General Compliance Training

Industry Collaboration Effort (ICE)

2020

Acronyms

Acronym	Title Text
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COM	Commercial Product
DHCS	Department of Health Care Service
DMHC	Department of Managed Health Care
FDR	First-tier, Downstream, and Related Delegated Entity
FWA	Fraud, Waste, and Abuse
HHS	U.S. Department of Health & Human Services
HMO	Health Maintenance Organization

Acronym	Title Text
IFP	Individual & Family Plan through exchange
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	Medicare Advantage Prescription Drug Plan
MLN	Medicare Learning Network
OIG	Office of Inspector General
PDP	Prescription Drug Plan
POS	Point of Service
PPO	Preferred Provider Organization

Introduction

- Throughout this training, the following will collectively be known as “Sponsors”:
  - DMHC licensed healthcare service plans
  - Staff involved in Medicare Parts C and D.
  - Staff of Medicare Advantage Organizations (MAOs)
  - Prescription Drug Plans (PDPs)
- Sponsors and their First Tier, Downstream, and Related Entities (FDRs) are responsible for establishing and executing an effective compliance program according to the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), California Department of Insurance (CDI) and Centers for Medicare & Medicaid Services (CMS) regulations and program guidelines. Completing this training in and of itself does not ensure a Sponsor or their FDRs have an “effective Compliance Program.”
- You will need to complete General Compliance training promptly upon initial hire and annually as required. Documented evidence of the completion of training must be maintained. Please contact your management team for more information.

Completing This Course

- This course consists of one lesson and a Post-Assessment. Successfully completing the course requires completing the lesson and scoring 80 percent or higher on the Post-Assessment. After successfully completing the Post-Assessment, you'll receive instructions to print your certificate. If you do not successfully complete the course, you can review the course material and retake the Post-Assessment.
- You do not have to complete this course in one session; however, you must complete the lesson before exiting the course. You can complete the entire course in about 30 minutes. After you successfully complete this course, you will receive instructions on how to print your certificate.

Training Requirements

You are required to complete General Compliance Training if you provide health or administrative services to any of the following programs:

Health Program	Description
Medicare Part C	▸ Medicare Part C, or Medicare Advantage (MA), is a health insurance program for seniors or those with disabilities. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who enroll in a MA plan.
Medicare Part D	▸ Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to Medicare beneficiaries enrolled in Part A and/or Part B who enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to individuals living in a plan's service area.
Medi-Cal	▸ Medi-Cal is California's Medicaid program; and provides coverage for those with limited income and resources. Medi-Cal is regulated by the state through DHCS.
Individual & Family Plan (IFP)	▸ IFPs offer affordable health insurance benefits to those who are unable to obtain insurance through their employer. IFP products are provided through the state health insurance exchange "Covered California".

Training Requirements (continued)

You are required to complete General Compliance Training if you provide health or administrative services to any of the following programs:

Health Program	Description
Commercial	▸ Commercial health insurance is offered to the general population through private insurance; it is not offered or provided by the government. ▸ The two most popular commercial plans are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).
Health Maintenance Organizations (HMOs)	▸ An HMO is a type of health insurance that has a list of providers, such as doctors, medical groups, hospitals, and labs. Members must obtain all of their health care from providers on this list, which is also called a network. HMOs are regulated by the state of California through DMHC.
Preferred Provider Organization (PPO)	▸ A PPO is a plan for people who want to see providers without prior approval from their health plan or medical group, and who do not want to choose a primary care provider. Indemnity PPO products are regulated by the state of California through the CDI.
Point of Service (POS) Plan	▸ A POS plan is a type of managed care health insurance system. It combines characteristics of the HMO and the PPO. A POS plan is regulated by the state of California through the DMHC.

Why Do I Need Training?

Compliance is everyone's responsibility!

- As an individual who provides health or administrative services for Commercial, IFP, Medi-Cal or Medicare enrollees, every action you take potentially affects members/enrollees, federal and state health programs, or the Medicare Trust Fund.

