!

Lesson Review
Now that you have completed the Compliance Program Training lesson, let’s do a quick knowledge check. The following questions do not contribute to your overall course score in the Post-Assessment.

Knowledge Check

You discover an unattended email address or fax machine in your office that receives beneficiary appeals requests. You suspect that no one is processing the appeals. What should you do?

Select the correct answer.
- A. Contact law enforcement
- B. Nothing
- C. Contact your compliance department (via compliance hotline or other mechanism)
- D. Wait to confirm someone is processing the appeals before taking further action
- E. Contact your supervisor

**CORRECT ANSWER**
C
Lesson: Knowledge Check continued

A sales agent, employed by the Sponsor’s First-Tier or Downstream entity, submitted an application for processing and requested two things: 1) to back-date the enrollment date by one month, and 2) to waive all monthly premiums for the beneficiary. What should you do?

Select the correct answer.
○ A. Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department
○ B. Make the requested changes because the sales agent determines the beneficiary’s start date and monthly premiums
○ C. Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions) – you will not file a report because you don’t want the sales agent to retaliate against you
○ D. Process the application properly (without the requested revisions) – inform your supervisor and the compliance officer about the sales agent’s request
○ E. Contact law enforcement and the Centers for Medicare & Medicaid Services (CMS) to report the sales agent’s behavior

You work for a Sponsor. Last month, while reviewing a monthly report from the Centers for Medicare & Medicaid Services (CMS), you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan. You spoke to your supervisor who said not to worry about it. This month, you have identified the same enrollees on the report again. What should you do?

Select the correct answer.
○ A. Decide not to worry about it as your supervisor instructed – you notified him last month and now it’s his responsibility
○ B. Although you have seen notices about the Sponsor’s non-retaliation policy, you are still nervous about reporting – to be safe, you submit a report through your compliance department’s anonymous tip line so you cannot be identified
○ C. Wait until the next month to see if the same enrollees appear on the report again, figuring it may take a few months for CMS to reconcile its records – if they are, then you will say something to your supervisor again
○ D. Contact law enforcement and CMS to report the discrepancy
○ E. Ask your supervisor about the discrepancy again

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Lesson: Knowledge Check continued

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

Select the correct answer.
○ A. Call local law enforcement
○ B. Perform another review
○ C. Contact your compliance department (via compliance hotline or other mechanism)
○ D. Discuss your concerns with your supervisor
○ E. Follow your pharmacy’s procedures

CORRECT ANSWER: E

You’ve completed the lesson! Now that you have learned about compliance programs, let’s take a post-assessment to see how much you’ve learned!

Post-Assessment

This assessment asks you 10 questions about Medicare Parts C and D compliance programs.

**Question 1 of 10**
Compliance is the responsibility of the Compliance Officer, Compliance Committee, and Upper Management only.
Select the correct answer.
○ A. True
○ B. False

**Question 2 of 10**
Ways to report a compliance issue include:
Select the correct answer.
○ A. Telephone hotlines
○ B. Report on the Sponsor’s website
○ C. In-person reporting to the compliance department/supervisor
○ D. All of the above

**Question 3 of 10**
What is the policy of non-retaliation?
Select the correct answer.
○ A. Allows the Sponsor to discipline employees who violate the Code of Conduct
○ B. Prohibits management and supervisor from harassing employees for misconduct
○ C. Protects employees who, in good faith, report suspected non-compliance
○ D. Prevents fights between employees

**Question 4 of 10**
These are examples of issues that can be reported to a Compliance Department: suspected Fraud, Waste, and Abuse (FWA); potential health privacy violation, and unethical behavior/employee misconduct.
Select the correct answer.
○ A. True
○ B. False
**Post-Assessment Continued**

**Question 5 of 10**
Once a corrective action plan begins addressing non-compliance or Fraud, Waste, and Abuse (FWA) committed by a Sponsor’s employee or First-Tier, Downstream, or Related Entity’s (FDR’s) employee, ongoing monitoring of the corrective actions is not necessary.

Select the correct answer.
○ A. True
○ B. False

**Question 6 of 10**
Medicare Parts C and D plan Sponsors are not required to have a compliance program.

Select the correct answer.
○ A. True
○ B. False

**Question 7 of 10**
At a minimum, an effective compliance program includes four core requirements.

Select the correct answer.
○ A. True
○ B. False

**Question 8 of 10**
Standards of Conduct are the same for every Medicare Parts C and D Sponsor.

Select the correct answer.
○ A. True
○ B. False

**Question 9 of 10**
Correcting non-compliance _____________.

Select the correct answer to fill in the blank.
○ A. Protects enrollees, avoids recurrence of the same non-compliance, and promotes efficiency
○ B. Ensures bonuses for all employees
○ C. Both A. and B.

**Question 10 of 10**
What are some of the consequences for non-compliance, fraudulent, or unethical behavior?

Select the correct answer.
○ A. Disciplinary action
○ B. Termination of employment
○ C. Exclusion from participation in all Federal health care programs
○ D. All of the above
Appendix A: Resources

Disclaimers
This Web-Based Training (WBT) course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This WBT course was prepared as a service to the public and is not intended to grant rights or impose obligations. This WBT course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Glossary

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Job Aid A: 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 Sponsor'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 Sponsor 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 Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor'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.

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 Sponsor and First-Tier, Downstream, or Related Entity (FDR) levels.

5. **Well-Publicized Disciplinary Standards** Sponsor 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 Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

   **NOTE:** Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

7. **Procedures and System for Prompt Response to Compliance Issues** The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

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### Appendix B: Job Aids

#### Job Aid B: Resources

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Office of Compliance and Ethics
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Adam Ribner, Director of Policies, Education, and Training

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