



Annual Compliance Training

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General Compliance

Fraud, Waste, and Abuse

HIPAA



Medicare Parts C and D General Compliance Training

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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.

Course Objectives

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

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

Compliance Program Requirement

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.

What Is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- ▶ Prevents, detects, and corrects non-compliance;
- ▶ Is fully implemented and is tailored to an organization's unique operations and circumstances;
- ▶ Has adequate resources;
- ▶ Promotes the organization's Standards of Conduct; and
- ▶ Establishes clear lines of communication for reporting non-compliance.

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as Fraud, Waste, and Abuse (FWA). It must, at a minimum, include the seven core compliance program requirements

Seven Core Compliance Program Requirements

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

- 1. Written Policies, Procedures, and Standards of Conduct** These articulate the 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.

Seven Core Compliance Program Requirements (Continued)

4. **Effective Lines of Communication** Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith reporting of compliance issues at 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.

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.

Ethics—Do the Right Thing!

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

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

How Do You Know What Is Expected of You?

Beyond following the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation? Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates. Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations. If you are not aware of your organization's standards of conduct, ask your management where they can be located.

Everyone has a responsibility to report violations of Standards of Conduct and suspected non-compliance.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

What Is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS has identified the following Medicare Parts C and D high risk areas:

- ▶ Agent/broker misrepresentation;
- ▶ Appeals and grievance review (for example, coverage and organization determinations);
- ▶ Beneficiary notices;
- ▶ Conflicts of interest;
- ▶ Claims processing;
- ▶ Credentialing and provider networks;
- ▶ Documentation and Timeliness requirements;
- ▶ Ethics;
- ▶ FDR oversight and monitoring;
- ▶ Health Insurance Portability and Accountability Act (HIPAA);
- ▶ Marketing and enrollment;
- ▶ Pharmacy, formulary, and benefit administration; and
- ▶ Quality of care.

Know the Consequences of Non-Compliance

Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences including:

- Contract termination;
- Criminal penalties;
- Exclusion from participation in all Federal health care programs; or
- Civil monetary penalties.

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training;
- Disciplinary action; or
- Termination.

Non-Compliance Affects Everybody

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

Harm to beneficiaries, such as:

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

Less money for everyone, due to:

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

How to Report Potential Non-Compliance

Employees of a Sponsor

- Call the Medicare Compliance Officer; or
- Call the Compliance Hotline 415-955-8810

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



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What is FWA?

Lesson 1

Fraud

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

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to \$250,000.

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

Understanding FWA

- ▶ To detect FWA, you need to know the law.
- ▶ The following screens provide high-level information about the following laws:
 - ▶ Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud;
 - ▶ Anti-Kickback Statute;
 - ▶ Stark Statute (Physician Self-Referral Law);
 - ▶ Exclusion; and
 - ▶ Health Insurance Portability and Accountability Act (HIPAA).

Civil False Claims Act (FCA)

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

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

Damages and Penalties

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

EXAMPLE

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare & Medicaid Services (CMS);
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported;
- Failed to report the unsupported diagnosis codes to Medicare; and
- Agreed to pay \$22.6 million to settle FCA allegations.

Civil FCA (continued)

Whistleblowers

- ▶ A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- ▶ Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- ▶ Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent but not more than 30 percent of the money collected.

Health Care Fraud Statute

- ▶ The Health Care Fraud Statute states that “Whoever knowingly and willfully executes, or attempts to execute, a scheme to ... defraud any health care benefit program ... shall be fined ... or imprisoned not more than 10 years, or both.”
- ▶ Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law.

▶ EXAMPLES

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;
- Pleaded guilty to health care fraud; and
- Received a 15-month prison sentence and was ordered to pay more than \$166,000 in restitution to the plan.

The owners of two Florida Durable Medical Equipment (DME) companies:

- Submitted false claims of approximately \$4 million to Medicare for products that were not authorized and not provided;
- Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;
- Were sentenced to 54 months in prison; and
- Were ordered to pay more than \$1.9 million in restitution.

Criminal Health Care Fraud

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

- ▶ Criminal fines up to \$250,000;
- ▶ Imprisonment for up to 20 years; or
- ▶ Both.

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare Program).

Damages and Penalties

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

EXAMPLE

A radiologist who owned and served as medical director of a diagnostic testing center in New Jersey:

- Obtained nearly \$2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests;
- Paid doctors for referring patients;
- Pleaded guilty to violating the Anti-Kickback Statute; and
- Was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest; or
- A compensation arrangement (exceptions apply).

Damages and Penalties

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

EXAMPLE

A physician paid the Government \$203,000 to settle allegations that he violated the physician self-referral prohibition in the Stark Statute for routinely referring Medicare patients to an oxygen supply company he owned.

Civil Monetary Penalties (CMP) Law

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

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

Damages and Penalties

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

EXAMPLE

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

Exclusion

- ▶ No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). You can access the LEIE on the Internet.
- ▶ The United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management website.
- ▶ If looking for excluded individuals or entities, make sure to check both the LEIE and the EPLS since the lists are not the same.