- Every year, **billions** of dollars are improperly spent because of fraud, waste, and abuse (FWA). It affects everyone—**including you**. This training helps you understand how to detect, correct, and prevent non-compliance and FWA. **You** are part of the solution.

Course Objectives

After completing this course, you should correctly:

- Recognize how a compliance program operates
- Understand your responsibilities in reporting actual or suspected non-compliance
- Understand how to ask questions, report suspected or detected non-compliance
- Recognize disciplinary guidelines for non-compliant and/or fraudulent behavior
- Understand non-retaliation and discrimination policies

Compliance Program Requirement

The Centers for Medicare & Medicaid Services (CMS) and the Department of Managed Health Care (DMHC) requires Sponsors to implement and maintain an effective compliance program.

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
- Provide guidance on how to identify and report compliance violations
- Ensure compliance program audits are performed by individuals independent of fiscal or administrative management.
- Include Standards of Conduct (or Code of Conduct).

Ethics: Do the Right Thing!

Compliance ensures we conduct our business within the boundaries of the law; and guides us in acting ethically and legally.

When we make ethical decisions and commit to doing the right thing, we build trust with our members/enrollees, providers, stakeholders, and regulators. We must:

- Act fairly and honestly
- Adhere to high ethical standards in all you do
- Act with integrity, transparency, and accountability
- Comply with all applicable laws, regulations, and CMS & DMHC requirements
- Report suspected violations
- Do the right thing!

How Do You Know What Is Expected of You?

Ethical standards, expectations, and operational principles and values are outlined in your organization's Standards of Conduct (or Code of Conduct).

- Standards of Conduct state the organization's compliance expectations and their operational principles and values.
- Ask management where to locate your organization's Standards of Conduct.
- Reporting Standards of Conduct violations and suspected non-compliance is **everyone's** responsibility.
- An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

What is Non-Compliance?

- Non-compliance is conduct that does not conform to law, State, or Federal health care program requirements, Code of Conduct/Ethics, and business policies.

Examples of Non-Compliance	Explanation
"My friend is one of our members, and I am concerned about her health. Even though she is not on my case load, I look at her medical records periodically to make sure she is doing okay."	Accessing a medical record when it is not related to your job is both unethical and illegal.
"A health plan has a program available for plan members shown to improve patient outcomes and member experience. The health plan is excited about the program and offers a doctor's office $250 for every patient it enrolls in the program."	The arrangement incentivizes the doctor's office to funnel patients to the health plan which is considered a kickback and a crime under the Anti-Kickback Statute.

What is Non-Compliance?

- Sometimes good intentions can lead to non-compliance. The key is to always act with integrity – always do what is right even when it is hard or when no one is looking.

Examples of Non-Compliance	Explanation
"My co-worker changed a date on a member's authorization request to avoid getting in trouble for being late. I know this is wrong, but it only happened once, so I won't say anything."	Covering up unethical behavior is wrong. While you intended to protect your co-worker, you allowed harm to occur to the member.
"One patient needed a doctor's office visit on December 29th. He stated his insurance would not be effective until January 1st. My co-worker wanted to help the patient and changed the date of service in the medical record to January 2nd to ensure the patient's insurance covers the visit."	Knowingly entering inaccurate information in a record to ensure compensation is fraud and is a crime under the Federal False Claims Act. If you know or suspect fraud is occurring, you must report it immediately to management or Compliance.

High Risk Areas for Non-Compliance

The following are examples of high-risk areas:

- Agent/broker/delegate misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims and Utilization Management 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
- Quality of care
- IT System access and safeguards
- Claims and Utilization Management documentation manipulation

Examples of Non-Compliance in High Risk Areas

Documentation and Timeliness Requirements

- Please follow all timelines required by your organization and/or Health Plan.

Examples of Non-Compliance	Explanation
"We received a request from a member to access their medical records. Our co-worker who handles these requests is out on medical leave for at least 2 more months. Due to our shortage of staff, can these types of requests wait until our co-worker returns?"	No. It is the law that medical records be provided within 30 days of the request.
"The mailroom where we send out denial letters has been having issues. We have not told anyone, even though outgoing mail has been delayed for at least 2 days. This should not be an issue, right?"	This is an issue because denial letters have sensitive timelines. Delays in mailing should be reported immediately.

