



Annual Provider Training

Revised May 2023

Welcome to MedPOINT Management's Annual Provider Training. The training is intended to provide you with an overview of resources related to the successful management of your assigned Medi-Cal and EAE D-SNP members.

If you would like more information, please reference the IPA-Specific Provider Manuals by visiting

<https://www.medpointmanagement.com/new-provider-training/>.

For assistance, please email us at

NPT@medpointmanagement.com

Topics Covered in this Training

- ▶ Model of Care (MOC)^
- ▶ Advance Directives & Physician Orders for Life-Sustaining Treatment (POLST)*^~
- ▶ California End of Life Services Information*^
- ▶ Member Rights & Responsibilities*
- ▶ Member Satisfaction Policy & Procedure*^~
- ▶ Cultural & Linguistic Sensitivity*^~
- ▶ HIPAA Privacy, Breach Notification and Compliance*^~
- ▶ Fraud, Waste & Abuse*^~
- ▶ General Compliance*^~
- ▶ Ethics Code of Conduct and Compliance*^~
- ▶ OIG/SAM/Medi-Cal Exclusions*^~
- ▶ Critical Incidents^
- ▶ Documentation Requests & Modifications*^~

Legend

- * - Medi-Cal
- ^ - EAE D-SNP
- ~ All other Lines of Business

SNP- Model of Care (MOC) Training for Contracted Network Providers

Content

- MMP Overview
- 2 Types of SNPs
- Vulnerable Population
- Care Coordination
- Case Management Process
- Care Transition Process
- HRA – Health Risk Assessment
- ICP – Individual Care Plans
- ICT – Interdisciplinary Care Team
- Grievances and Appeals
- Member Rights & Assistance Responsibilities
- Training Requirements and FAQs

Overall Goals of the Model of Care (MOC)

Improve Access

- Improving access to medical and mental health and social services
- Improving access to affordable care, long-term supports and services (LTSS) and preventive health services

Improve Coordination

- Improving coordination of care through an identified point of contact
- Improving transitions of care across health care settings, provider and health services
- Assuring appropriate utilization of services

Improve Health Status

- Improving patient health outcomes

MOC Description

What is Model of Care (MOC)?

- The Model of Care (MOC) is the comprehensive plan for delivering our integrated care management program for patients with special needs
- It is the architecture for promoting quality, care management policy and procedures and operational systems.

MOC – Special Needs Plan (SNP)/Medicare-Medicaid Plan (MMP) Population

- The MOC includes characteristics of the patients that MedPOINT and providers serve including social factors, cognitive factors, environmental factors, living conditions and co-morbidities
- The MOC also includes:
 - Determining and tracking eligibility
 - Specially tailored services for patients
 - Working with community partners

MMP Overview

- Eligibility rules can vary from state to state.
- General eligibility guidelines are that patients are eligible for Medicare and Medicaid and have no private insurance
- MMP patients have full Medicare and Medicaid rights and benefits
- The Medicare and Medicaid benefits are integrated as one benefit
- SNPs and MMPs follow a team based MOC, however, individual states may establish additional regulations and requirements for MMPs

Effective January 2023

- Medicare-Medicaid Plan (MMP) was referred to as Cal Medi-Connect (CMC).
 - The Cal Medi-Connect plan (Medicare-Medicaid plan) was developed to help the nation's lowest-income individuals – those who qualify for both Medicare and Medi-Cal (i.e., dual eligible members)
- Dual-Eligible Special Needs Plan (D-SNP) look-alike (LAL) plans are Medicare Advantage (MA) plans that are designed specifically to attract dual eligible beneficiaries who have secondary coverage through Medi-Cal
- Effective January 1, 2023, both plans are ending.
 - D-SNP plans in certain counties will transition to the Exclusive Aligned Enrollment (EAE) D-SNP if available
- Dual Special Needs Plans (D-SNPs) – Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal and offer care coordination and wrap-around services. States and health plans may vary in determining their eligibility categories
- EAE D-SNP – D-SNPs where enrollment is limited to D-SNP members who are also enrolled in the affiliated Medi-Cal managed care plan by the same parent organization

SNP Types

- SNP is a special needs plan. Medicare Advantage (MA) plan designs special and unique benefit package to meet the needs of our most vulnerable members
- 2 IPA applicable SNP types in 2023
 - Dual eligible SNPs (D-SNPs) for patients that are dually eligible for Medicare and Medicaid
 - Chronic SNPs (C-SNPs) for patients with chronic and disabling disorders; one or more of the following chronic diseases is required depending on the specific plan:
 - Diabetes
 - Chronic Heart Failure
 - Cardiovascular Disorders:
 - Cardiac Arrhythmias
 - Coronary Artery Disease
 - Peripheral Vascular Disease
 - Chronic Venous Thromboembolic Disorder

Vulnerable Sub-Populations

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- **Complex and multiple chronic conditions** – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- **Disabled** – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- **Frail** – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- **Dementia** – patients at risk due to moderate/severe memory loss or forgetfulness
- **End-of-life** – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

Coordinate Medicare/Medicaid

Medicare and Medicaid benefits for D-SNPs and MMP should be coordinated:

- Patients informed of benefits offered by both programs
- Patients assisted to maintain Medicaid eligibility
- Patient access to staff that has knowledge of both programs
- Clear communication regarding claims and cost-sharing from both programs
- Coordinating adjudication of Medicare and Medicaid claims when health plan is contractually responsible
- Patients informed of rights to pursue appeals and grievances through both programs
- Patients assisted to access providers that accept Medicare and Medicaid

Benefits to Meet Specialized Needs

- **Disease Management** – whole person approach to wellness with comprehensive online and written educational and interactive health materials
- **Medication Therapy Management** – a pharmacist reviews medication profile quarterly and communicates with patient and doctor regarding issues such as duplications, interactions, gaps in treatment, adherence issues
- **Transportation** – the number of medically related trips up to unlimited may be under the health plan or Medicaid benefit and vary according to the specific SNP/MMP and region
- Additional benefits vary by region and type of SNP/MMP but may include **Dental, Vision, Podiatry, Gym Membership, Hearing Aides** or lower costs for items such as **Diabetic Monitoring supplies, Cardiac Rehabilitation**

Language/Communication Needs

SNP/MMP patients may have greater incidence of limited English proficiency, health literacy issues and disabilities that affect communication with negative impact on health outcomes. Services to meet these needs include;

- Office interpretation services – in-person and sign-language with minimum of 3-5 days notice
- Health Literacy – training materials and in-person training available
- Cultural Engagement – training materials and in-person training available
- Translation of vital documents
- 711 relay number for hearing impaired

Communication Systems

Integrated communication systems are necessary to implement the SNP/MMP care coordination requirements:

- An **Electronic Medical Management System** for documentation of care management, care planning, input from the interdisciplinary team, transitions, assessments and authorizations
- A **Customer Call Center** to assist with eligibility and coordination of benefit questions and able to meet individual communication needs (language or hearing impairment)
- A secure **Provider Portal** to communicate HRA results and new patient information to SNP/MMP delegated medical groups
- A **Member Portal** for access to online health education, interactive programs and the ability to create a personal health record
- **Member and Provider Communications** such as member and provider newsletters and educational outreach may be distributed by mail, phone, fax or online

What is Care Coordination?

Case Management services for members with increased needs:

- Episodic
- Increased resources
- Multiple services along the continuum
- May be accessing MLTSS services
- Additional designated care coordinator, appropriate specialty providers, and additional service providers.

The goal is to have seamless service coordination.

Primary Care and Specialty Care providers play an important role in Care Coordination.



Care Coordination

Care Coordination Standards

- Five elements of a person-centered approach:
 - Individualized service planning and delivery
 - Participation of the person and, as appropriate, family members and others chosen by the person in service planning and delivery
 - Consideration of the person's values, culture, traditions, experiences and preferences in the definition of quality
 - Recognition and support of a person's self-care capabilities
 - Integration of formal and informal supports

Care Coordination Processes

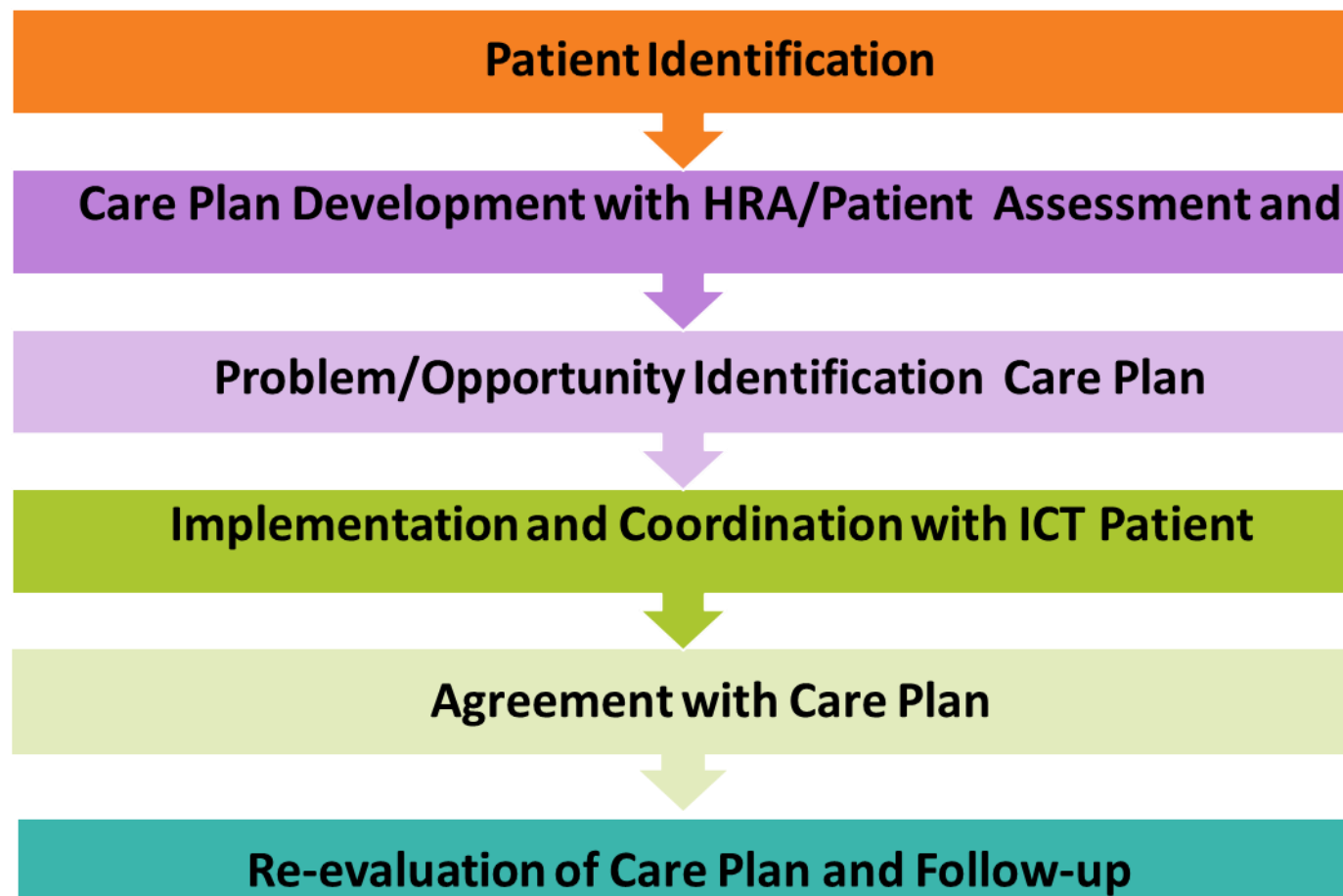
- Targeted assessment of identified member needs
- Creation of individualized care plan
- Facilitation of identified referrals
- Facilitation of Continuity of Care with non-contracted providers
- Development of short term goals
- Follow up communications
- Discussion of ICP with ICT

What is a Case/Care Manager?

Care Managers are healthcare professionals like nurses and social workers trained to meet healthcare needs by assisting the patient to navigate the healthcare system and collaborating with providers, their social support system, their Community and other professionals associated with their care.



Case Management Process Overview



Case Management of Transitions

Patients are at risk of adverse outcomes when transitioning between settings (hospital, nursing home, rehabilitation center, outpatient surgery centers or home health).

- Patients experiencing inpatient transition identified/managed (pre- authorization, facility notification, inpatient census)
- Important elements (diagnoses, medication reconciliation, treatments, providers and contacts) of care plan transferred between care settings before, during and after a transition
- Patient is able to communicate their health information to healthcare providers in different settings
- Patient educated on health status and self-management skills: discharge needs, meds, follow-up care, and how to recognize and respond to issues (discharge instructions, post-discharge calls)

MOC CM Requirements

CMS requires all SNP and MMP members to have the following:



HRA

Health Risk Assessment



ICP

Individualized Care Plan



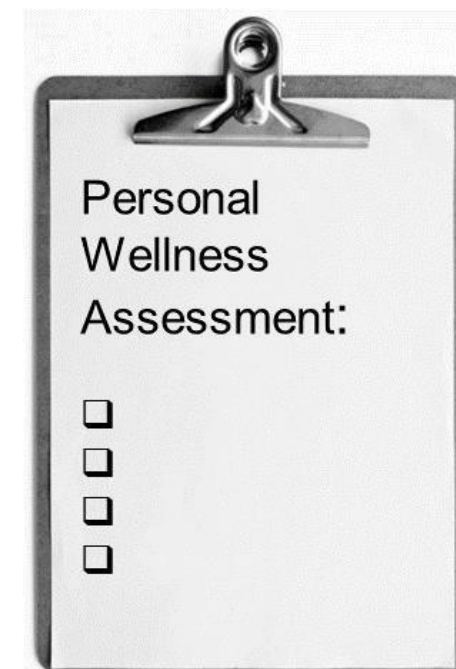
ICT

Interdisciplinary Care Team

Health Risk Assessment (HRA)

- A health questionnaire that provides an overview of patient's health risks and quality of life
- Health plans attempt to complete the HRA within 90 days of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the patient's provider
- Clinical review of the HRA must be completed by a licensed staff member*
- Patients have the right to refuse to complete the HRA

* Licensed person includes RN, LCSW or MD/DO



What Does the HRA Assess?

The HRA is a Medicare requirement for all SNP and MMP members. The HRA screens for:

- Health status, chronic health conditions/health care needs
- Clinical history
- Mental health and cognitive status Activities of daily living (ADLs)/Instrumental activities of daily living (IADLs)
- Depression
- Medication review
- Cultural and linguistic needs, preferences or limitations
- Evaluate visual and health needs, preferences or limitations
- Quality of Life
- Life planning activities
- Caregiver support
- Available benefits
- Continuity of care needs
- Fall prevention
- Managed Long Term Services and Supports, including HCBS

This tool, along with other resources, is used to develop the Individualized Care Plan (ICP)

HRA Utilization

1

Encourage patients to complete HRA over telephone or by mail

2

Explain the information helps the Care Manager and ICT to meet their healthcare needs

3

Register for and check the provider portal regularly for new HRAs

4

Use the HRA responses to stratify patient outreach

What is a Care Plan?

Case Management Society of America defines a Care Plan as:

- “A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; measurable goals to demonstrate resolution based upon the problem/need, timeframe, the resources available, and the desires/motivation of the client/family.”