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

Health Insurance Portability and Accountability Act (HIPAA)

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

HIPAA safeguards help prevent unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

Damages and Penalties

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

EXAMPLE

- ▶ A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

Summary Lesson 1: What is FWA?

There are differences among FWA. One of the primary differences is intent and knowledge. Fraud requires that the person have intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment but do not require the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties;
- Civil prosecution;
- Criminal conviction/fines;
- Exclusion from participation in all Federal health care programs;
- Imprisonment; or
- Loss of provider license.



Your Role in the Fight Against FWA

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Lesson 2

Introduction and Learning Objectives

This lesson explains the role you can play in fighting against Fraud, Waste, and Abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. Upon completing the lesson, you should be able to correctly:

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

Where Do I Fit In?

As a person who provides health or administrative services to a Medicare Part C or Part D enrollee, you are either an employee of a:

- ▶ Sponsor (Medicare Advantage Organizations [MAOs] and Prescription Drug Plans [PDPs]);
- ▶ First-tier entity (Examples: Pharmacy Benefit Management (PBM), hospital or health care facility, provider group, doctor office, clinical laboratory, customer service provider, claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, and contracted sales agent);
- ▶ Downstream entity (Examples: pharmacies, doctor office, firms providing agent/broker services, marketing firms, and call centers); or
- ▶ Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®).

What Are Your Responsibilities?

- ▶ You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare non-compliance.
 - ▶ FIRST, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
 - ▶ SECOND, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations that you may be aware of.
 - ▶ THIRD, you have a duty to follow CCHP's Code of Conduct that articulates your and CCHP's commitment to standards of conduct and ethical rules of behavior.

How Do You Prevent FWA?

- ▶ Look for suspicious activity;
- ▶ Conduct yourself in an ethical manner;
- ▶ Ensure accurate and timely data/billing;
- ▶ Ensure you coordinate with other payers;
- ▶ Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the CMS guidance; and
- ▶ Verify all information provided to you.

Stay Informed About Policies and Procedures

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

Report FWA to Compliance

- ▶ Everyone must report suspected instances of FWA. CCHP's Code of Conduct clearly state this obligation. CCHP may not retaliate against you for making a good faith effort in reporting.
- ▶ Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to CCHP's compliance department. The compliance department will investigate and make the proper determination.

If you suspect Fraud, Waste or Abuse...

 **Say Something!** 

Call CCHP's CONFIDENTIAL and ANONYMOUS
Compliance Hotline

1-415-955-8810

You are protected from retaliation per CCHP Policy and Procedure PRIV 1.12

Reporting FWA Outside Your Organization

- ▶ If warranted, CCHP Compliance Officer will report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the Department of Justice (DOJ), or CMS.
- ▶ Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.
- ▶ Details to Include When Reporting FWA
- ▶ When reporting suspected FWA, you should include:
 - ▶ Contact information for the source of the information, suspects, and witnesses;
 - ▶ Details of the alleged FWA;
 - ▶ Identification of the specific Medicare rules allegedly violated; and
 - ▶ The suspect's history of compliance, education, training, and communication with your organization or other entities.

Correction

- ▶ Once fraud, waste, or abuse has been detected, it must be promptly corrected. Correcting the problem saves the Government money and ensures you are in compliance with CMS requirements.
- ▶ Develop a plan to correct the issue. Consult your organization's compliance officer to find out the process for the corrective action plan development. The actual plan is going to vary, depending on the specific circumstances. In general:
- ▶ Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- ▶ Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions;
- ▶ Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action; and
- ▶ Once started, continuously monitor corrective actions to ensure they are effective.

Corrective Action Examples

- ▶ Corrective actions may include:
 - ▶ Adopting new prepayment edits or document review requirements;
 - ▶ Conducting mandated training;
 - ▶ Providing educational materials;
 - ▶ Revising policies or procedures;
 - ▶ Sending warning letters;
 - ▶ Taking disciplinary action, such as suspension of marketing, enrollment, or payment; or
 - ▶ Terminating an employee or provider.

Indicators of Potential FWA

- ▶ Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.
- ▶ The following pages present issues that may be potential FWA. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in the delivery of Medicare Parts C and D benefits to enrollees.

Key Indicators: Potential Beneficiary Issues

- ▶ Does the prescription, medical record, or laboratory test look altered or possibly forged?
- ▶ Does the beneficiary's medical history support the services requested?
- ▶ Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- ▶ Is the person receiving the medical service the actual beneficiary (identity theft)?
- ▶ Is the prescription appropriate based on the beneficiary's other prescriptions?

Key Indicators: Potential Provider Issues

- ▶ Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- ▶ Does the provider bill the Sponsor for services not provided?
- ▶ Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- ▶ Is the provider performing medically unnecessary services for the member?
- ▶ Is the provider prescribing a higher quantity than medically necessary for the condition?
- ▶ Is the provider's diagnosis for the member supported in the medical record?