Examples of Non-Compliance in High Risk Areas

Claims Documentation Manipulation

Examples of Non-Compliance	Explanation
"Our patient wants a procedure not covered by his insurance as it is not considered medically necessary. A Physician Assistant knows the procedure would be covered by insurance for treatment of a specific diagnosis and adds this diagnosis to the insurance claim to ensure the procedure is covered."	Knowingly entering inaccurate information in a record to ensure compensation is fraud and is a crime under the Federal False Claims Act. If you know or suspect fraud is occurring, you must report it immediately to management or Compliance.

Examples of Non-Compliance in High Risk Areas

Conflict of Interests

Examples of Non-Compliance	Explanation
"A pharmaceutical representative has given our office tickets to a highly coveted sporting event in appreciation of all the business that we do with them. We know these are expensive and hard to come by – can we accept the tickets?"	No. This would be a conflict of interest and may create the perception that business is only conducted with those pharmaceutical companies that provide perks, and not those in the best interest of the member/enrollee.

Know the Consequences of Non-Compliance

Failure to follow ethical standards, contractual obligations, regulations, and CMS/DMHC guidance can lead to serious consequences, including:

- Contract termination
- Criminal penalties
- Exclusion from participating in all Federal health care programs
- 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
- Termination

Non-Compliance Affects Everybody

Without programs to prevent, detect, and correct non-compliance, we all risk harm to our enrollees/members and to everyone.

Risk Harm to Enrollees/Members

- Delayed treatment/services
- Denial of benefits
- Increased member financial liability
- Difficulty in using providers of choice
- Other barriers to care

Overall Impact Affecting Everyone

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower provider reimbursement
- Regulatory/legal penalties and fines.
- Lower Star ratings
- Lower profits

Reporting Non-Compliance

You have a responsibility to report Standards of Conduct violations and suspected compliance issues (Privacy, FWA, or non-compliance). This is **everyone's** responsibility.

- Your organization's Standards of Conduct and Policies and Procedures will tell you how to report suspected non-compliance. At a minimum, you can report to your Supervisor or to Compliance.
  - Various methods of reporting may also include calling a confidential hotline, sending an email or mail

Reporting Non-Compliance

Reports of suspected non-compliance may be made anonymously and are kept confidential to the extent allowed by law.

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

Whistleblowers and persons who report in good-faith any suspected violations or issues, are protected from retaliation and intimidation.

Examples of Non-Compliance	**Explanation**
"After I reported irregularities in my department, my manager began excluding me from meetings and moved me to an undesirable location in the office."	Retaliation or intimidation is not tolerated. The manager's behavior is unacceptable and should be reported to management or to Compliance.

Anonymity vs. Confidentiality

- Remaining **anonymous** means that your identity will not be known and will not be attempted to be known.

  Reports made anonymously should include as much detail as possible, including any examples, so that investigations can be made thoroughly.

- Regardless if you choose to remain anonymous, information shared will be kept **confidential**.

  This means that the information about the person who made the report (if not anonymous), and any details about the situation/issue will only be shared with persons on a need to know basis and only to the extent allowed by law.

What Happens After Non-Compliance Is Detected?

Non-compliance must be investigated immediately and corrected promptly. Internal monitoring and auditing should ensure:

- No recurrence of the same non-compliance
- Ongoing CMS/DMHC compliance requirements
- Efficient and effective internal controls
- Protected enrollees

Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.

Internal auditing is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

Commitment to Compliance and Effective Compliance Program

Supporting this commitment to ethical conduct, your organization is required to adopt and implement 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
- Establishes clear lines of communication for reporting non-compliance
- Builds a firm non-retaliation policy and culture to support reporting of non-compliance without fear of retribution.