Building Individualized Care Plans (ICP)

Individualized care plans include, but are not limited to, the following:

- Establishing patient prioritized goals: what is important **TO** the patient and **FOR** the patient
- Identifying resources that might benefit the patient, including recommendations for the appropriate level of care
- Planning for continuity of care, including assisting the patient in making the transition from one care setting to another.
- Collaborative approaches to health and care management which can include the PCP, family or patient representative.
- Established timeframes for ongoing evaluation of patient's goals

Building ICP (Cont'd)

Person Centered Care Plan

<u>Problems</u>	<u>Goals</u>	<u>Barriers</u>	<u>Interventions</u>
Communicated by the patient regarding their life, health, worries and behaviors	What the patient hopes to achieve regarding their health	Lack of transportation, finances, housing, treatment side effects	Actions to support problem resolution and support goal decrease stress

ICP Problems

- Medical conditions not being well managed
- Ineffective pain management
- Cognitive deficits (dementia, brain injury)
- Unable to meet financial obligations (rent, utilities, food)
- Unsafe housing, lack of social support
- Lack of knowledge to self-manage health
- Lack of caregiver or family support
- Communication needs: language or sensory deficits
- Cultural or other beliefs interfere with prescribed treatment



ICP Problems (Cont'd)

Review, Prioritize and Set Problems

Risk



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graph TD; A[Risk] --> B[Member ability/willingness]; B --> C[Potential improvement]; C --> D[Potential complications]; D --> E[Improvement of quality of life];
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Member ability/willingness

Potential improvement

Potential complications

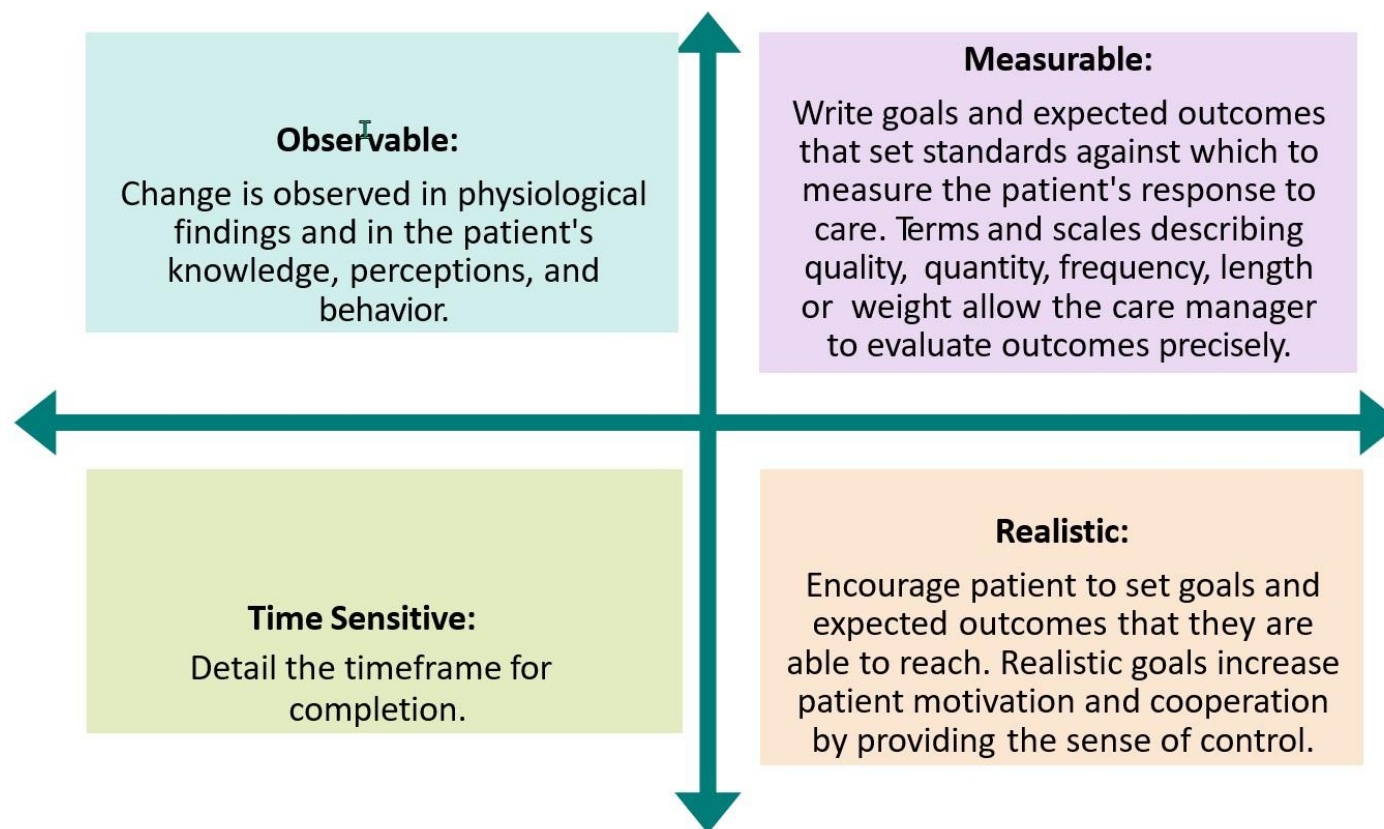
Improvement of quality of life

Member Centered Goals

- **Measurable goals** provide a clear description for the patient and care manager on how and when the goals have been achieved, patient behavior and improvement in health outcomes.
- **Goals and outcomes** reflect patient behaviors and responses expected as a result of nursing interventions. Write a goal or outcome to reflect a **patient's** specific behavior, not to reflect the **care manager's** goals or interventions.
- Each goal should address only **one behavior or response**. The outcome should be **measurable** and **evidence-based**.
- **Goals** can be short term or long term.



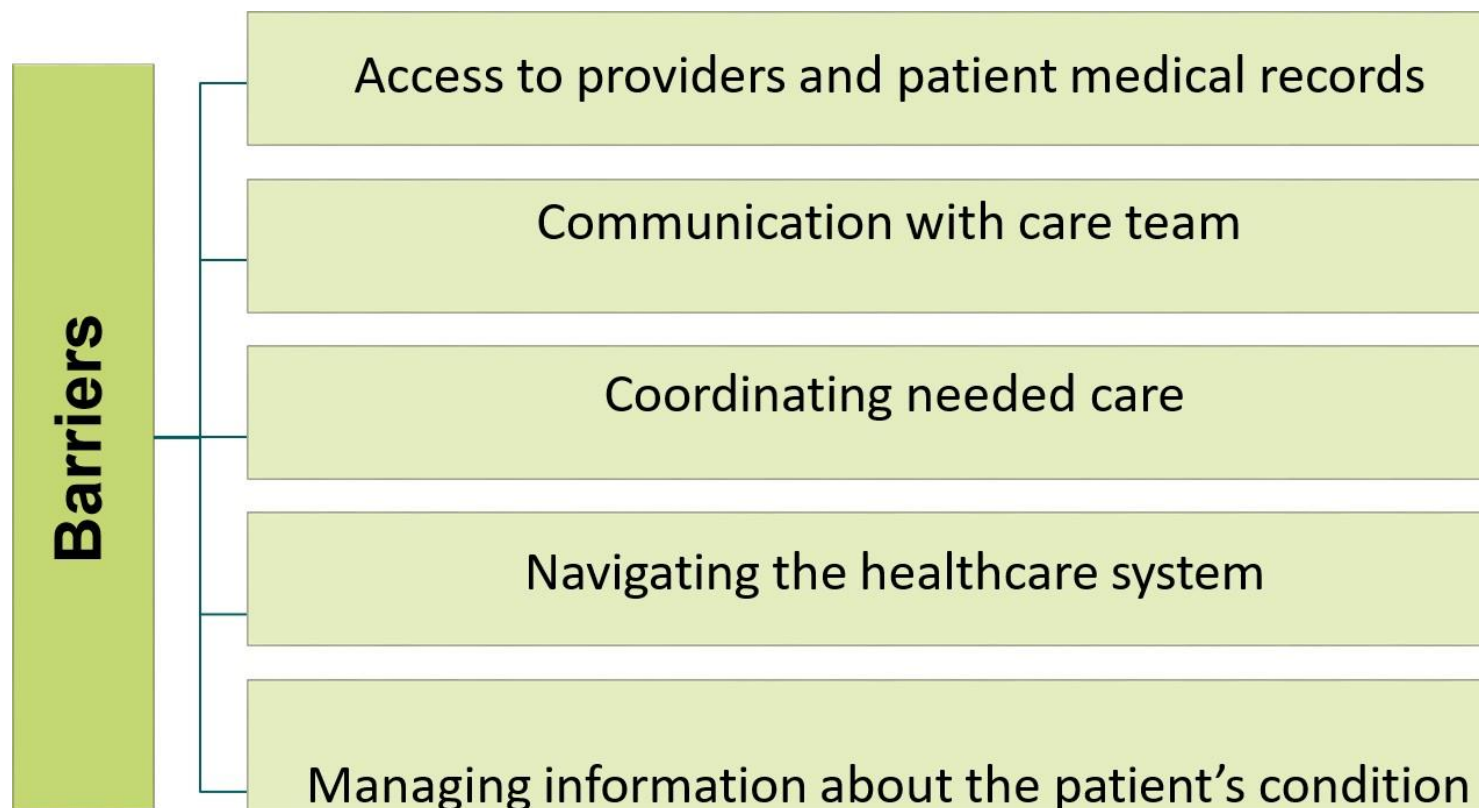
Member Centered Goals (Cont'd)



ICP Steps



ICP Barriers



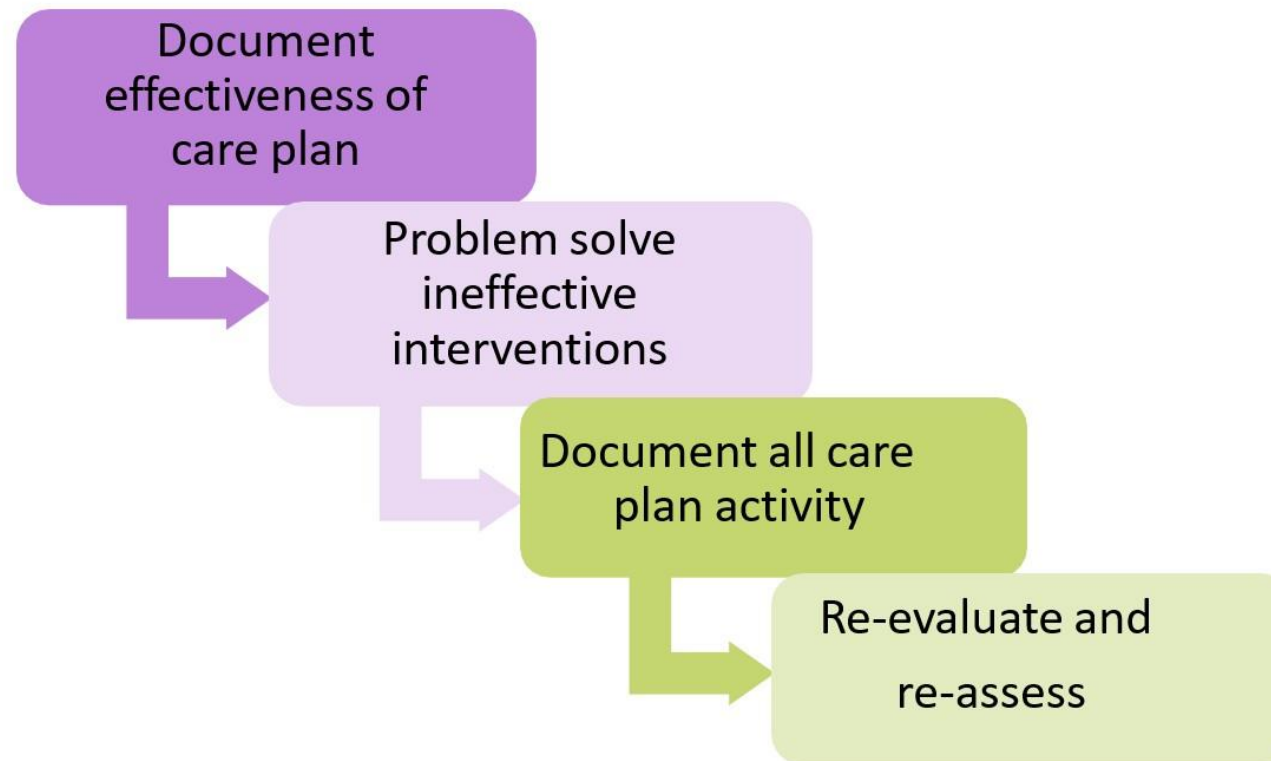
ICP Interventions

- An intervention is an action to help the patient achieve their goals (including overcoming barriers)



Monitoring the Care Plan

The care plan is an active, dynamic document

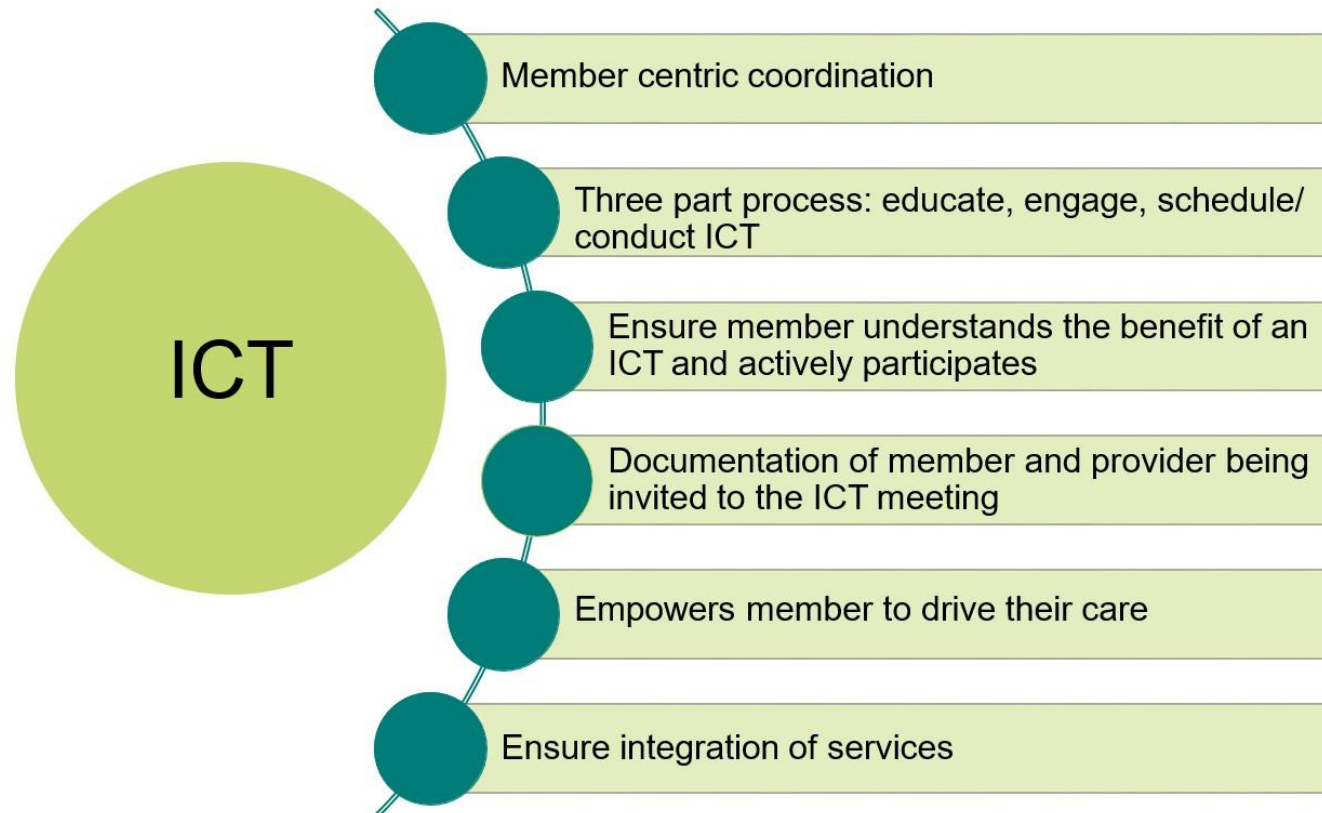


Updating the Care Plan

- Update the patient's care plan when changes in condition or transitions of care (TOC) occur
- Close problems, goals and interventions accurately using:
 - Claims data
 - Prescription drug event (PDE)
 - Lab, radiology etc.
- All updates are documented and communicated as needed



Interdisciplinary Care Team (ICT)



What is an ICT?

An (ICT) Interdisciplinary Care Team is a collaborative, multidisciplinary team who:

- Analyzes and incorporates the results of the initial and annual health risk assessment into the care plan.
- Develops a collaborative Individualized Care Plan (ICP) and annually update the member's ICP.
- Manages the medical, cognitive, psychosocial and functional needs of each member.
- Communicates the ICP to all caregivers for care coordination.
- Coordinates with and facilitates referrals to the appropriate resources, medical, behavioral health or home and community based providers, i.e. MLTSS



Membership



The Care Manager leads and determines ICT membership with the patient and can include:

- Patient/caregiver
- Medical Expertise*
- Social Services Expertise*
- Behavioral Health as indicated*
- Pharmacist
- LTSS Coordinator

- Nursing Facility Representative
- Discharge Planner
- PT/OT/ST
- Community agencies
- Other health care professionals

*Indicates minimum required

Regular Meetings

ICT meetings are conducted at least annually and more frequently based on the patient's needs. They can be in the form of:

- Virtual/Conference calls
- In-person meetings (Grand Rounds)
- Inpatient facility care conference



Patient Centered

The member is at the center of the care planning process and may choose to include clinical or non-clinical staff and/family or caregivers. **The member may also choose to exclude participants as part of their right to self-direct care.** The patient should attend or be kept informed of ICT meeting outcomes and identify preferences for ICT members. Example:

[Add Note](#)

As part of our care coordination we will be having a care team meeting to discuss your health care needs. Who would you like to attend this meeting with you? Check all that apply

- ☒ PCP
- ☐ Specialist
- ☐ Home Health
- ☐ Therapist
- ☐ Pharmacist
- ☒ Caregiver
- ☐ Authorized Representative
- ☐ Clergy
- ☒ Family member / neighbor
- ☐ Other

* Does the member display any cognitive impairment such as problems with memory, trouble communicating, etc.? ☐ Yes ☐ No

Documentation Required

Example: ICT Conference Note

Note Type: Interdisciplinary Care Team Conference_V1

Note Category: * Admin Note

Encounter Date: 09/09/2015

Interdisciplinary Team meeting conducted on: 09/09/2015

Location/Method of IDCT: Facility/Clinic

Reason for conference: Initial

Communication needs: -- Select --

Member was invited to ICT: Yes

Member's health care provider was invited to ICT: Yes

Interdisciplinary care team members participating in meeting::

Member: Yes

Member designee: -- Select --

Case Manager: Yes

Behavioral Case Manager: -- Select --

Primary Care Provider: -- Select --

Long term supports and services: Yes

Medical Director: -- Select --

Pharmacy: Yes

Disease Management: -- Select --

Facility discharge planner: -- Select --

Occupational/Speech/Physic: Select

MOC - Member Rights

- Members have specific rights about information, privacy, participation in their treatment, voicing complaints, choosing a PCP within the Contractor's Network, enrollment/disenrollment, and receiving emergency services.
- MedPOINT Management does not discriminate against enrollees due to:
 - Age
 - Ancestry
 - Color
 - Disability (Physical or Mental)
 - Ethnic group identification
 - Evidence of insurability (including conditions arising out of acts of domestic violence)
 - Gender
 - Gender identity
 - Genetic information
 - Health status
 - Marital status
 - Medical condition
 - National origin
 - Race
 - Religion
 - Sex
 - Sexual orientation
 - Source of payment
 - Status as a parent

MOC - Member Rights (Cont'd)

- Members have the right to:
 - Receive information about MedPOINT Management, its services, its practitioners and providers.
 - Privacy and right to be treated with respect, dignity, and courtesy from MedPOINT Management's providers and staff.
 - Participate with practitioners with any care their practitioner provides or recommends, discuss all treatment options, and participate in making decisions about their health care, presented in a manner appropriate to the enrollee's condition(s) and ability to understand.
 - Right to say "no" to treatment.
 - Talk candidly to their practitioner about inappropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Right to decide in advance how they want to be cared for in case they have a life-threatening illness or injury.