Key Indicators: Potential Pharmacy Issues

- ▶ Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- ▶ Are the dispensed drugs expired, fake, diluted, or illegal?
- ▶ Are generic drugs provided when the prescription requires that brand drugs be dispensed?
- ▶ Are PBMs being billed for prescriptions that are not filled or picked up?
- ▶ Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- ▶ Do you see prescriptions being altered (changing quantities or Dispense As Written)?

Key Indicators: Potential Sponsor Issues

- ▶ Does the Sponsor encourage/support inappropriate risk adjustment submissions?
- ▶ Does the Sponsor lead the beneficiary to believe that the cost of benefits is one price, only for the beneficiary to find out that the actual cost is higher?
- ▶ Does the Sponsor offer cash inducements for beneficiaries to join the plan?
- ▶ Does the Sponsor use unlicensed agents?

Summary Lesson 2: Your Role in the Fight Against FWA

- ▶ As a person who provides health or administrative services to a Medicare Parts C or D enrollee, you play a vital role in preventing FWA. Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
- ▶ Report potential FWA. CCHP has a mechanism for reporting potential FWA. You are able to make anonymous reports. CCHP cannot retaliate against you for reporting.
- ▶ Promptly correct identified FWA with an effective corrective action plan.

HIPAA

Health Insurance Portability and Accountability Act

Who Needs Training and Why

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

What exactly is HIPAA?

- Overseen by: Department of Health & Human Services (HHS) and enforced by Office for Civil Rights (OCR)
- HIPAA contains Regulations on:
 - Privacy of health information – Provides individual the right to have their health information private.
 - Security of health information – Requires covered entities, those working with health information, to have safeguards to keep individual's private information confidential.
 - Notification of breaches of confidentiality – Requires covered entities have in place policy and procedures for addressing any confidentiality or HIPAA breach.
 - Penalties for violating HIPAA – Allows HHS to penalize covered entities for violating individual's civil rights to their protected health information.

What is Protected by HIPAA?

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

EXAMPLES

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

What is PHI?

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

The Use and Disclosure of PHI

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

- ▶ The use or disclosure of PHI is limited to the minimum amount necessary to perform your assigned task.

- ▶ Individuals and members expect their health information to be kept private and confidential
 - ▶ Do not access PHI that you do not need
 - ▶ Do not discuss PHI with others that do not need to know
 - ▶ Do not provide PHI to anyone not authorized to receive it

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

Safeguarding PHI

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

Secure Transmission of Electronic PHI

ePHI in email

- ▶ Email is not secure when sent to outside entities
- ▶ Email can be used to transmit PHI within our organization (CCHP or CHA) because it never leaves our network
- ▶ If you must email PHI to external entity, put “[**secure**]” in the subject line of the email. The server will automatically replace the body and attachments with a link.
- ▶ This utility does not encrypt the subject line of the email and it does not prevent you from sending to the wrong person.
- ▶ It also doesn't prevent the content from being forwarded

What to do when a HIPAA violation occurs

- ▶ Take prompt and appropriate action to correct the situation and/or minimize harmful effects
- ▶ Notify your supervisor immediately of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI and/or company data
- ▶ Notify CCHP Compliance, Privacy, and Security Officers of the occurrence
 - ▶ It is the Compliance Department's responsibility to:
 - ▶ Assess the risk of the suspected or actual breach;
 - ▶ Determine whether or not member and/or regulatory notification is necessary; and
 - ▶ Document all incidents of suspected or actual breach.

URAC Standards

Version Core 3.0 and HIM 7.3

URAC Standards

- ▶ Utilization Review Accreditation Committee (URAC) is the organization through which CCHP is accredited.
- ▶ There are approximately 40 Core Standards and over 100 Health Insurance Marketplace Standards CCHP must comply with to maintain accreditation status.
- ▶ CCHP is currently only accredited for the Covered California products.
- ▶ Reply on your departmental job trainings and Policy and Procedures for standards related to your specific job functions.

- ▶ Current location of URAC Core 3.0 and HIM 7.3 standards
 - ▶ [\\cchpfiles01](#) → URAC Accreditation → 2018 → Health Plan HIM Guide Version 7.3

Questions, Contacts, References

- ▶ If you have any questions regarding this annual training, contact:
 - ▶ Daniel Quan, CCHP Compliance Officer
 - ▶ 628-228-3340
 - ▶ Daniel.Quan@CCHPHealthPlan.com

- ▶ CCHP Corporate Compliance Hotline: 415-955-8810
- ▶ Current location of all CCHP P&Ps and Manuals
 - ▶ [\\cchpfiles01](#) → Policies and Procedures
- ▶ Current location of URAC Core 3 and HIM 7.3 standards
 - ▶ [\\cchpfiles01](#) → URAC Accreditation → 2018 → Health Plan HIM Guide Version 7.3