Seven Core Compliance Program Requirements

An effective compliance program must, at minimum, include the following 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 accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.
- The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

Seven Core Compliance Program Requirements (continued)

An effective compliance program must, at minimum, include the following seven core requirements:

3. Effective Training and Education

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

4. Effective Lines of Communication

- Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith compliance issues reporting at Sponsor and first-tier, downstream, or related entity (FDR) levels. Having "effective lines of communication" means that several avenues to report compliance concerns are available.

5. Well-Publicized Disciplinary Standards

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

Seven Core Compliance Program Requirements (continued)

An effective compliance program must, at minimum, include the following seven core requirements:

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

- Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS & DMHC requirements as well as the overall effectiveness of the compliance program. Auditors should be independent of the audit function to prevent self-policing and conflicts of interest.
- **NOTE:** Sponsors must ensure FDRs performing delegated administrative or health care service functions comply with Medicare Program and DMHC 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.

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.

Summary

Compliance Is Everyone's Responsibility!

- **Prevent:** Operate within your organization's ethical expectations to prevent non-compliance!
- **Detect & Report:** Report detected potential non-compliance!
- **Correct:** Correct non-compliance to protect beneficiaries and save money!

Disclaimer

- This training course was current at the time it was published or uploaded onto the web. Medicare and DMHC policy changes frequently so links to the source documents have been provided within the course for your reference.
- This course was prepared as a service and is not intended to grant rights or impose obligations. This 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.

Fraud, Waste, and Abuse and Non-Compliance Reporting Mechanisms

All reports made are treated confidentially and you may choose to remain anonymous. Whistleblowers and persons who report suspected violations in good faith are protected against retaliation.

Government Authority	FWA / Ethics & Compliance Hotline	TTY; Email; or Mail	Online Tool
CMS Hotline	1-800-MEDICARE Or 1-800-633-4227	1-877-486-2048	https://www.stopmedicarefraud.gov
HHS Office of Inspector General	1-800-HHS-TIPS Or 1-800-447-8477	TTY 1-800-377-4950 HHSTips@oig.hhs.gov	https://forms.oig.hhs.gov/hotlineoperations
HHS and US Department of Justice (DOJ)	N/A	N/A	https://www.stopmedicarefraud.gov
For Medicare Parts C and D: National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)	1-877-7SafeRx Or 1-877-772-3379	N/A	N/A
State of California Bureau of Medi-Cal Fraud or Elder Abuse (BMFEA) Hotline	1-800-722-0432	Email using On-line Form: https://oag.ca.gov/bmfea/reporting	https://oag.ca.gov/bmfea/reporting
State of California Department of Health Care Services Hotline	1-800-822-6222	fraud@dhcs.ca.gov Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations PO Box 997413, MS 2500 Sacramento, CA 95899-7413	https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

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Sponsor	FWA / Ethics & Compliance Hotline	Email	Online Tool	Mail
Alignment	844-215-2444	compliance@ahcusa.com	www.reportlineweb.com/ahc	N/A
Blue Shield of California	855-296-9092 855-296-9083	stopfraud@blueshieldca.com corporate-compliance@blueshieldca.com	www.blueshieldca.com/fraud-report	Blue Shield of California Special Investigations 3300 Zinfandel Drive Rancho Cordova, CA 95670
Brand New Day	866-255-4795 x4071	hotline@universalcare.com	N/A	Compliance Officer: 5455 Garden Grove Blvd., 5th floor Westminster, CA 92683
Central Health Plan of California	626-388-2392	compliance@centralhealthplan.com	N/A	1540 Bridgegate Drive Diamond Bar, CA 91765
Chinese Community Health Plan	415-955-8810	N/A	N/A	Compliance Officer 445 Grant Ave Suite 700 San Francisco, CA 94108
Cigna Health Plan	800-667-7145 800-472-8348	specialinvestigations@cigna.com	N/A	Cigna Special Investigations 900 Cottage Grove Road W3SIU Hartford, CT 06152
Community Health Group	800-651-4459	emarti@chgsd.com	N/A	Compliance Officer Community Health Group 2420 Fenton St., Ste. 100 Chula Vista, CA 91914