MOC - Member Assistance Responsibilities

- Access barriers and disability conditions: Efforts will be made to provide access to care in accordance with DMHC timelines.
- Referral to appropriate clinical staff: Providers will evaluate patient's clinical and functional needs through assessments and refer patients to appropriate clinical staff to further diagnose and treat patients.
- Grievances & Appeals: If dissatisfaction is expressed by the member or a representative on behalf of the member, member services representatives will warm transfer the member to the health plan to file a formal grievance or service appeal. Member services will also document the grievance and assist with requests for appropriate documents should this be requested by the health plan.

HRA/ICP/ICT Frequently Asked Questions

1. What if the HRA is not received timely?
 - *Initiate the ICP. Document that there was no HRA at time of completion of ICP.*
2. What if HRA arrives after I have completed the initial assessment?
 - *Review HRA and update ICP with any additional or clarified information.*
3. Do I need to monitor ICP once completed?
 - *Yes. All ICPs should be updated and monitored based on the patient's current status and changes.*
4. When should I initiate an ICT?
 - *Documentation and implementation of the ICT should start along with the ICP.*
5. What are requirements if a patient chooses to opt-out?
 - *The ICP and ICT must still be completed per MOC requirements. Best practice is to reach out to member at least annually and/or when there is a change or transition to offer case management services.*

Additional Resources

- Clinical Care Coordination Questions regard this training please contact:
 - **Russel Soria**, Director - Clinical Care Coordination
 - Email: Rsoria@medpointmanagement.com
 - Phone: 818-702-0100, ext. 1300
 - **Vanessa Murillo**, Manager - Clinical Care Coordination
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 - **Dyna Ambunan**, Lead – Regulatory Nurse Case Manager
 - Email: DAmbunan@medpointmanagement.com
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 - **Dianne Samonte**, Lead – Case Management Coordinator, Episodic Case Management
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Advance Directives & Physician Orders for Life-Sustaining Treatment (POLST) - All Lines of Business (LOBs)

Overview

- Advanced Directives
 - Living Will
 - Durable Power of Attorney
- Physician Orders for Life-Sustaining Treatment (POLST)
- Member/Caregiver/Provider responsibilities
- Additional Resources

What is an Advanced Directive?

- An advance directive is a document that indicates in writing:
 - Your choices about the treatments you want or do not want
 - Who will make healthcare decisions for you if you become incapacitated and cannot express your wishes
- Wishes examples:

Dialysis	Medicines
Feeding Tube	Blood and Water Transfusion
Breathing Machines or Ventilator	Surgery
Organ or Tissue Donation	Funeral or Burial Wishes
Cardiopulmonary Resuscitation (CPT)	Autopsy

Why have an Advanced Directive?

- An advance directive speaks for you when you are unable to do so. It tells others the care and treatments you do or do not want and/or who will make healthcare decisions for you when you cannot express your wishes. It may relieve your family from the burden of guessing what you would want. Providing such guidance may also prevent painful family arguments about how you would want to be treated.
- There are two kinds of Advance Directives
 - **Living Will** - Indicates what kind of treatments you would want, and what treatments you wouldn't want
 - **Durable Power of Attorney** - Names a person of your choosing to make decisions for you

Living Will

- A living will is a written statement in which you specify what kind of healthcare you do or do not want to receive. It can act as a guide for those who may need to make your medical decisions. A living will allows you to make decisions regarding treatment or machines that keep your heart, lungs or kidneys functioning when they are unable to function on their own.
- Although you may write your living will on your own, it is best to inform your family, close friends and physician of your wishes

Durable Power of Attorney in Health Care

- The power of attorney for healthcare is a form that allows you to appoint another person (a "healthcare agent") to make healthcare decisions for you if you are not capable of making them for yourself. When you complete this form, you give authority to your healthcare agent to make a wide range of decisions for you, such as:
 - Whether or not you should have an operation,
 - Receive certain medications
 - Be placed on life support
- In some areas of healthcare, your healthcare agent is not allowed to make decisions for you unless you give him or her specific authority in these areas when you complete the form. These areas are listed on the form.
- You can also include specific instructions about the type of treatments you want or do not want (such as surgery or tube feedings) when you complete the form. A power of attorney for healthcare goes in effect only when two physicians, or a physician and a psychologist, agree in writing that you can no longer understand your treatment options or express your wishes to others.

Physician Orders for Life-Sustaining Treatment (POLST)

- This form is used to direct paramedics, physicians and other health care professionals on what life sustaining measures are required.
 - The POLST **does not** replace an Advance Directive. This form should be reviewed in conjunction with the Advance Directive, to ensure that there is no conflict.
- It is a doctor's order that is recognized throughout the medical system.
- It is a portable document that transfers with the patient from one care setting to another.
- It is easily distinguished by its bright pink color.
- It is a standardized form for the whole state.
- Allows individuals to choose medical treatments they want to receive, and identify those they do not want.
- Provides direction for healthcare providers during serious illness.

POLST vs Advance Healthcare Directive (AHCD)

POLST	AHCD
For Seriously ill/frail, at any age	For anyone 18 and older
Specific orders for <u>current</u> treatment	General instructions for <u>future</u> treatment
Can be signed by decision maker	Appoints decision maker

What should I do with the forms?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.
- For California Nursing Home Residents ONLY
 - Give this form to your nursing home administrator. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.
- Print and carry a wallet card

Member/Caregiver Responsibility

- Members have a right to enact Advance Directives.
- Advance Directives should be provided to the primary care provider upon enacting an Advance Directive.
- When Advance Directives are revoked and/or the agent made changes, the information should be updated with the health care provider.
- The Member has a right to not be discriminated against because there is an Advance Directive in place.
- Members have the right to be treated with dignity.

Provider Responsibility

- Advance Directives are to be copied and maintained in the Medical Records.
- In the event that a physician or other appropriate health care professional refuses to comply with an Advance Directive on the basis of policies based on moral convictions, religious beliefs or other conscientious objections, at the request of the Member or authorized representative care of the Member, the Member must be transferred to another physician willing to care them.
- Members/caregivers are allowed to have input into their plan of care.

Additional Resources

- Advance Directive
<https://prepareforyourcare.org/en/advance-directive>
- POLST – California
<https://capolst.org/>
- POLST – National
<https://polst.org/>



California End of Life Services Information

Content Summary

- ▼ California End-of-Life Option Act
- ▼ End-of-Life Care Services Eligibility Criteria
- ▼ How to Find an End-of-Life Physician
- ▼ How to Obtain an Aid-in-Dying Request
- ▼ Attending Physician Responsibilities
- ▼ MedPOINT Management Responsibilities
- ▼ Provider Education

California End-of-Life Option Act

- ▶ The California End-of-Life Option (EOL) Act went into effect June 9, 2016.
- ▶ EOL services are a “carve out” for Medi-Cal Managed Care Health Plans (MCPs) and are covered by Medi-Cal Fee-For-Service (FFS).
- ▶ The EOL Act authorizes an adult who meets certain qualifications, and who has been determined by their attending physician to be suffering from a terminal disease, as defined, to make a request for an aid-in-dying drug for the purpose of ending their life.
- ▶ EOL services include consultations and the prescription of an aid-in-dying drug.
- ▶ The procedures to make these requests include 2 oral requests, one written request, specified forms to request an aid-in-dying drug under specified circumstances, and a final attestation.
- ▶ The EOL Acts specifies required information to be documented in the member’s medical record, include oral and written requests for an aid-in-dying drug.

End-of-Life Eligibility Criteria

- ▼ Resident of California
- ▼ Must be 18 years of age or older.
- ▼ Has a life-limiting illness that is incurable and irreversible.
- ▼ Has a prognosis of 6 months or less.
- ▼ Is mentally capable of making informed medical decisions.
- ▼ Voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.
- ▼ Voluntarily requested the prescription without influence from others.
- ▼ Can self-administer and ingest the medication themselves (eat, drink, swallow, or inject)

How to find an End-of-Life Physician

- ▼ Members are responsible for finding a Medi-Cal Fee-for-Service (FFS) Physician for all aspects of the End-of-Life (EOL) benefit.
- ▼ During an unrelated visit with a Managed Care Provider (MCP) physician, a member may provide an oral request for EOL services.
 - If the MCP physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that MCP physician may elect to become the member's attending physician as the member proceeds through the steps in obtaining EOL services.
 - EOL services following the initial visit are no longer the responsibility of the MCP physician and must be completed by a Medi-Cal FFS attending physician, or a Medi-Cal FFS consulting physician.
 - If the MCP physician is not a Medi-Cal FFS provider, the MCP physician may document the oral request in their medical records as part of the visit; however, the MCP physician should advise the member that following the initial visit, they must select a Medi-Cal FFS physician for all the remaining requirements to be satisfied.

How to obtain aid-in-dying request

- ▶ A member must make three requests for an aid-in-dying medication to their attending physician.
 - Two requests orally at least 48 hours apart.
 - One request in writing with a minimum of 15 days apart on a special form that is witnessed.

- ▶ The valid written request must meet all the following conditions:
 - Request must be signed and dated in the presence of two adult witnesses.
 - The two adult witnesses must attest that to the best of their knowledge and belief that the individual is all the following:
 - An individual who is personally known to them or has provided proof of identity.
 - An individual who voluntarily signed this request in their presence.
 - An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.
 - Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.
 - Only one of the witnesses may:
 - ❖ Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.
 - ❖ Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

Attending Physician Responsibilities

- ▼ Be willing to prescribe an aid-in-dying medication and make sure the member legally qualifies.
- ▼ Make the initial determination of all the following:
 - Whether the member has the capacity to make medical decisions.
 - If there are indications the member has a mental disorder, the physician should refer the member to a mental health specialist.
 - If this referral is to be made, no aid-in-dying drugs are to be prescribed until the mental health specialist determine that the member has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
 - Whether the member has a terminal disease.
 - Whether the member has voluntarily made the request for an aid-in-dying pursuant to Sections 443.2 and 443.3.
 - Whether the member is a qualified individual pursuant to subdivision of Section 443.1.
- ▼ Explain all end-of-life options to the member and review what it means to ingest an aid-in-dying medication.
- ▼ For members and their families who refuse hospice care, it is the responsibility of the MedPOINT Management Case Manager and the member's physicians to continue appropriate care.

Attending Physician Responsibilities cont.

- ▼ Notify the next of kin the member's request for an aid-in-dying drug.
- ▼ Confirm that the member is making an informed decision by discussing all the following:
 - The member's medical diagnosis and prognosis.
 - The probable result of ingesting the aid-in-dying drug.
 - Medication usage, storage, and disposal.
 - The possibility that the member may choose to obtain the aid-in-dying drug, but not take it.
 - The feasible alternative or additional treatment options including, but not limited to comfort care, hospice care, palliative care, and pain control.
- ▼ Offer an opportunity to withdraw or rescind their request for the aid-in-dying drug before prescribing the drug.
- ▼ Complete the Attending Physician Checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.

- ▼ The Utilization and Case Management staff will follow the Center for Gerontology and Health Care Research guidelines and toolkits to support members at the end of life.
- ▼ For members and their families who refuse hospice care, it is the responsibility of the Case Manager and the member's physicians to continue appropriate care such as:
 - Ensuring the member and their family understand the disease and its future trajectory.
 - Providing the desired physical comfort and emotional support.
 - Promoting shared medical decision-making.
 - Understanding the member's needs and expectations.
 - Attending to the needs of those who care for and love the member.
 - Coordination and continuity of care, especially if the member moves to a different setting (i.e., home care agency, acute care hospital, hospice, nursing home).
 - Receiving health providers must know what to expect, what to monitor, and who the member is (i.e., their desires, expectations, and values).

▼ MedPOINT Management will educate contracted providers regarding end-of-life services through the following methods:


- Educational posting on the MedPOINT Management website.
- Updating the MedPOINT Management Provider Manual to include policies and procedures that outline processes.
- Provide provider trainings through webinars, newsletters, fax-blast and/or mailings.

1. **Adult:** an individual 18 years of age or older.
2. **Aid-in-dying drug:** a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease.
3. **Attending physician:** the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease
4. **Attending physician checklist and compliance form:** a form, as described in Section 443.22, identifying every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.
5. **Capacity to make medical decisions:** in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual can understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.
6. **Consulting physician:** a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.
7. **Informed decision:** a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual's life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all the following:
 - The individual's medical diagnosis and prognosis.
 - The potential risks associated with taking the drug to be prescribed.
 - The probable result of taking the drug to be prescribed.
 - The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.
 - The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

8. **Medically confirmed:** the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.
9. **Mental health specialist assessment:** one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
6. **Mental health specialist:** a psychiatrist or licensed psychologist.
7. **Physician:** a Doctor of Medicine or osteopathy currently licensed to practice medicine in this state.
8. **Qualified individual:** an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.
9. **Self-administer:** a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about their own death.
10. **Terminal disease:** an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

Member Rights & Responsibilities

– Medi-Cal

	DEPARTMENT: Utilization Management		SUBDEPARTMENT: N/A
	POLICY NO. OP15	ORIGINAL EFFECTIVE DATE: 01/1999	REVIEWED/REVISED DATE(S): 04/2014, 08/2021, 02/2022, 02/09/2023
PREPARED BY: Adriana Martinez, UM Delegation Specialist		APPROVED BY: Sandy Hazel, RN- VP of Medical Affairs	
TITLE OF POLICY: Statement of Member's rights and Responsibilities			
ATTACHMENTS: [Attachment #1], [Attachment #2]			
LOB: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial <input type="checkbox"/> Cal Medi Connect <input type="checkbox"/> Salud Con <input type="checkbox"/> Covered CA <input type="checkbox"/> POS <input type="checkbox"/> All <input type="checkbox"/> N/A			

POLICY

MedPOINT Management's commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities

PURPOSE

MedPOINT Management recognizes the specific needs of and maintains a mutually respectful relationship with members

PROCEDURE

A. Member rights and responsibilities statement specifies that members have:

1. Member Rights

- a. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- b. A right to be treated with respect and recognition of their dignity and their right to privacy.
- c. A right to participate with practitioners in making decisions about their health care.
- d. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- e. A right to voice complaints or appeals about the organization or the care it provides.
- f. A right to make recommendations regarding the organization's member rights and responsibilities policy.
- g. A right to receive information on available treatment options and alternative, presented in a manner appropriate to the members condition and ability to understand
- h. A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- i. **A right to authorize / deny the release of PHI beyond uses for treatment, payment or Health Care operations**
- j. A right to request and receive a copy of his/her medical records, and to request that the medical records be amended or corrected

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k. Receive reasonable accommodations

2. Member Responsibilities

- a. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- b. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- c. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

B. Distribution of Rights Statement

- 1. MedPOINT Management distributes its member rights and responsibilities statement to the following groups:
 - a. New members, upon enrollment.
 - b. Existing members, if requested.
 - c. New practitioners, when they join the network.
 - d. Existing practitioners, if requested.
- 2. MedPOINT Management distributes information to members and practitioners by:
 - a. Mail, fax or email, or on its website if it informs members and practitioners that the information is available online.
 - b. The notice includes a description specific enough to give readers a clear idea of the topic and the general content and a link or direction to the specific information.
 - c. MedPOINT Management may group or summarize the information by theme.
 - d. MedPOINT Management mails the information to members and practitioners who do not have fax, email or internet access

C. Documentation

- 1. MedPOINT Management documents and logs when it has distributed the rights and responsibilities statement to a member and practitioner upon request.
 - a. If MedPOINT Management has had no requests, the log will include “no request for audit period”
 - b. MedPOINT Management documents and distributes the rights and responsibilities statement to all members and practitioners annually

D. No Member Discrimination in Delivery of Health Care

- 1. MedPOINT Management will make sure members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, receipt of healthcare, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment, Disability, Gender, including gender identity or gender expression (Health and Safety Code Section (§)1365.5
 - a. No Prohibition on Health Care Professional Advise to Patients

ATTACHMENT 1

[TITLE OF ATTACHMENT]


ATTACHMENT 2

[TITLE OF ATTACHMENT]

POLICY REVISION HISTORY

Originally Written By:		Creation Date:	
Approved By:		Date:	Signature
Revised By:	Adriana Martinez, UM Delegation Specialist	Date: 02/2022	
Revision(s) Description:	New Template		
Approved By:	Sandy Hazel, RN VP of Medical Affairs	Date:02/2022	Signature Sandy Hazel, RN
Revised By:	Adriana Martinez, UM Delegation Specialist	Date: 02/09/2023	
Revision Description:	Annual Review & approval		
Approved By:	Sandy Hazel, RN VP of Medical Affairs	Date: 02/09/2023	Signature Sandy Hazel, RN
Revised By:		Date:	
Revision Description:			
Approved By:		Date:	Signature
Revised By:		Date:	
Revision Description:			
Approved By:		Date:	Signature

Member Satisfaction Policies & Procedures – All Lines of Business (LOBs)

	DEPARTMENT: Quality Management		SUBDEPARTMENT: N/A	
	POLICY NO. QM-6.9	ORIGINAL EFFECTIVE DATE: 01/01/2007	REVIEWED/REVISED DATE(S): 01/01/2021, 03/08/2022	
PREPARED BY: Linda Deaktor, R.N., VP, Quality Management		APPROVED BY: Richard Powell, M.D., CMO		
TITLE OF POLICY: Member Satisfaction				
ATTACHMENTS / REFERENCES: None				
LOB: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial <input type="checkbox"/> Cal Medi Connect <input type="checkbox"/> Salud Con <input type="checkbox"/> Covered California <input checked="" type="checkbox"/> All <input type="checkbox"/> N/A				

POLICY

- All contracted IPA/Medical Group members or their legal guardians will be aware of the member rights and responsibilities and the process to express concerns/grievances regarding care and payment for care
- A list of the member's rights and responsibilities will be available for posting in the provider offices.
- An explanation of the process for expressing concerns/grievances will be available to all contracted IPA/Medical Group members.
- Member concerns will be directed to providers and/or MedPOINT Management on behalf of the contracted IPA/Medical Group
- Quality Management issues will be directed to the VP, Quality Management, and the Quality Management Committee
- Risk Management issues will be evaluated by the Quality Management Committee and reviewed in collaboration with the compliance department.
- The member or legal guardian via telephone, in writing or in person, will express an issue of concern or grievance. The information will be handled according to the contracted IPA/ Medical Group approved confidentiality policies and procedures.
- The appropriate staff member will identify the core issue of the concern/grievance and determine if it is a claim processing problem, a member concern or a complaint.
- The impact of the situation will be assessed, and the VP, Quality Management, will define the resource criteria whether it be medical staff, nursing, quality of care, billing or other (such as hospital system)
- The documented events and provider/staff response will be taken to the Quality Management Committee for analysis, problem resolution and recommended follow-up action.
- The documented member concern and follow-up process will be kept in a confidential file
- The Quality Management staff will assist with the periodic assessment and enhancement of member satisfaction with IPA/medical group services. The assessment will include review of:
 - Member complaints/grievances
 - Member requests to change providers or facilities
- Quality Management staff will assist with the process of conducting member satisfaction surveys which will be done at least annually in accordance with managed entity and contractual requirements. Population-specific studies also will be conducted. Other MedPOINT Management departments will be involved in the survey process as appropriate. Managed entity and especially the provision of health care services will be evaluated by the members.

PURPOSE

- To establish a process to measure members' satisfaction with managed entity's delivery of care and service
- To evaluate member concerns and to provide information that will assist in the delivery of high-quality services




PROCEDURE

- Mechanisms to ensure member satisfaction have been implemented to:
 - i. Respond to each member's concern in an effective, efficient, and professional manner
 - ii. Develop a strong working relationship with Contracted IPA/ Medical Group management as well as the providers and their staff
- Assist members in selecting or changing a primary care physician and correspond with the contracted health plan regarding this activity
- Provide assistance to members and providers who wish to terminate a relationship with each other
- Maintain member confidentiality
- Sustain provider respect and reputation
- Provide assistance to members who would like to change the site of healthcare delivery
- Educate members regarding the managed care system
- Provide a cordial response to all member concerns
- Identify patterns of member concerns
- Evaluate voluntary disenrollments
- Contribute to the resolution of problems associated with member concerns
- Report trends to the appropriate administrative departments and suggest workable resolutions
- Participate in problem resolution projects

APPENDIX A

[TITLE OF ATTACHMENT]

POLICY REVISION HISTORY

Originally Written By:	Linda L. Deaktor, R.N., VP, Quality Management	Policy Committee Review Date: N/A	
Approved By:	Richard L. Powell, M.D., CMO	Date: 01/01/2007	Signature 
Revised By:	Linda L. Deaktor, R.N., VP, Quality Management	Date: 03/08/2022	Signature 
Revision(s) Description:	Updated statement that member grievance policy will be made available to members, added that risk management issues will be resolved in collaboration with the compliance department,		
Approved By:	Richard L. Powell, M.D., CMO	Date: 03/11/2022	Signature 
Revised By:		Date:	Signature
Revision Description:			
Approved By:		Date:	Signature
Revised By:		Date:	Signature
Revision Description:			
Approved By:		Date:	Signature
Revised By:		Date:	Signature
Revision Description:			
Approved By:		Date:	Signature

Cultural & Linguistic Sensitivity - All Lines of Business (LOBs)

Culturally and Linguistically Appropriate Service (CLAS) Provider Toolkit – ICE for Health

Purpose

- To provide resources to assist with addressing health care delivery to a diverse population of patients while adhering to legal mandates

Benefits

- Provides tips for the following:
 - How to interact with diverse patients
 - How to communicate across language barriers
 - How to develop an understanding of patients from diverse cultural backgrounds
 - Where to access resources and important references, including a summary of the "Culturally and Linguistically Appropriate Service (CLAS) Standards."
- For the provider toolkit, please visit: [ICE C&L Provider Toolkit](#)

Contents

- Communication Tips
- Healthcare and Culture
- Language Assistance
- Social Determinants of Health (SDOH)
- Refusal of Interpretive Services
- Provider Health Plan Limited English Proficiency (LEP) Grid

Tips for Successful Patient Encounters - ICE

To enhance patient/provider communication and to avoid being unintentionally insulting or patronizing, be aware of the following:

- Styles of Speech – People vary greatly in length of time between comment and response, the speed of their speech, and their willingness to interrupt.
- Eye Contact – The way people interpret various types of eye contact is tied to cultural background and life experience.
- Body Language – Sociologists say that 80% of communication is non-verbal. The meaning of body language varies greatly by culture, class, gender, and age.
- Gently Guide Patient Conversation – English predisposes us to a direct communication style, however other languages and cultures differ.

Tips for Office Staff to Enhance Communication - ICE

- Build rapport with the patient
- Make sure patients know what you do
- Keep patients' expectations realistic
- Work to build patients' trust in you
- Determine if the patient needs an interpreter for the visit
- Give patients the information they need
- Make sure patients know what to do

Non-Verbal Communication and Patient Care - ICE

Non-verbal communication is a subtle form of communication that place in the **initial three seconds** after meeting someone for the first time and can continue through the entire interaction. This may account for 70% of a communication episode.

A **stereotype** is an ending point; no attempt is made to learn whether the individual in question fits the statement. A **generalization** is a beginning point; it indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.

Generalizations can serve as a guide to be accompanied by individualized in-person assessment. As a rule, ask the patient, rather than assume you know the patient's needs and wants.

- Eye Contact
- Touch and Use of Space
- Gestures
- Body Posture and Presentation
- Use of Voice

Guidelines for Gender Inclusive Language

ICE – Communications Tool Kit

Purpose

- This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).
- We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents- whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use.

COMMUNICATIONS TOOL KIT



This document will help you in the design of written materials to be both inclusive, sensitive, and compliant with the National Culturally and Linguistically Appropriate Service (CLAS) Standards and Section 1557 of the Affordable Care Act (ACA).



We do not want to be exclusionary, insensitive, or contribute to people feeling they are not welcome. Using gender neutral and culturally sensitive wording when creating any documents-whether for staff, members, providers, or the community is best practice, aligns with regulations and it fosters inclusivity. We need to be aware of the language we use. Utilize the below list when writing or reviewing documents. The list includes either offensive or non-inclusive phrases or words that have been found in materials, written as indicated. When reviewing documents, perform a search for the words as written below in the various ways (utilize the "find" function – select "Control F") and replace them with sensitive terms as applicable:

Exclusionary	Inclusive
his, her, his or her, his/her	their, the members
he, she, he or she, he/she	they, the members
him, her, him or her, him/her	them
himself, herself, himself or herself	themselves
woman, man, men or women	the member or the individual, members, or individuals
gender specific screenings – well-woman etc.	take out the gender term and leave as "preventative screening" or "annual well-check". In general, we need to use medical terms – do not "gender" services. Documents often reference "women should have a mammogram..." and instead should say "members should have a mammogram" etc.
pregnant women, pregnant woman	pregnant individuals, child-bearers, child-bearer
mother, father, mom, dad	parent as applicable
maternity	excluding any formal contract/program language requirement or information-change to "pregnancy", "childbirth", "pregnancy and childbirth" "prenatal", "postnatal" etc. as applicable
Gender-Male, Female - Sex and Gender/Gender Identity are different. Stay away from using them synonymously because it can be exclusionary; sex should reference medical terminology and gender/gender identity should reference the social construct of gender/gender identity...gender identities.	When need to know sex – include sex terms: male, female, or intersex When need to know gender – include gender/gender identity terms: woman, man, transgender, boy, girl, nonbinary, gender fluid, two-spirit, etc.- many more terms available. Consider asking "sex assigned at birth" and "gender identity" to be more inclusive.
both sexes	for sex there is male, female, intersex if inferring gender/gender identity there are many terms (Based on context change to "individuals" or just say "sex" of member or "gender identity of member")

Offensive/Insensitive	Sensitive
hearing impaired	deaf or hard of hearing
visual impairment	blind or low vision
LEP members	members with limited English proficiency
gender reassignment surgery, sex change	gender affirming surgery, transition
sexual preference	sexual orientation
hermaphrodite, hermaphroditism	"intersex" if applicable or if actually referencing gender affirming procedures, use "gender affirming treatment"
transgenders, a transgender, transgendered	Transgender should be used as an adjective, not a noun. For example, "Tony is a transgender man". Adding "ed" is insensitive-being transgender is a part of someone's identity, nothing happened to make someone transgender as the "ed" may suggest.

For additional questions on creating culturally sensitive materials: email Diana M. Carr, ICE Co-Chair at Diana.M.Carr@healthnet.com or Peggy Payne, ICE Co-Chair at peggy.payne@cigna.com

What is Culture?

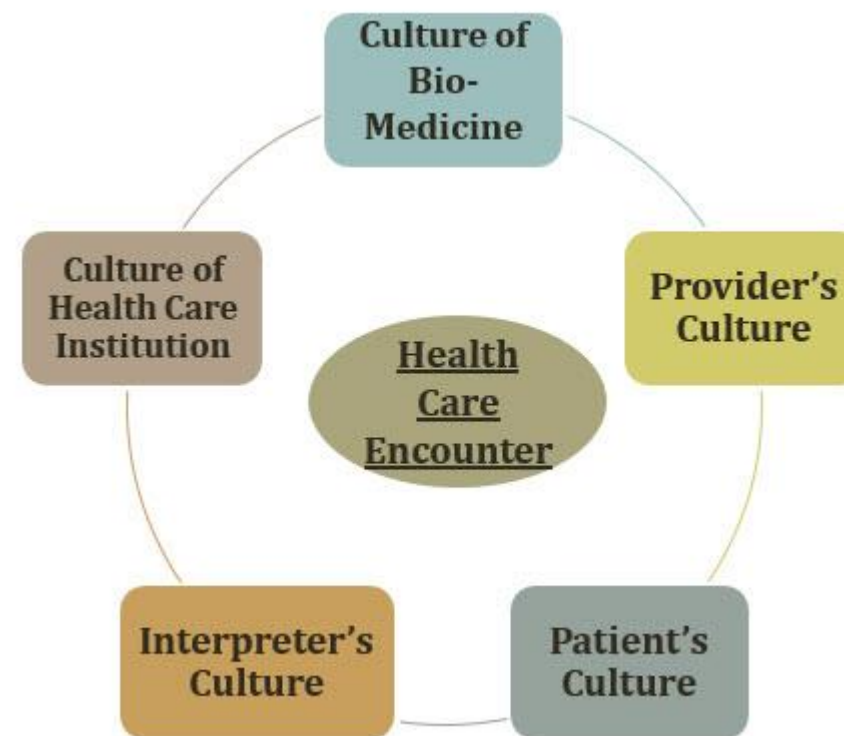
- Integrated patterns of human behavior that include language, thoughts, actions, customs, beliefs, values, and institutions that unify a group of people.
 - Influences how people act in social contexts
 - Informs the choices people make
 - Is used to create standards for social behavior



For the complete Training Module, please visit: [ICE Cultural Competency & Patient Engagement](#)

Health Care and Culture

- Each individual's culture is a unique representation, learned throughout life, shaped by society, and changes throughout the course of one's life.
- Each individual's culture is present wherever they go, including each health care encounter.
- Culture affects:
 - Views of illness and its causes
 - Attitudes toward health care providers
 - When health care assistance is sought out
 - Attitude toward seniors and those with disabilities
 - Caregiver roles
- There are many cultures at work in each health care visit.



Cultural Competency Continuum

For Each row, CIRCLE where you are now

Area of Competency	Stage 1 Culturally Unaware	Stage 2 Culturally Resistant	Stage 3 Culturally Conscious	Stage 4 Culturally Insightful	Stage 5 Culturally Versatile
Knowledge of Patients	Doesn't notice cultural differences in patients' attitudes or needs.	Denigrates differences encountered in racial/ethnic patients.	Difficulty understanding the meanings of attitudes/ beliefs of patients different from self.	Acknowledges strengths of other cultures and legitimacy of beliefs whether medically correct or not.	Pursues understanding of patient cultures. Learns from other cultures.
Attitude Towards Diversity	Lacks interest in other cultures.	Holds as superior the values, beliefs and orientations of own cultural group	Ethnocentric in acceptance of other cultures.	Enjoys learning about culturally different healthcare beliefs of patients.	Holds diversity in high-esteem. Perceives as valuable contributions to healthcare, medicine, patient well-being from many cultures.
Practice Related Behaviors	Speaks in a paternalistic manner to patient. Doesn't elicit patient's perspectives.	Doesn't recognize own inability to relate to differences. Tends to blame patient for communication or cultural barriers.	May overestimate own level of competent communication across linguistic or cultural boundaries.	Able to shift frame of reference to other culture. Can uncover culturally based resistance, obstacles to education & treatment	Flexibly adapts communication, interactions to different cultural situations. Can negotiate culture-based conflicts in beliefs and perspectives.
Practice Perspective	Believes one approach fits all patients. No "special treatment."	Has lower expectations for compliance of patients from other cultural groups.	Recognizes limitations in ability to serve cultures different from own. Feels helpless to do much about it.	Incorporates cultural insights into practice where appropriate.	Incorporates cultural insights into practice where appropriate.

Impacts of Clear vs Unclear Communication



Clear Communication

- Safety & Adherence
- Physician & Patient Satisfaction
- Office Process
- Saves Time & Money



Unclear Communication

- Malpractice Risk
- Medical Error
- Reduces Cost

A Professionally Trained Interpreter



Is...

- A Qualified Medical Interpreter (In-person or Telephone)
- A Certified Bilingual Staff Member



Is not...

- A Self-Assessed Language Employee
- A Patient's Family Member
- A Minor

Effective Use of A Professionally Trained Interpreter

- Hold a brief introductory discussion with the interpreter
 - Introduce yourself and provide a brief description of the call/visit
 - Reassure the patient about your confidentiality practices
- Speak directly to the patient, not the interpreter
- Speak in the first person
- Speak in a normal voice; try not to speak too loud or quickly
- Pace your discussion with the patient to allow time for interpretation and avoiding interrupting during interpretation
- Speak in concise sentences
- While interpreters are trained in medical terminology, interpretation will be smoother if you avoid acronyms, medical jargon, and technical terms
- Be aware of the cultural context of body language

Limited English Proficiency

Here's What Patients Wish Their Health Care Team Knew...

- My English is pretty good but at times I need an interpreter
- Some days it's harder for me to speak English
- When I don't seem to understand, talking louder in English intimidates me
- If I look surprised, confused or upset I may have misinterpreted your nonverbal cues

Here's What Your Team Can Do...