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Sponsor	FWA / Ethics & Compliance Hotline	Email	Online Tool	Mail
Humana	**Ethics**: 877-584-3539 **Fraud**: 800-614-4126	ethics@humana.com siureferrals@humana.com	www.ethicshelpline.com Fax: 1-920-339-3613	Humana Special Investigation Unit 1100 Employers Blvd. Green Bay, WI 54344
Inland Empire Health Plan	866-355-9038	compliance@iehp.org	https://iehp.org/en/about/compliance-program	IEHP Compliance Officer P.O. Box 1800 Rancho Cucamonga, CA 91729
Inter Valley Health Plan	888-372-8325	N/A	http://www.reportlineweb.com/ivhp	Compliance Dept. PO Box 6002 Pomona, CA 91769
Molina Healthcare, Inc.	866-606-3889	N/A	https://molinahealthcare.Alertline.com	N/A
SCAN Health Plan	877-863-3362	N/A	www.ethicspoint.com	N/A
United Healthcare	844-359-7736	N/A	https://secure.ethicspoint.com/domain/media/en/gui/51176/index.html	N/A
Vitality Health Plan		N/A	N/A	N/A
WellCare of California, Inc.	866-678-8355 866-364-1350	N/A	N/A	N/A

Resources/References

Hyperlink URL	Linked Text/Image
https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5cff780d3df38cc4183f2802223859ba&mc=true&r=PART&n=pt42.3.423	42 CFR Section 423.504
https://www.ecfr.gov/cgi-bin/text-idx?SID=c66a16ad53319afd0580db00f12c5572&mc=true&node=pt42.3.422&rgn=div5#se42.3.422_1503	42 Code of Federal Regulations (CFR) Section 422.503
https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7b&num=0&edition=prelim	Anti-Kickback Statute (AKS) - 42 USC Section 1320a-7b(b)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf	Chapter 21 of the Medicare Managed Care Manual
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf	Chapter 9 of the Medicare Prescription Drug Benefit Manual

Resources/References (continued)

Hyperlink URL	Linked Text/Image
https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html	CMS Compliance Program Policy and Guidance webpage
https://oig.hhs.gov/compliance/101	Compliance Education Materials: Compliance 101
https://www.dhcs.ca.gov/Pages/default.aspx	DHCS oversees Medi-Cal, the state Medicaid program directly governed by California state laws.
http://wpso.dmhc.ca.gov/regulations/#existing	DMHC state laws relating to managed health care plans in California
https://uscode.house.gov/view.xhtml?path=/prelim@title31/subtitle3/chapter37/subchapter3&edition=prelim	Federal Civil False Claims Act (FCA) - 31 USC Section 3729-3733
https://oig.hhs.gov/compliance/provider-compliance-training	Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training

Resources/References (continued)

Hyperlink URL	Linked Text/Image
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf	Medicare Fraud & Abuse: Prevent, Detect, Report
https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp	Office of Inspector General's (OIG's) Provider Self-Disclosure Protocol
https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits	Part C and Part D Compliance and Audits - Overview
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral	Physician Self-Referral
https://oig.hhs.gov/compliance/safe-harbor-regulations	Safe Harbor Regulations
https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey.aspx#.V-rJEfkrKM9	Technical Assistance Guides to support DMHC laws as they apply to managed health care (HMO/POS)

Quiz Questions

1. You discover an unattended email address or fax machine in your office receiving beneficiary appeals requests. You suspect no one is processing the appeals. What should you do?
    a. Contact law enforcement
    b. Contact your compliance department (via compliance hotline or other mechanism)
    c. Wait to confirm someone is processing the appeals before taking further action
    d. Do nothing

Quiz Questions

2. A sales agent, employed by the Sponsor's first-tier, downstream, or related entity (FDR), 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?

   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.