- Office staff should confirm language preferences during scheduling
- Consider offering an interpreter for every visit.
- Match the volume and speed of the patient's speech
- Mirror body language, position, eye contact
- Ask the patient if they're unsure

Language Assistance Services

- Language assistance is available at no cost to Members & Providers:
 - Interpreter support at a medical point of contact
 - Sign language interpreters
 - Speech to text interpretation for hearing loss in patients who do not sign
 - Member informing materials in alternative formats (i.e., large print, audio, and Braille)
- **Contact the Health Plan for assistance with Language services**

Provide Alternate Forms of Communication

- Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication.
- Effective communication means to communicate with people with disabilities as effectively as communicating with others. Alternative communications that support a patient encounter include Sign Language interpreters, Tactile interpreters, captioning and assisted listening devices.

Social Determinants of Health (SDOH)

- What are social determinants of health?
- Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains:
- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context



SDOH Priority Codes

DHCS Priority SDOH Codes*	
Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

SDOH codes are in the ICD-10-CM range Z55-65. A full list of ICD-10-CM codes is here: <https://www.cms.gov/Medicare/Coding/ICD10>

Refusal of Interpretive Services Document (English)

Request/Refusal Form for Interpretive Services

Patient name: _____

Primary language: _____

☐ Yes, I am requesting interpretive services.

Language(s):

☐ No, I prefer to use my family or friend as an interpreter.

☐ No, I do not require interpretive services.

☐ Not Applicable.

Please explain:

Patient Signature

Date

Please place this form in the patient's medical record.
RRequest/Refusal - English

Refusal of Interpretive Services Document (Spanish)

Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente: _____

Idioma preferido: _____

☐ Si, necesito servicios de intérprete.
Idioma(s): _____

☐ No, Prefiero utilizar un familiar o amistad como intérprete.

☐ No, requiero servicios de intérprete.

☐ No, me corresponde.

Por favor explique:

Firma del paciente

Fecha

Please place this form in the patient's
medical record. Request/Refusal -
SSpanish

Provider Health Plan LEP Contact Grid

Purpose

- To identify and provide a list Health Plan Interpreter services that are affiliated with MedPOINT Management clients

Interpreter Service Contact Information for Health Plans Affiliated with MedPOINT Management

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Aetna	Over 200 languages - using LanguageLine	<p>Medi-Cal/Medi-Care/Commercial LanguageLine Interpreter Services: (855) 380-5345 Client ID# 737610 4 digit pin code: 1020</p> <p>Face to Face appointment: 4 days notice for onsite interpretation service</p> <p>Additional Resource: www.aetna.com</p>
Alignment Health Plan	All Threshold Languages - using CyraCom International Language Services	<p>Medicare: CyraCom International Language Services: (866) 998-0338 Account Number: 30488 4 digit pin code: 1099</p> <p>Face to Face: Not Available</p> <p>Additional Resource: http://cyracominternational.com/</p>
Anthem Blue Cross	All Threshold languages	<p>Services are arranged through Anthem Blue Cross Health Plan's Member Services department. Face to face visit require advanced notification.</p> <p>Medi-Cal (888) 285-7801 (inside Los Angeles County) (800) 407-4627 (outside Los Angeles County)</p> <p>After business Hours: call the 24/7 Nurse Line at (800) 224-0336</p> <p>Commercial and Medicare Advantage Providers can call the Anthem's Provider Services Department at (800)677-6669 to receive assistance with translation and interpretation services.</p> <p>Members can contact the number on the back of their ID card for assistance.</p> <p>Additional Resource: https://mediproviders.anthem.com/ca/pages/free-interpreting-services.aspx</p>
Blue Shield of California	All languages - over 200 languages	<p>Blue Shield of California's Provider Services can direct calls to their vendor for interpreter Services.</p> <p>Provider Services: (800)541-6652</p> <p>Or call the number on the back of the member's ID card. A Blue Shield Representative will connect the call to LanguageLine (a third party vendor) for assistance with interpreting, translations and face to face visits</p> <p>Additional Resource: https://www.blueshieldca.com/provider/guidelines-resources/patient-care/language-assistance.sp</p>
Blue Shield of California, Promise Health Plan (formally Care1st)	Oral translations in all languages, print translations Spanish & Traditional Chinese	<p>Face to Face and telephonic interpreting services are arranged by Blue Shield of California, Promise Health Plan. Face to face visits need to schedule 4 days in advance.</p> <p>Medi-Cal (800) 605-2556 Medicare (800) 544-0088 CalMedi Connect (855) 905-3825</p> <p>After Business Hours: Call Pacific Interpreters: (877) 904-8195 ACCESS CODE: 828201</p>
Brand New Day	Spanish, Vietnamese, Mandarin Chinese, Cantonese Chinese, Cambodian, Tagalog. Pacific Interpreter (third party vendor) provides interpreter services for languages not available through Brand New Day.	<p>Face to Face Interpreter services is only provided for members who require assistance with Sign Language.</p> <p>Telephonic services are available by appointment only.</p> <p>All services require a 3-5 business day notice and must be arranged through Brand New Day's Member Services department.</p> <p>Member Services Department: (866) 255-4795</p>

Interpreter Service Contact Information for Health Plans Affiliated with MedPOINT Management

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Central Health Plan	All languages	<p>Face to Face Interpreter services is only provided for members who require assistance with Sign Language. Services require a 3-5 business day notice.</p> <p>All services must be arranged through Central Health Plan's Member Services department.</p> <p>Member Services Department: (866) 314-2427</p> <p>Additional Resource: https://www.centralhealthplan.com/Materials/MultiLanguage</p>
CIGNA	Interpretation - any language Translation of documents -Spanish, Traditional Chinese	<p>Interpretation is available in any language Call (800) 806-2059 or call the number on the back of member's Cigna ID card. You will need the member's CIGNA ID number, date of birth and your TAX ID number (or NCPDP for pharmacies) to confirm eligibility and access interpretation services. Advanced arrangements are not necessary.</p> <p>Face to Face interaction: (800) 997-1654</p> <p>Additional Resource: https://www.cigna.com/health-care-providers/resources/topic-cultural-competency-health-equity</p>
Health Net of California, Inc.	Interpretation available in all languages	<p>Services are arranged through Health Net. Telephonic and Face to Face services available.</p> <p>Service available 24 hours a day, 7 days a week. Medi-Cal: (800) 675-6110 Cal Medi-Connect – Los Angeles: (855) 464-3571 Cal Medi-Connect – San Diego (855) 464-3572</p> <p>Commercial: (800) 522-0088 After Hours, weekends and holidays: (800) 546-4570</p> <p>Medicare Advantage: (800) 929-9224 (M-F 8AM – 5PM)</p> <p>TTY: 711</p> <p>Additional Resource: www.healthnet.com (Click 'Language' tab on the top part of the website)</p>
IEHP	All languages	<p>Member Services: (800) 440-4347 or (800) 718-4347 for TTY users, at least 5 days before appointment.</p> <p>IEHP tries to accommodate same day requests as well, but prefers to schedule in advance when possible.</p> <p>To cancel your request, call at least 2 days before appointment.</p> <p>Additional Resources: https://ww3.iehp.org/en/providers/provider-resources (Scroll All the way down)</p>
LA Care Health Plan	All languages	<p>All Lines of Business; (855) 322.4034 Provide the member's LA Care Member ID and the Physician's NPI number.</p> <p>Face to Face and Telephonic services</p> <p>Medi-Cal: (888) 839-9909 Cal Medi-Connect: (888) 522-1298 L.A. Care Covered: (855) 270-2327 PASC-SEIU: (844) 854-7272</p> <p>Face to face visits require advanced notification:</p> <p>Additional Resource: http://www.lacare.org/nondiscrimination-notice</p>

Interpreter Service Contact Information for Health Plans Affiliated with MedPOINT Management

Health Plan Name	Plan LAP Threshold Languages (Other than English)	Plan Interpreter Access
Molina Healthcare of California	All languages through Globo, third party vendor	<p>Globo: (844) 311-9777 Location Code: 1011 (California) Product Line: 1 - Medi-Cal 2 - Marketplace 3 - CalMedi Connect (Duals) 4 - Medicare Department Code: 088 (Provider Office) or Medi-Cal: (888) 665-4621 Mon-Fri, 7am-7pm Marketplace: (888) 858-2150 Mon-Fri, 8am-6pm Medicare: (800) 665-0898 Mon-Fri, 8am-8pm EAE D-SNP (Duals): (855) 665-4627 Mon-Fri, 8am-8pm</p> <p>After Hours and Weekends, call Molina's Nurse Advice Line to arrange for service: English: (888) 275-8750 Spanish: (866) 648-3537</p> <p>Face to Face services must be arranged in advance through Molina's Member Services department.</p> <p>Additional Resource: http://www.molinahealthcare.com/providers/ca/medicaid/resource/Pages/ask_cultural.aspx</p>
United Healthcare of California	Spanish, Chinese (Traditional Chinese Characters), Vietnamese, Tagalog, Armenian, Russian, Japanese	<p>Medi-Cal and Medicare Dual Plans Member Services (866) 270-5785</p> <p>Medicare Advantage: (888) 866-8297 Commercial: (866) 633-2446 Provider Services: (877) 842-3210</p> <p>Additional Resource: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notice</p>
SCAN	All languages - through CQ Interpreter Services	<p>CQ Interpreter Services: (888) 338- 5514 Provider code: TPSCAN</p> <p>or contact SCAN's Member Services department: Phone Number: (800) 559-3500 Press # 4 for Provider Press # 6 for Interpreter services</p> <p>Additional Resource: http://www.molinahealthcare.com/providers/ca/medicaid/resource/Pages/ask_cultural.aspx</p>
WellCare/Easy Choice Health Plan	Vietnamese, Cantonese Chinese, Mandarin Chinese, Spanish and Korean. All other languages available through third party vendor.	<p>All services must be arranged through WellCare/Easy Choice Health Plan's Member Services department.</p> <p>Member Services: (866) 999-3945 (5 major languages listed) Press #1 for English Press #2 for provider Member Services will connect the call to an Interpreter.</p> <p>Face to Face: <u>Member</u> has to request interpretation services 1 week in advance - onsite service (based on the member's benefit coverage). If denied by the plan, the IPA's delegate will provide service.</p>

Additional Resources

- ICE – [Cultural Competency Training for Health Care Providers](#)
- ICE – [Better Communication, Better Care – Provider Tools to Care for Diverse Populations](#)
- ICE – [Interpreter Services for Health Plans in California](#)
- ICE – [Interpreter Quality Standards Guidance](#)
- SAMHSA - [Resource on Cultural Competency](#)



Simplifying Healthcare Administration

HIPAA PRIVACY TRAINING

Health Insurance
Portability and
Accountability Act
Developed: June 2023

OBJECTIVES



- Protecting Privacy and Security
- Review key terms and definitions
- Understand when it is appropriate to access Member/Patient information – “Minimal Necessity Rule”
- Member Rights
- Understand your role for identifying and reporting HIPAA Privacy and Security issues

PROTECTING



- Members/Patients routinely share personal information with health care providers. If the confidentiality of this information is not protected, trust in the physician-patient and healthcare relationship would be affected.

PRIVACY & SECURITY



Health care entities must take steps to ensure that Member/Patient protected health information (PHI) is not viewed by anyone without “a business need to know,” and is not stolen, lost, or accidentally destroyed.

Posting ANY member information or photos even without names may lead to termination, fines and jail time



KEY TERMS



What is HIPAA?

Health Insurance Portability and Accountability Act of 1996 is a federal law that required the creation of national standards to protect patient health information (PHI) from being disclosed without the patient's consent or knowledge.

KEY TERMS



What is PHI?

Protected Health Information (PHI) is information that relates to a member's/patient's past, present or future physical or mental health care or condition, including any payment for physical or mental health care, as well as any associated personally identifying information (PII)**

**** PII** - A general term used to describe any form of sensitive data that could be used to identify or contact an individual. For example, any payment or authentication information (i.e., mother's maiden name) is considered PII. When PII is used in connection with a member/patient's physical or mental health care or condition or payment for said care, PII becomes PHI.

KEY TERMS



What types of PHI are protected?

- Paper Records
- Electronic Records
- Oral Communication
- Fax/Email documents
- Any information that can identify the member and is related to the person's past, present or future physical or mental health condition
- Anything associated with healthcare services or treatment

IDENTIFIERS

THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) LISTS THE 18 HIPAA IDENTIFIERS THAT ARE CONSIDERED PERSONALLY IDENTIFIABLE:



- Names
- Address / Geographic area
- All elements of dates such as Date of Birth, Admit / discharge date, Date of Death
- Telephone numbers
- Fax numbers
- Email addresses
- Social Security numbers
- Medical Records numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- VIN and serial numbers, including license plate numbers
- Device identifiers and serial numbers

IDENTIFIERS (CONT.)

THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) LISTS THE 18 HIPAA IDENTIFIERS THAT ARE CONSIDERED PERSONALLY IDENTIFIABLE:



- Web URLs
- IP address numbers
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code, except as permitted

MEMBER RIGHTS



Mandated by HIPAA, members have the right to

- Receive the Notice of Privacy Practice
- Access their medical records
- Request amendments to their medical records
- An accounting of disclosures of their medical records
- Request restrictions on release of PHI
- File a complaint

MEMBER RIGHTS (CONT.)



[Access Member Rights and Notice of Privacy Practices](#)



Member Rights Policy

MedPOINT Management Member Rights Policy. The designated Independent Practice Association/Medical Group Member has rights. This document outlines those rights. Please review it carefully.



Member Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

ACCESSING PHI



The law allows access and disclosure of Member/Patient PHI when a request or need for information falls under Treatment, Payment or Operations (TPO).

Access to PHI without member/patient authorization is not limited to TPO (see [45 CFR 164.502](#)).

(T) Treatment

PHI is used in the treatment of the Member/Patient.

Example- A nurse reviews a Member's/Patient's immunization record to assess which vaccines they will need at an upcoming visit.

(P) Payment

PHI is needed to provide payment for services a Member/Patient received.

Example- A request from IEHP to a Provider to obtain medical records in order to remit payment.

(O) Operations

PHI is needed to carry out health administration operations.

Example- A compliance investigator accessing authorizations for a Member/Patient when conducting a fraud investigation.

MINIMUM NECESSARY RULE



Understand when it is appropriate to access Member/Patient information

“Minimum Necessary” Rule

- Clinical staff, physicians and employees are required to access only the information *they need to do their job* for treatment, payment or healthcare operations (TPO)
- Release of PHI without a signed Authorization Form is not permitted
- Access to your family/friends' records is not permitted without a signed Authorization Form from the member

YOUR ROLE IN PROTECTING



1. Only access information your job REQUIRES for TPO (Treatment, Payment, Healthcare Operations)
2. Prior to release of PHI, ensure Authorization Form is obtained (as needed for compliance with the Privacy Rule)
3. If transmitting PHI electronically, ensure that you are sending the transaction through a secure portal or through a secure email
4. If faxing is required, a cover sheet can be sent to a physician office or other health care facility's fax machine that is within a secure location. Before faxing, make sure to:
 - Confirm the fax number prior to sending
 - Send fax to approved fax numbers, or make sure the recipient is waiting by the machine to receive the fax
 - If sent to an inappropriate fax number, report the matter to your supervisor immediately

YOUR ROLE IN PROTECTING (CONT.)



5. Do not share member information in open areas where you can be overheard by others
6. Lock your computer every time you walk away, and/or log off at the end of the day
7. Do not share or disclose member information with family, friends or co-workers
8. Do not email, post or text (including photos) anything that can identify a member
9. Know the permission level granted by the member in order to leave a HIPAA-compliant voice message
10. Know how and where to dispose of all PHI – shred, locked bins, etc.
11. **PROMPTLY REPORT MEMBER PRIVACY INCIDENTS** to your supervisor, privacy officer per your company policy

The Privacy & Security Auditor is responsible for receiving complaints and documenting the investigation, outcome, and all mitigation. Email ComplianceConcerns@medpointmanagement.com

RAC 007 Privacy Complaints Policy

SECURE EMAILS



Securing Emails is mandatory for all HIPAA-protected information going outside MedPOINT Management.

MedPOINT Management has implemented encryption checks for Zix encryption on the receiver's side of an e-mail first. If Zix encryption is not-found, the system checks to see if the receiver's e-mail server has a protocol of Transport Layer Security (TLS). If the receiver does not have Zix or the TLS protocol on their Exchange server or internet mail, then they have to create a login to the portal.

OVERSIGHT



The Compliance Officer monitors oversight of HIPAA and security:

Ways to Report Compliance Concerns

Anne Rohr, Compliance Officer: arohr@Medpointmanagement.com

Phone Number: 818-702-0100 x1531

Fax Number: 818-702-1743

Anonymous Reporting: [ComplianceConcern](#)

Mail: MedPOINT Management

15301 Ventura Blvd. Bldg. D Suite 200

Sherman Oaks, CA 91403

ComplianceConcerns@medpointmanagement.com

DISCLAIMER



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. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

POST-ASSESSMENT QUIZ



1. The primary Federal Law pertaining to the medical information privacy is:
 - a. American Recovery and Reinvestment Act (ARRA)
 - b. Health Information Technology for Economic and Clinical Health Act (HITECH)
 - c. Health Insurance Portability and Accountability Act (HIPAA)
 - d. All of the above
 - e. None of the above
2. What is PHI?
 - a. Privacy Health Information
 - b. Protected Health Information
 - c. Patient Health Insurance
3. Which of the following are examples of PHI?
 - a. Patient's Name
 - b. Patient's Date of Birth
 - c. Patient's Address
 - d. Medical Record Number
 - e. Admission date, time, and reason
 - f. All of the above
 - g. None of the above

POST-ASSESSMENT QUIZ



4. The “minimum necessary” requirement of HIPAA refers to using or disclosing/releasing only the minimum PHI necessary to accomplish the purpose for which it is being used, requested, or disclosed.
 - a. True
 - b. False
5. The HIPAA Privacy Rule protects all PHI, electronic, verbal and written.
 - a. True
 - b. False
6. If you need to report a HIPAA concern or violation, which of the following can you do?
 - a. Contact my organization’s HIPAA Compliance Officer
 - b. Contact my supervisor or manager
 - c. All of the above
 - d. None of the above

POST-ASSESSMENT QUIZ



7. HIPAA mandates that members have the right to:
 - a. Request restrictions on release of PHI
 - b. File complaints
 - c. Receive the notice of privacy practices
 - d. Access medical records
 - e. All of the above
 - f. None of the above
8. It is not mandatory to secure emails for HIPAA protected information on outgoing email
 - a. True
 - b. False
9. Only access the information your job requires for treatment, payment, Healthcare Operations
 - a. True
 - b. False
10. An authorization form is not needed prior to releasing PHI
 - a. True
 - b. False



Simplifying Healthcare Administration

HEALTH CARE FRAUD, WASTE AND ABUSE TRAINING

FWA
Developed: June 2023

INTRODUCTION



Health care fraud can cost **TAXPAYERS** billions of dollars

The Fall 2022 [Semiannual Report to Congress](#) (SAR) highlights nearly \$1.29 billion in expected recoveries as a result of HHS-OIG audits and investigations conducted from April 1, 2022, to September 30, 2022.

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.

OBJECTIVES



- **Identify** fraud and abuse
- **Understand** fraud and abuse laws & penalties
- **Recognize** risk areas or red flags*
- **How** to report fraud and abuse
- **What** happens after detection
- **Recognize** government agencies and partnerships dedicated to fighting fraud and abuse

* **Red flags** are warnings or discrepancies that attract attention to potential fraud and abuse. Although not evidence of fraud and abuse, a pattern of red flags can increase suspicion and justify further investigation.

* **Red flags** can be general or specific to a line of business and should be reported immediately!

WHAT IS HEALTH CARE FRAUD?



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

EXAMPLES OF FRAUD RED FLAGS



Intentional Act for Gain

FRAUD

UM – Making prohibited referrals for certain designated health services.

UM – Documenting a verbal denial falsely attributed to a medical professional.

Staff – Knowingly receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal or private health care programs.

Claims – Knowingly submitting, or causing to be submitted, false claims, or making misrepresentations of facts to obtain payment.

Deception

FRAUD

UM – Falsifying documents to indicate notifications had taken place for approval, modification, or denying a referral request.

UM – Redirecting care from a contracted provider because of economic profiling (cost) without regulatory approval.

Claims – Submitting inaccurate financial reports related to outstanding claims liability.

Claims – Altering claim audit files to fraudulently show compliance with health plan audits to hide failure to pay claims due to financial insolvency.

WHAT IS HEALTH CARE WASTE?



Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

For the definitions of fraud, waste and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) website.

[mc86c21.pdf \(cms.gov\)](https://www.cms.gov/mc86c21.pdf)

EXAMPLES OF WASTE RED FLAGS



Actions that may
constitute WASTE
include:

Conducting excessive office visits

Writing excessive prescriptions

Prescribing more medications
than necessary for treating a
specific condition

Ordering excessive laboratory
tests

WHAT IS HEALTH CARE ABUSE?



Abuse applies to practices that are inconsistent with sound fiscal, business, medical or recipient practices that result in unnecessary cost to a health care program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Mistakes that are repeated after discovery or represent an on-going pattern could constitute abuse.

Action can directly or indirectly result in unnecessary costs to the Medicare Program.

EXAMPLES OF ABUSE

RED FLAGS



Actions that may
constitute Abuse
include:

- *Unknowingly billing for unnecessary medical services*
- *Unknowingly billing for brand name drugs when generics are dispensed*
- *Unknowingly excessively changing services or supplies*
- *Unknowingly misusing codes on a claim, such as upcoding or unbundling codes*

DIFFERENCES BETWEEN FRAUD, WASTE AND ABUSE



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

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

Waste and Abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but does not require the same intent and knowledge.

HOW TO PREVENT FWA



- Make sure you are up to date with laws, regulations, policies
- Conduct yourself in an ethical manner
- Ensure you coordinate with other payers
- Ensure data/billing is both accurate and timely
- Know FWA policies and procedures, standards of conduct, laws, regulation
- Verify information provided to you
- Be on the lookout for non-compliant activity
- Be aware of what could be non-compliant activity

POTENTIAL FWA RED FLAGS FOR POTENTIAL MEMBER ISSUES



- Does the Medicare record or lab test look altered or forged?
- Does the member medical history support the services requested?
- Have you reviewed numerous identical authorization requests for members from this physician that seem suspicious?
- Member questioning services such as not knowing the physician or stating they did not take the test in question.

POTENTIAL FWA RED FLAGS FOR POTENTIAL PROVIDER ISSUES



- Are the provider's authorization requests appropriate for the member's health condition?
- Unusual billing practices or suspicious activity
 - Altering dates of services
 - Unbundling or upcoding services
- Is the provider requesting a higher quantity of a service than medically necessary for the condition?
- Is the provider's diagnosis for the member supported in the medical records?

REPORTING FWA AT MEDPOINT MANAGEMENT



Everyone *must* report suspected instances of FWA. Your Code of Conduct clearly states this obligation. MedPOINT Management will not retaliate against you for making a good-faith effort in reporting.

Ways to Report Compliance Concerns

Anne Rohr, Compliance Officer: arohr@Medpointmanagement.com

Phone Number: 818-702-0100 x1531

Fax Number: 818-702-1743

Anonymous Reporting: [ComplianceConcern](#)

Mail: MedPOINT Management

15301 Ventura Blvd. Bldg. D Suite 200

Sherman Oaks, CA 91403

ComplianceConcerns@medpointmanagement.com

REPORTING FWA AT MEDPOINT MANAGEMENT



If warranted, report fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS. Reporting to MedPOINT Management Compliance will facilitate evaluation of every report to identify if external notification is warranted.

Individuals or entities (physicians, companies) who voluntarily disclose a 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.

Do not be concerned
about whether it is
fraud, waste or abuse.

REPORTING FWA AT MEDPOINT MANAGEMENT



If warranted:

HHS Office of Inspector General:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Email: HHSTips@oig.hhs.gov

Online: <https://oig.hhs.gov/fraud/report-fraud/>

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

WHAT WILL HAPPEN AFTER REPORTING



Once suspected or actual fraud, waste or abuse is detected, work starts promptly to confirm and identify the extent of the issues. Once identified, measures to correct start immediately. Correcting the problem saves the government money and ensures compliance with CMS requirements & other regulatory / governing body.

MedPOINT Management will develop a plan to correct the issue. If it does not interrupt the investigation, Compliance Department and Leadership may be able to provide the steps in the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances.

1. Design the corrective action to correct the underlying problem that resulted in FWA program violations and to prevent future noncompliance.

2. Tailor the corrective action to address the specific FWA problem or issues identified. Timelines for actions are important to ensure completion.

All corrective actions addressing noncompliance or FWA committed must be documented, including consequences for failure to satisfactorily complete the corrective action.

It is necessary to monitor corrective action continuously until the team can ensure the effectiveness of the correction.

FWA LAWS



The five most important Federal fraud and abuse laws that apply to physicians are the:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark law)
- Exclusion Authorities
- Civil Monetary Penalties Law (CMPL)

<http://oig.hhs.gov/fraud/PhysicianEducation/>

FWA LAWS FALSE CLAIMS ACT (FCA)



False Claims Act (FCA) prohibits:

- Presenting a false claim for payment or approval
- Making or using a false record or statement in support of a false claim
- Conspiring to violate the False Claims Act
- Falsely certifying the type/amount of property to be used by the Government
- Certifying receipt of property without knowing if it is true
- Buying property from an unauthorized Government officer
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government

• 31 United States Code § 3729-3733

FWA LAWS ANTI-KICKBACK STATUTE



Anti-Kickback Statute (AKS)

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 (which includes the Medicare program).

- 42 United States Code §1320a-7b(b)

FWA LAWS STARK LAW



Physician Self-Referral Law (Stark law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

- 42 United States Code §1395nn

FWA LAWS CIVIL MONETARY PENALTIES LAW



Civil Monetary Penalties Law

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

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

FWA LAWS EXCLUSIONS



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

The U.S. General Services Administration (GSA) administers the System for Award Management (SAM), which contains debarment actions taken by various Federal agencies, including the OIG. Access to the EPLS is available through the System for Award Management (SAM) website.

Medi-Cal maintains the Suspended and Ineligible (S&I) Provider List of healthcare providers and entities barred from participating in the Medi-Cal program.

FWA LAWS EXCLUSIONS (CONT.)



Exclusion (continued)

Exclusions are reviewed before hiring or contracting a new employee, temp or consultant and monthly thereafter.

A review of monthly exclusions is essential to prevent inappropriate payment to anyone on the exclusion lists.

See [MPM Policy Tracker](#) on your desktop or request a copy of the *RAC 013 Sanction Screening Policy* from the Compliance Department, your Leadership Team, or HR.

FWA LAWS

CIVIL MONETARY PENALTIES



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

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

HEALTH CARE LAWS



The False Claims Act

- Statute: 31 U.S.C. §§ 3729–3733

The Anti-Kickback Statute

- Statute: 42 U.S.C. § 1320a–7b(b)
- Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law

- Statute: 42 U.S.C. § 1395nn
- Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities

- Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5
- Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law

- Statute: 42 U.S.C. § 1320a–7a
- Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute

- Statute: 18 U.S.C. §§ 1347, 1349

HEALTH CARE LAWS CALIFORNIA



Welfare Institutions Code 14107 [False Claims] - Prohibits claim submission, with intent to defraud, to obtain greater compensation than legally entitled.

Welfare Institutions Code 14107 (a-b) [Anti-Kickback] - Solicits or receives any kickback, bribe or rebate to either refer or promise to refer person(s) for services or merchandise.

CA Penal Code 550(a)(6-7) [False claims] - Imposes liability to knowingly make, or cause to be made, any false or fraudulent claim for health care benefit or which was not used by or on behalf of the claimant.

DISCLAIMER



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. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

POST-ASSESSMENT QUIZ



1. Allegations of fraud are limited to the intentional billing for services that do not meet professionally recognized standards.
 - a. True
 - b. False
2. What are some of the penalties for violating fraud and abuse (FA) laws?
 - a. Fines
 - b. Imprisonment
 - c. Exclusion from participation in all health care programs
 - d. All of the above
3. All of these government agencies except one are involved in fraud and abuse prevention, which one?
 - a. CMS
 - b. OIG
 - c. LDR
 - d. DMHC

POST-ASSESSMENT QUIZ



4. What is/are cause(s) for improper payment?
 - a. Upcoding
 - b. Billing for services not needed or not rendered
 - c. Misrepresentation of facts
 - d. All of the above

5. Abuse may be intentional or unintentional: improper practice that either directly or indirectly results in unnecessary costs to health care program.
 - a. True
 - b. False

6. It is acceptable to obtain a verbal denial from the medical director without follow-up electronic or written signature.
 - a. True
 - b. False

POST-ASSESSMENT QUIZ



7. It is always acceptable for a medical group to suppress availability of high cost specialists in their system to encourage use of preferred providers.
 - a. True
 - b. False
8. The exclusion statute is a federal law which bans any provider or entity convicted of fraud from participating in any federally funded programs.
 - a. True
 - b. False
9. An example of Health Care fraud being an intentional act for gain is making prohibited referrals for certain designated services.
 - a. True
 - b. False

POST-ASSESSMENT QUIZ



10. It is acceptable for a provider to receive cash or below-fair market value rent for a medical office space in exchange for referrals.
 - a. True
 - b. False

11. Which is NOT an example of Best Practices for Preventing Fraud and Abuse.
 - a. Developing a compliance program
 - b. Providing effective education of physicians, providers, suppliers, and members
 - c. When encountering a potential violation of laws, regulations, policies, or contractual obligations, it is not our responsibility to report immediately
 - d. Monitoring claims and medical records

12. When reporting Fraud, the group shall only report to their internal departments and regulators.
 - a. True
 - b. False

POST-ASSESSMENT QUIZ



13. If economic profiling is practiced by the delegate, they must disclose to the plan and follow the economic profiling policy of the health plan or have their policy submitted to the DMHC for approval.
 - a. True
 - b. False

14. Red Flags are warnings or discrepancies that attract attention to potential fraud and abuse and do not require reporting until you have specific evidence of fraud and abuse.
 - a. True
 - b. False

15. When fraud is identified it must be reported internally and/or to affected Sponsors.
 - a. True
 - b. False

POST-ASSESSMENT QUIZ



16. When preparing files for an audit, it is important to modify the dates on audit documents to ensure you are compliant with timeframes.
 - a. True
 - b. False
17. Once a corrective action plan (CAP) is started, the corrective actions must be monitored annually to ensure they are effective.
 - a. True
 - b. False

POST-ASSESSMENT QUIZ



18. Ways to report potential Fraud and Abuse include:
- a. Telephone hotlines
 - b. Mail drops
 - c. In-person reporting to the compliance department / supervisor
 - d. Special Investigations Units (SIUs)
 - e. All of the above
19. Some of the laws governing health care fraud and abuse include the False Claims Act and the Anti-Kickback Statute.
- a. True
 - b. False

Compliance Program

IPAs and Medical Groups enter into written agreements with First tier, Downstream, or Related Entities (FDR) to provide administrative or healthcare services to Medicare enrollees. Per the Centers for Medicare & Medicaid Services (CMS), MedPOINT Management (MPM) must ensure FDRs comply with program requirements within Chapter 42 of the Code of Federal Regulations, Parts 422 and 423, also referred to as Medicare Parts C and D.

Code of Conduct Distribution

42 CFR 422.503 and 423.504(b)(4)(vi)(A)

As a First Tier, Downstream or Related Entity (FDR), your organization is required to distribute a Code of Conduct (Code) to employees:

- Within 90 days of when an employee is hired
- When changes are made to the Code
- Annually

You can distribute our Ethics, Code of Conduct, and Compliance or your organization's own Code (if the content is comparable to ours).

We may ask you to provide evidence of the distribution of the Code to your employees. Evidence can vary by organization, but it must demonstrate that your employees were provided with the Code.

Some examples of evidence of distribution include:

- Email employees with a link to the Code of Conduct and an instruction to review it
- Screenshot of an intranet posting with a notification to employees to review it
- Code of Conduct attestations
- Evidence of Code of Conduct training attendance log or certificate of completion

Reporting issues of non-compliance and FWA to MPM

42 CFR 422.503 and 423.504(b)(4)(vi)(E)

You must report non-compliance issues, including potential conflicts of interest and Fraud Waste and Abuse (FWA), to MedPOINT Management. The requirement for reporting such problems can be found in the Chapter 21 Compliance Program Guidelines and Prescription Drug Benefit Manual. The provision states that the sponsor (Health Plan) must require FDRs to report compliance concerns and suspected or actual violations related to the Medicare program. See **Ways to Report Compliance Concerns**



A **first-tier** entity is any party that enters into a written arrangement with an organization to provide administrative or healthcare services for Medicare business.

A **downstream** entity is any party that enters into a written arrangement with persons or entities below the level of the first tier's arrangement with an organization. These arrangements continue down to the level of the ultimate provider of both health and administrative services.

A **related** entity is an entity that is linked to our organization by common ownership or control and provides functions to support Medicare business.