Quiz Questions

3. You work for a Sponsor. Last month, while reviewing a Centers for Medicare & Medicaid Services (CMS) monthly report, you identified multiple individuals not enrolled in the plan but for whom the Sponsor is paid. You spoke to your supervisor who said don't worry about it. This month, you identify the same enrollees on the report again. What should you do?

   a. Decide not to worry about it as your supervisor instructed—you notified your supervisor last month and now it's their responsibility.

   b. Although you know 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 to avoid identification.

   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.

Quiz Questions

4. Compliance is only the responsibility of the Compliance Officer, Compliance Committee, and Upper Management.
   a. True
   b. False

Quiz Questions

5. Ways to report a compliance issue include:
   a. Telephone hotlines
   b. Report on the Sponsor's website
   c. In-person reporting to the compliance department/supervisor
   d. All of the answers.

Quiz Questions

6. What is the purpose of the non-retaliation policy?
   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.

Quiz Questions

7. These are examples of issues that can be reported to a Compliance Department: suspected fraud, waste, and abuse (FWA), potential health privacy violations, unethical behavior/employee misconduct, and:
    a. Marketing inappropriate incentives to members to join certain Medical Groups and/or Health Plans.
    b. Documentation and timeliness issues.
    c. Quality of care issues.
    d. All of the answers including many other high risk areas.

Quiz Questions

8. 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.
    a. True – management can be trusted to always ensure the plan of correction is implemented.
    b. False – internal monitoring is essential for corrective action plan follow-up.
    c. False – ongoing monitoring is not required by federal or state laws.
    d. True – the organization must report to CMS only.

Quiz Questions

9. Commercial, Medicare Parts C and D Plan Sponsors are not required to have a compliance program.
    a. True – a compliance program is not required if they have a Quality and Ethics committee.
    b. False – a compliance program is required and must include measures to prevent, detect, and correct non-compliance as well as fraud, waste, and abuse.
    c. True – a compliance program is not required if compliance training is provided every 2 years.
    d. True – a compliance program is only needed if they have commercial customers.

Quiz Questions

10. At a minimum, an effective compliance program includes four core requirements: 1) written policies and procedures, 2) well-publicized disciplinary guidelines, 3) effective lines of communication, and 4) effective training and education.

    a. True – the compliance director can manage these 4 core requirements.

    b. False – at a minimum, there must be 7 core elements.

    c. False – the Sponsor is not required to enforce standards through well-publicized disciplinary guidelines.

    d. False – written policies and procedures are not required as a core element.

Quiz Questions

11. Correcting non-compliance_____.
    a. Protects enrollees, avoids recurrence of the same non-compliance, and promotes efficiency.
    b. Ensures bonuses for all employees.
    c. Should be fully implemented and tailored to an organization's unique operations and circumstances.
    d. Both A and C.

Quiz Questions

12. What are some of the consequences for non-compliance, fraudulent, or unethical behavior?
    a. Disciplinary action
    b. Termination of employment
    c. Exclusion from participating in all Federal health care programs
    d. All of the answers

Quiz Questions

13. Whistleblowers and persons who report in good-faith any suspected violations or issues are protected from retaliation and intimidation.
    a. True
    b. False

Quiz Questions

14. You are working as a prior authorization nurse reviewer, your team has been short staffed for the past 6 months and there has been a delay in getting denial letters distributed timely. Your co-worker has an upcoming health plan audit and she asked you to quality check the cases that have been selected. Upon review of quality check you see all files are at 100 % compliance with letter distribution. Given the back log you are suspicious and believe it is likely the co-worker has changed dates on the letters to show compliance with mailing. What would you do?

    a. Do nothing and be glad the health plan audit will have a good outcome.

    b. Contact your supervisor and/or compliance department and report your findings and suspicions.

    c. Talk to your co-worker and ask her how she did this as you have several upcoming audits yourself.

    d. Ask your friend from the claims department what you should do.

Quiz Questions

15. When a strong compliance program is established there is less risk to the customer. Benefits of a strong compliance program include all EXCEPT:

    a. Decreased member financial liability
    b. Appropriate access to providers of choice
    c. Decreased barriers to care
    d. Delayed treatment/services