Quick links

- [Medicare Managed Care Manual](#)
- [Medicare Prescription Drug Benefit Manual](#)
- [MPM Code of Conduct](#)
- [MPM FWA Training](#)
- [MPM General Compliance Training](#)
- [MPM Privacy & Security Training](#)

Exclusion list links

- [OIG's List of Excluded Individuals and Entities \(LEIE\)](#)
- [GSA's System for Award Management \(SAM\)](#)
- [Medi-Cal Suspended and Ineligible List](#)

Ways to Report Compliance Concerns

Anne Rohr, Compliance Officer:

arohr@Medpointmanagement.com

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Fax Number: 818-702-1743

Anonymous Reporting: [ComplianceConcern](#)

Mail: MedPOINT Management

15301 Ventura Blvd. Bldg. D Suite 200

Sherman Oaks, CA 91403

ComplianceConcerns@medpointmanagement.com

What You Need to Know About Compliance

- **We are all responsible for compliance and obligated to report potential compliance issues, including FWA.**
- **Anyone who makes a report in good faith will be protected from retaliation.**
- **All reports will be investigated and treated confidentially.**
- **Disciplinary actions will be prompt, fair, and consistent in all areas of non-compliance.**

Non-intimidation and Non-retaliation

42 CFR 422.503 and 423.504(b)(4)(vi)(A)

MedPOINT Management enforces a no-tolerance policy for intimidation and retaliation. No individual or organization should fear retribution for reporting known or suspected issues or non-compliance or FWA to MedPOINT Management, Sponsor organization, or authorities if reported in good faith. Your report will be kept confidential to the extent permitted by law, and anyone who engages in intimidation and retaliation will be subject to disciplinary action up to and including termination.

Investigations and Resolution

42 CFR 422.503 and 423.504(b)(4)(vi)(G)

MedPOINT Management has procedures in place to respond to compliance issues identified promptly, and the remedial action taken for non-compliance is documented for review and reporting to the MPM CEO, IPA or Medical Group governing body, and appropriate authorities.

Disciplinary Action

42 CFR 422.503 and 423.504(b)(4)(vi)(E)

Providers must understand the requirements for disciplinary standards and duty to promptly and consistently enforce corrective action in instances of non-compliance, including unethical, illegal, and FWA activity.

General Compliance and Fraud, Waste, and Abuse (FWA) Training

42 CFR 422.503 and 423.504(b)(4)(vi)(C)

MedPOINT Management presents compliance training to all new and established providers as part of new provider orientation and annually after that. You can distribute our FWA and General Compliance training or your organization's training (if the content is comparable to ours). Evidence must show that your employees completed training by attendance log, attestation, or certificates and can be classroom led or self-navigated as long as you can demonstrate that training was completed.

Exclusion Screening

42 CFR 422.503 and 423.504(b)(4)(vi)(F), 422.752(a)(8), 423.752(a)(6)

Providers must screen against the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), the General Services Administration (GSA) System for Award Management (SAM), and the Suspended and Ineligible List before contracting or hiring and monthly after that. This must include any current employee, new employee, temporary employee, volunteer, and consultant to ensure individuals are not excluded or become excluded from participation in state and federal programs.

Record Retention

42 CFR 422.503 and 423.504(b)(4)(vi)(C)

Providers must agree to comply with Medicare laws, regulations, and CMS instructions regarding maintaining training records and exclusion screenings for ten years.

Auditing and Monitoring

42 CFR 422.503 and 423.504(b)(4)(vi)(E)

MedPOINT Management has systems to monitor compliance with Medicare program requirements. We perform a risk assessment to identify high-risk areas for auditing with oversight by an established compliance committee. The status and activities of our compliance program are well documented and reported to the MPM CEO and IPA or Medical Group governing body.



Simplifying Healthcare Administration

GENERAL COMPLIANCE

Developed: June 2023

OBJECTIVES



After this course you should correctly:

1. Recognize the 7 elements of an effective Compliance Program
2. Understand Ethics – Doing the Right Thing
3. Recognize how compliance program violations should be reported

WHY DO I NEED TRAINING?



Compliance is Everyone's Responsibility

***Failure to follow Medicare, CMS guidance, Health Plan and regulatory agency requirements can lead to serious consequences, including:**

- Contract termination
- Criminal penalties for both the organization and the offending individual
- Exclusions from participating in all Federal health care programs
- Civil monetary penalties for both the organization and the offending individual

WHAT IS AN EFFECTIVE COMPLIANCE PROGRAM?



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

- Prevents, detects and corrects non-compliance
- Is tailored and implemented to an organization's unique operations and circumstances
- Has adequate resources
- Promotes the Code of Conduct
- Establishes clear lines of communication

COMPLIANCE PROGRAM REQUIREMENTS



Requirements of an Effective Compliance Program:

1. Written Policies, Procedures and Standards of Conduct
2. Compliance Officer, Compliance Committee and High-Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. Effective System for Routine Monitoring, Auditing and Identifying Compliance Risks
7. Procedures and System for Prompt Response to Compliance Issues

COMPLIANCE PROGRAM REQUIREMENTS

1. CONDUCT



1. Written Policies, Procedures, and Standards of Conduct

- a) Policies articulate commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Code of Conduct.
- b) MedPOINT Management policies are located in the [MPM Policy Tracker](#) desktop link on your computer, or you can ask for a copy from your Supervisor, the Compliance department, or HR.
- c) The *Ethics, Compliance, and Code of Conduct Handbook* is updated annually and located in the MedPOINT employee portal [ADP Workforce Now](#) under Resources/Company Policies
- d) Please know that we will protect you if you report a possible or actual compliance issue in good faith. MedPOINT Management has a strict policy against retaliation. Any employee who engages in intimidation and retaliation will be subject to disciplinary action up to and including termination.

COMPLIANCE PROGRAM REQUIREMENTS

2. OVERSIGHT



2. The Compliance Committee includes the following members of MPM Leadership:

- CEO/President: Kimberly Carey
- Compliance Officer: Anne Rohr
- Controller: Cory Vinson-Vestal
- Director, Claims Operations: Erica Tate
- Vice President of Information Technology: Aaron Goodale
- Vice President of Legal Affairs: Shayna Rasmussen
- Vice President of Medical Affairs: Sandy Hazel
- Vice President of Operations: Alex Carey
- Vice President of Provider Network Operations: Carrie Hasson
- Vice President of Quality Management: Linda Deaktor

MedPOINT Management designated 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 senior management and the governing body are engaged and exercise reasonable oversight of the compliance program.

COMPLIANCE PROGRAM REQUIREMENTS

3. TRAINING AND EDUCATION



3. Effective Compliance Education and Training

This covers the elements of the compliance plan and preventing, detecting, and reporting FWA.

Training and education are covered in many ways. The training and education will be tailored for the different employees and their roles and responsibilities. This is attained through Annual Compliance Training, staff meetings, email notifications, and departmental educational training.

Per CMS, Refer to Chapter 21, GC training 50.3.1 for a review of laws that govern employee conduct in the Medicare program (<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c21.pdf>)

COMPLIANCE PROGRAM REQUIREMENTS

4. COMMUNICATION



4. **Effective Lines of Communication**

- a. Chain of Command
- b. Management Team
- c. Compliance Department
- d. Hot Line – Anonymous Reporting

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, more commonly known as subcontractors.

COMPLIANCE PROGRAM REQUIREMENTS

5. DISCIPLINE



5. Well-Publicized Disciplinary Standards

MedPOINT Management must enforce standards through well-publicized disciplinary guidelines. These should be provided during new employee orientation, Annual Compliance training, and staff meetings and be present in policy to articulate expectations for reporting compliance issues and assist in their resolution when appropriate. To outline actions such as:

- Mandatory training or re-training
- Disciplinary action that is consistent and equitable
- Termination

COMPLIANCE PROGRAM REQUIREMENTS

6. MONITORING



6. Effective System for Routine Monitoring and Identification of Compliance Risk

The system should include routine internal monitoring and audits of operations to evaluate compliance with requirements. As appropriate, external audits, to evaluate the sponsor's, including FDRs', compliance with CMS requirements and the overall effectiveness of the compliance program.

- Audit compliance with regulations, contractual agreements and all State and Federal laws
- Monitor activities are performed as expected and ensure corrective actions are undertaken and effective

COMPLIANCE PROGRAM REQUIREMENTS

7. REPORTING



7. Established System to Promptly Respond to Compliance Issues

Establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified during self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS, state regulatory agencies and Health Plan requirements.

ETHICS: DO THE RIGHT THING



It is really that simple ... Do the right thing by:

- **Conducting** yourself in an ethical and legal manner
- **Acting** fairly and honestly
- **Adhering** to high ethical standards in all you do
- **Acting** with integrity, transparency and accountability
- **Complying** with all laws, regulations and regulatory agencies
- **Reporting** suspected/actual violations

WHAT IS EXPECTED OF ME?



- ✓ Follow MPM's Code of Conduct
- ✓ Read and understand company policies
- ✓ Know how to report violations or suspected non-compliance
- ✓ Speak up if you don't understand something; ask your Leadership Team, Human Resources, or the Compliance Officer!

Ways to Report Compliance Concerns

Anne Rohr, Compliance Officer:

arohr@Medpointmanagement.com

Phone Number: 818-702-0100 x1531

Fax Number: 818-702-1743

Anonymous Reporting: [ComplianceConcern](#)

Mail: MedPOINT Management

15301 Ventura Blvd. Bldg. D Suite 200

Sherman Oaks, CA 91403

ComplianceConcerns@medpointmanagement.com

WHAT IS NON-COMPLIANCE?



Non-compliance is any conduct that does not conform with State and Federal law and/or program requirements, with contract requirements, or with ethical and business policies. Areas of risk include (but are not limited to):

- Agent/Broker misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Member notices
- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- **Health Insurance Portability and Accountability Act (HIPAA)**
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

EXAMPLES OF NON-COMPLIANCE



Example

My co-worker changed a date on a member's authorization request to avoid getting in trouble. She is my friend and she said she will not do it again, so I won't say anything.

My friend's neighbor is ill and came in to see the doctor I work for. My friend called me on behalf of the neighbor's spouse wanting information on the visit. My friend says the neighbor's spouse only wants to confirm that neighbor wasn't lying about the visit.

Explanation

Covering up **unethical behavior** is wrong. While you don't want your friend to be in trouble, you are harming the member and breaking the company code of conduct.

Releasing patient information without the proper reason/authorization is prohibited. Even though you may desire to help your friend and the neighbor's spouse, providing any information on the visit is non-compliance unless the neighbor authorized their spouse right of access.

EXAMPLES OF NON-COMPLIANCE (CONT.)



Example

You receive an alert about claims from XYZ Lab. For the last six months, the lab consistently billed for code 80055 (CPT Code for a prenatal panel with CBC). In your review, you find that the code is used for both male and female patients and that reimbursement for code 80055 is higher than the standard codes for a CBC. You also find that orders are from Dr. John Doe, your favorite doctor.

A parent brings their child to an appointment at your office. As you check-in the child, the child's demographic states that the child's DOB would make the child 8 years old, but the child in your office appears to be significantly younger. This is the last patient, you don't want any trouble, and you just want to go home.

Explanation

This is considered a form of upcoding, which is **fraud**. Irrespective that Dr. Doe is your favorite doctor, your findings should be reported immediately so that the matter may be investigated. Failure to report is considered non-compliance and, if fraud is proven, there is a risk of being considered complicit with the fraud.

The parent is committing **fraud** and by covering up for a patient – whether intentionally or otherwise – you are in violation of your provider's office patient verification policy, and are at risk of being considered complicit in the fraud as well as excluded from participation in most healthcare programs.

NON-COMPLIANCE AFFECTS ALL



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

Potential and possibly catastrophic harm to members through:

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

Failure to follow the requirements can lead to serious consequences, such as:

- Financial sanctions
- Contract termination
- Criminal penalties
- Exclusions from participating in most health care programs

HOW TO REPORT POTENTIAL NON-COMPLIANCE



Anne Rohr, Compliance Officer:

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Phone Number: 818-702-0100 x1531

Fax Number: 818-702-1743

Anonymous Reporting: [ComplianceConcern](#)

Email: ComplianceConcerns@medpointmanagement.com

Call: 1-800-MEDICARE

Do Not Hesitate to Report Non-Compliance

When you report suspected non-compliance in good faith, MedPOINT Management cannot retaliate against you – RAC 038 Ethics Code of Conduct and Compliance Policy

REPORTING NON-COMPLIANCE



Who is a "**Whistleblower**"? A Whistleblower is any individual who exposes information or activity that *may* be deemed illegal, dishonest, or violates professional or clinical standards.

When reporting in "*good faith*," an employer cannot retaliate against you for exercising your rights under the Department of Labor's "Whistleblower Protection" laws.

Example of Retaliation

"After I reported irregularities in my department, my manager began excluding me from meetings and moved me to another department."

Explanation

Retaliation or intimidation is not tolerated. The manager's behavior is unacceptable and should be reported to leadership or to Compliance.

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 regulatory compliance requirements
- Efficient and effective internal controls
- Members are protected



INTERNAL MONITORING AND AUDITS



Monitoring and auditing to test and confirm compliance with policies, laws, contracts, State and Federal regulations is part of ensuring an effective compliance program

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 (policies, laws, regulations, contract commitments) used as base of measures.

Medicare Managed Care Manual
Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual
Chapter 9 - Compliance Program Guidelines
Section 50.6.1 – Routine Monitoring and Auditing

COMPLIANCE IS EVERYONE'S JOB



Prevent

- Operate within ethical expectations to prevent non-compliance

Detect & Report

- If you see it, report it - report potential non-compliance

Correct

- Correct non-compliance that includes ongoing monitoring to protect members

APPENDIX



Appendix: Laws and Regulations to Consider in Standards of Conduct and/or Training (Chapter 21-Rev. 109 & Chapter 9-Rev. 15-Issued: 07-27-12, Effective: 07-20-12; Implementation 07-20-12)

- Title XVIII of the Social Security Act
- Medicare regulations governing Parts C and D found at 42 CFR §§ 422 and 423 respectively
- Patient Protection and Affordable Care Act (Pub. 1., No. 111-148, 124 Stat. 119)
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191)
- False Claims Acts (31 U.S.C. §§ 3729-3733)
- Federal Criminal False Claims Statutes (18 U.S.C. §§ 287, 1001)
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
- The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))

APPENDIX (CONT.)



- Civil monetary penalties of the Social Security Act (42 U.S.C. § 1395w-27 (g))
- Physician Self-Referral (“Stark”) Statute (42 U.S.C § 1395nn)
- Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act
- Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the Federal Government (42 U.S.C. § 1395w-27(g)(1)(G))
- Fraud Enforcement and Recovery Act of 2009
- Department of Labor Whistleblower Protection Laws

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POST-ASSESSMENT QUIZ



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

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.

POST-ASSESSMENT QUIZ



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

POST-ASSESSMENT QUIZ



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

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.

7. There 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. Marking 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.

POST-ASSESSMENT QUIZ



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.

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.

POST-ASSESSMENT QUIZ



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.
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

POST-ASSESSMENT QUIZ



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

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

POST-ASSESSMENT QUIZ



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.
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



Ethics, Code of Conduct & Compliance

2023

Introduction

MedPOINT Management is committed to conducting business ethically, with integrity, and in accordance with all applicable laws, rules, and regulations. We perform our tasks daily, knowing what's right and what's wrong. We have a passion for our business and deliver high-quality service at all times, doing what is right for all our customers, whether members, providers, health plans, regulators, or co-workers.

You play an essential role in helping to reach these goals. *This Ethics, Code of Conduct and Compliance Handbook* has been created to communicate the minimum standards by which all are expected to conduct themselves.

Our Mission

To support our clients with such profound care and expertise, they would not entrust the health of their members to anyone else.

MPM Core Values

Company culture is the key to making MPM operate at its highest potential. Our culture isn't what we do. It's who we are and how we do things. And it's constantly evolving as we grow.



The infographic lists six core values, each with a corresponding icon and a list of three bullet points. The values are: Accountability (target icon), Community (group of people icon), Celebration (people celebrating icon), Integrity (compass icon), Innovation (lightbulb icon), and Collaboration (gears icon).

- Accountability**- "Do what you say you will do."
 - ▶ We take **ownership** and **initiative**.
 - ▶ Our clients and our members can **rely on us**.
 - ▶ We always follow through and **follow up**.
- Community**- "Make everyone feel like family."
 - ▶ We **respect** the differences and dignity of others.
 - ▶ We show unwavering **support** for our teammates, clients, and members.
 - ▶ We always act with **compassion** and **empathy**.
- Celebration**- "Enjoy life, but don't get hurt."
 - ▶ We embrace **fun**...and a little friendly competition!
 - ▶ We honor **achievements**, big and small.
 - ▶ We always **enjoy life** to the fullest.
- Integrity**- "Behave."
 - ▶ We conduct our business with the **highest** ethical standards.
 - ▶ We are **trustworthy** and **dependable**.
 - ▶ We always **do the right thing**.
- Innovation**- "Be the best in the business."
 - ▶ We embrace **change** and overcome the fear of it.
 - ▶ We believe no **idea** is too big.
 - ▶ We will **never stop improving**.
- Collaboration**- "Take care of your friends."
 - ▶ We believe in **teamwork**.
 - ▶ Our best work is done **together**.
 - ▶ **WE** before ME...ALWAYS.

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Code of Conduct

The framework for conducting business at MedPOINT Management is in this Ethics, Code of Conduct, and Compliance Handbook. Our commitment is to professional integrity, legal compliance, and ethical conduct. The Code of Conduct is an umbrella under which all other standards of conduct or other policies operate. This Code provides foundational values and standards and is built on the premise that we all know right from wrong. That we make our decisions and choose our actions based on what we know to be right, on all applicable laws and regulations, and on the policies and procedures we all agree to follow as associates of MedPOINT Management.

The Code cannot contain all the rules, policies, and procedures we are each expected to follow. It cannot outline every possible situation or decision in which the right course of action is unclear. But it does give concrete guidance in specific areas and guiding principles to consider in other choices. We expect the highest business conduct standards from every employee, temporary worker, IPA Board Member, contractor, volunteer, or other MedPOINT Management representative. Dishonesty of words, actions, or intent to defraud anyone of money, property, or services will not be tolerated.

Putting the Code in Action

MedPOINT Management Employees, temporary workers, contingent workers officers, IPA Board of Directors, contractors, volunteers, and other representatives are expected to comply with this Code. We demonstrate individually and as an organization by complying with the applicable federal and state standards, statutes, regulations, sub-regulatory guidance, and contractual commitments.

If you become aware of a violation of this Code, the law, or our policies—you must report it promptly. Following this Code is everyone's responsibility and enables us to deliver on our mission.

MedPOINT Management's Anti-Corruption Policy prohibits bribes, kickbacks, improper or illegal inducements, or other unlawful payments from being directly or indirectly offered, provided, or authorized in any way related to MedPOINT Management's business. All Employees, volunteers, temporary workers, and IPA Leadership must comply with the anti-corruption laws that apply to MedPOINT Management's operations, including the Foreign Corrupt Practices Act (FCPA) and the anti-corruption laws of the State and Federal government.

Principles of Conduct

We are committed to providing all our customers with the highest level of service. While listing every principle of conduct that may apply to our day-to-day work is impossible, we have described some of the most important ones below.

Conflicts of Interest

A conflict of interest is when employment outside of MedPOINT Management (or other activities or relationships) creates any actual, potential, or apparent conflict in your ability to do your job. In particular, your ability to make an objective decision is in MedPOINT Management's best interest. Simply put, any such activities and relationships are prohibited without disclosing the potential conflict and obtaining consent beforehand from MedPOINT Management.

Examples of such conflicts of interest may include, but are not limited to:

- Acting as a consultant, advisor, employee, or independent contractor of/with a competitor, customer, or vendor without prior permission of MedPOINT Management.
- Owning any significant interest (other than as a shareholder of a publicly-traded company) in any business or organization that does or seeks to do business with MedPOINT Management.
- Using any company assets or resources for personal gain or advantage.
- Business dealings with relatives or close friends.
- Investments and financial interests in business partners without prior permission of MedPOINT Management.

If you face such a situation, discuss it with MedPOINT Management Compliance Officer. By signing this Code of Conduct, you attest that you are free of any conflict of interest. Employees must complete an attestation or certification related to conflict of interest at the time of hire and annually after that.

Gifts/Hospitality/Entertainment

Business transactions with vendors, suppliers, contractors, and other third parties must be free from influence and the appearance of influence. You can generally accept gifts and business courtesies under specific conditions and in limited amounts. Most important is that there are no strings attached. Use good judgment about receiving gifts. Avoid taking anything with more than a small value, such as gifts, meals, entertainment, or services. If possible, share any gifts with your co-workers. What if you're not sure about accepting a gift? Ask your supervisor.

Inducements

Also known as bribes or kickbacks, inducements are strictly prohibited. You cannot use any financial or other rewards that could be seen as trying to induce:

- Potential enrollees to join a particular health plan.
- Employees and other licensed professionals to deny or limit care.
- Patients/clients/members to commit fraud, waste, or abuse.

Physician Self Referral ("Stark Law")

The Stark Law prohibits physicians from referring patients to receive "designated health services" "payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/ investment interests and compensation arrangements. The law prohibits the submission or causing the submission of claims in violation of the law's restrictions on referrals; proof of specific intent to violate the law is not required. Exceptions under the Stark Law:

General Exceptions Related to Ownership/Investment and Compensation Arrangements:

- Physician Services
- In-Office Ancillary Services
- Services furnished by an Organization to Enrollees
- Academic Medical Centers
- Implants supplied by an Ambulatory Service Center (ASC)
- Erythropoietin (EPO) and Other Dialysis-Related Drugs
- Preventing Screening Tests, Immunizations, and Vaccines
- Eyeglasses and Contact Lenses Following Cataract Surgery
- Intra-Family Rural Referrals

Exceptions Related to Ownership and Investment Interest:

- Publicly-Traded Securities
- Mutual Funds
- Specific Providers (Rural Providers, Hospitals in Puerto Rico)

Exceptions Related to Compensation Arrangements:

- Rental of Equipment
- Bona Fide Employment Relationships
- Personal Services Arrangements
- Physician Recruitments
- Specific Arrangements with Hospitals (remuneration unrelated to DHS)

- Group Practice Arrangements with Hospitals
- Payments by a Physician
- Charitable Donations by a Physician
- Nonmonetary Compensation
- Fair Market Value Compensation
- Medical Staff Incidental Benefits
- Risk-Sharing Arrangements
- Compliance Training
- Referral Services
- Retention Payments in Underserved Areas
- Community-wide Health Information Systems
- Electronic Prescribing Items and Services
- Electronic Health Records Items and Services

Visit <http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral> on the CMS website for more information on Stark Law.

For a comparison of the AKS and Stark Law, refer to <http://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf>

To learn more about the Foreign Corrupt Practices Act (FCPA), click here:

<https://www.justice.gov/criminal-fraud/foreign-corrupt-practices-act>

Member Discrimination in the Delivery of Health Care

MedPOINT Management shall enforce a non-discrimination policy against any members of health care service plans (aka HMOs or Plans). The decision-making process will not be based on race, color, national origins, sex, age, mental or physical disability, or medical condition, such as ESRD, sexual orientation, gender identity*, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment, or on any basis that is prohibited under state and/or federal laws, in the delivery of non-access to covered health care services for such members.

*Healthcare providers must treat individuals in a manner consistent with their gender identity, not their sex assigned at birth. The term gender identity means an 'individual's internal sense of gender, which may be different from an 'individual's sex assigned at birth. Providers may not deny or limit treatment for any health services that are ordinarily or exclusively available to individuals of one gender because a person seeking such services identifies as belonging to another gender. Furthermore, a Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) individual need not have binary gender identification. In other words, an LGBTQI+ individual's gender identity does not have to be singularly male or female; the individual may identify with more than one. This significantly expands the range of treatment that providers must offer individuals identified as transgender or gender-nonconforming, as birth-sex-assigned males and females who now identify as the opposite sex or both can demand treatment for female and male-specific diseases, provided the treatment is substantially related to the achievement of an important health-related or scientific objective. Required prior authorization for any gender-specific treatments an individual is seeking shall not be denied on the sole basis of the 'individual's sex or gender identity.

Affirmative Statement Regarding Utilization-Related Incentives

Utilization Management (UM) decision-making is based solely on medical necessity, appropriateness of care and service, and the existence of coverage, and MedPOINT Management does not specifically compensate practitioners or individuals conducting utilization reviews for issuing denials, nor does MedPOINT Management offer incentives to encourage decisions that result in underutilization or denials. Practitioners are ensured independence and impartiality in making referral decisions that will not influence the following: Hiring, Compensation, Termination, Promotion, or any other similar matters.

Confidentiality

We work in an industry that contains highly sensitive information—the confidentiality of which is also highly regulated. There is a constant flow of information within MedPOINT Management and out to other companies we work with. Every employee must be aware of confidential and proprietary information, maintain the security of what confidential and proprietary information is, and maintain the security of MedPOINT Management and member information according to the rules, regulations, and sub-regulatory guidance provided by the government (and other legal and ethical standards).

Confidential means that it is inappropriate for general public knowledge; it may cause harm to an individual or organization if that information becomes public knowledge.

Proprietary means that it is related to or involves MedPOINT Management. Other organizations and individuals would also have proprietary information specific to them.

MedPOINT Management's confidential and proprietary information is nonpublic information created, recorded, or used to support its business. It involves much of our daily work processes and outputs—including the MedPOINT Management's plans and strategies.

Confidential and proprietary information related to patient care or patient identification is called "Protected Health Information" or "PHI."

- Only share information with authorized individuals who have a legitimate business need
- Ensure nondisclosure agreements are in place before releasing confidential or proprietary information outside our company
- Secure documents, data, and devices in accordance with our security policies
- Only dispose of paper documents using our secure shred bins
- Avoid discussing confidential information in public and take steps to prevent people from viewing it on our mobile devices
- Report misuse or unauthorized disclosure to the Privacy & Security Auditor at complianceconcerns@medpointmanagement.com

MedPOINT Management Information

Generally, you should discuss confidential, proprietary, or protected health information with co-workers on a "need-to-know" basis. HIPAA (The Health Insurance Portability and Accountability Act of 1996) includes information on these essential concepts:

- **Role-Based Access** means you can access certain information depending on your MedPOINT Management tasks. That same access may not be granted to your co-worker.
- **Physical Access** means your authorization to be onsite at MedPOINT Management's office has been granted for common areas and some secured areas if required for your role.
 - You must always use your badge when entering the MedPOINT Management facility
 - Tailgating is not allowed- if you don't have your badge, go to reception for a temporary one
 - All visitors must sign in at reception and be escorted when on MedPOINT Management premises.
- **Minimum Necessary Disclosure** means that you give only the information necessary to meet the request of the person asking for it (provided they are authorized to receive it).

For requests for information from persons outside MedPOINT Management, follow your job-specific procedures for requesting and granting confidential information. If you are unsure, ask your supervisor. You should never discuss any sensitive information (HIPAA-protected or otherwise) at all in social or routine business conversations.

Protected Health Information and HITECH Act

Protected Health Information, or PHI, identifies a patient/member and relates to their past, present, or future health or condition, provision of care, or payment for care. The Health Information Technology for Economic and Clinical Health Act (HITECH) is part of the American Recovery and Reinvestment Act of 2009 (ARRA). Some of the requirements of HITECH are restrictions on certain disclosures, accounting of certain protected health information disclosures; access to certain information in electronic format and designating a third party be the recipient of the PHI, breach notification for unauthorized uses, and disclosure of unsecured PHI.

Examples of PHI include:

Member Name AND Case Management notes

Member ID Number AND A list of current medications

Member Social Security Number AND Medical claim information

There are some employees who never or rarely come across PHI. For others, their jobs may revolve around processing PHI. Regardless, you must always abide by your job-specific procedures for handling and protecting PHI.

In general, follow these PHI guidelines.

- Be attentive to PHI that you may handle as part of your daily job.
- Be aware of documents with PHI on shared printers, fax machines, and copiers:
 - Take abandoned documents to your supervisor.
 - Immediately retrieve your documents with PHI.
 - Always use shredding receptacles for data that is no longer needed.
- Be conscientious when discussing PHI, where others might hear.
- Do not allow visitors access to MedPOINT Management facilities, workstations, or documents without appropriate authorization
- Protect your passwords the same as you protect your wallet
- Never set your computer to "Remember" passwords
- Lock your workstation—Ctrl+Alt+Del when you leave your seat!
- Log off your computer at the end of the workday
- All data transmitted via the Internet must be encrypted and used solely for the business needs of MedPOINT Management
- All data copied using USB/CD/DVD storage must be encrypted and approved by Executive Leadership for the business needs of MedPOINT Management. Your USB/CD/DVD ports are disabled per our security policies. Use of external storage devices is limited to the IT department ONLY.
- Maintain records in a secure and organized manner, so they can be easily retrieved
- Follow procedures for storing documents offsite
- Sharing information via sftp or share sites is limited to only information required for MedPOINT Management operations, authorized by IT Leadership, and tracked for audit purposes
- If you receive data that the sender has not appropriately protected, you are responsible for reporting it and protecting the data in your possession
- Do not upload pictures and videos of MedPOINT Management offices and employees to social media sites that might compromise our office or employees' security or disclose confidential or proprietary information

Many employees have access to other patients' or members' (and, for that matter, employee and vendor) information that, while not considered PHI, must also be kept confidential.

How We Are Accountable

Inappropriate use of our technology and information systems can drain resources, compromise our security, and damage our brand and reputation.

- We grant system access only to authorized individuals and remove access as soon as it is no longer needed
- We keep confidential information off unapproved internet or social media sites
- We never send messages that contain harassing or offensive content
- We consider privacy implications when selecting and implementing new systems
- We follow procedures to make sure data is securely erased before disposing of equipment
- We keep non-business use of our technology and information systems to a minimum

What you must do

- Complete all mandatory Information Security Training on time
- Avoid visiting inappropriate websites
- Do not install unapproved software or open suspicious attachments
- Protect your login credentials
- Do not connect personal devices to networks
- Remain alert to phishing scams or other attempts to penetrate our systems or accounts

Releasing Protected Health Information

Occasionally, you may encounter a request to release information from an individual or organization you are not acquainted with. You may ask your supervisor when you doubt or question the need for information or the requester's identity. Additionally, you can verify the 'requester's identity through their main switchboard number (not via a direct number) or ask that the request is in writing (on letterhead or email) with the specific information requested.

- OCR's guidance on the HIPAA right of access is available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html>
- OCR's guidance on the HIPAA Privacy Rule and personal representatives is available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html>.

All requests from Attorneys, Judicial and Administrative Proceedings, Law Enforcement, and other Public Health Authorities must be directed to the Privacy and Security Auditor for tracking purposes and, in some cases, involve written authorization from the member to release protected health information. Forward all requests to the Privacy & Security Auditor at complianceconcerns@medpointmanagement.com

Dealing with an "Excluded Person or Entity"

An excluded person or entity cannot participate in Medicare and Medicaid programs for any reason. Most commonly, these individuals have been found guilty of fraudulent billing or misrepresenting credentials. MedPOINT Management cannot, directly or indirectly, employ or contract with any excluded person or entity. If you find out that we are doing so, you must report it to the Compliance Department—even if 'you've found that the excluded person is you! MedPOINT Management monitors exclusions for all employees, providers, and vendors/subcontractors monthly to validate adherence to these regulations.

The Compliance Program

MedPOINT Management contracts with and performs work on behalf of other companies that are government contractors. Because MedPOINT Management is a downstream or related entity, we must follow the same rules. As such, we must perform our business activities as both Federal and State governmental agencies legally and contractually require us. Policies and Procedures and the Code of Conduct helps ensure that our organization has systems to prove we comply with the laws, regulations, guidance, and specific contract provisions we are bound to follow. Everyone has a role to play in making sure this can be accomplished.

Your Responsibilities and Obligations

The first step is to understand that **we are all responsible for compliance and must report potential compliance issues**. You are responsible for and obligated to help prevent, detect, and correct instances of non-compliance.

WHAT YOU NEED TO KNOW ABOUT COMPLIANCE

1. We are all responsible for compliance and obligated to report potential compliance issues.
2. If you suspect a compliance issue, report it.
3. Anyone who makes a report in good faith will be protected from retaliation.
4. All reports will be investigated and treated confidentially.
5. Speak up if you 'don't understand something; ask your superior!

To make sure you can recognize non-compliance, MedPOINT Management is committed to:

- Job-specific training and education
- Following policies and procedures
- Enforcing our standards through disciplinary guidelines
- Routine auditing and monitoring
- Communicating on general and specific topics
- Reporting potential issues

- Designated a Compliance Officer to maintain our program, policies, and governance

How to Report Compliance Issues

MedPOINT Management expects employees, IPA Leadership, temporary workers, and volunteers to report concerns to the Compliance Department. MedPOINT Management's policy is to treat all such matters with the utmost respect and confidentiality. Federal and state whistleblower laws protect all employees who report compliance concerns in good faith and MedPOINT Management's non-retaliation policy.

Who is MedPOINT Management's Compliance Officer?

Anne Rohr

What should you do if you suspect potential compliance issues?

Report it. Your compliance concerns or questions can be reported using one of the methods listed below:

1. Tell your supervisor or the Compliance Officer
2. Call the Compliance Officer at (818) 702-0100 x1247
3. Email the Compliance Officer at arohr@medpointmanagement.com
4. Call the Compliance Hotline at (818) 702.0100 x1531
5. Email ComplianceConcerns@medpointmanagement.com
6. Fax the Compliance Department at (818) 702-1743
7. Mail your compliance concern or issues to MedPOINT Management
Attention: Compliance Officer
15301 Ventura Blvd. Bldg D Suite 200
Sherman Oaks, Ca 91403
8. Survey Monkey – submit at <https://www.surveymonkey.com/r/ComplianceConcerns>

Your Protections

If you report a potential violation of this Code, your report will be kept confidential to the extent permitted by law. Please know that we will protect you if you report a possible or actual compliance issue in good faith. MedPOINT Management has a strict policy against retaliation. Any employee who engages in intimidation and retaliation will be subject to disciplinary action up to and including termination.

Fraud, Waste, and Abuse (FWA)

MedPOINT Management is committed to preventing, detecting, and correcting fraud, waste, and abuse related to health care service delivery and benefits. As a representative of MedPOINT Management, you are responsible for reporting any suspected instances of healthcare fraud, waste, or abuse to any of the following resources:

- Report any concerns to the Compliance Officer for assistance
- Directly to the applicable fraud hotline or website

Office of the Inspector General

<https://forms.oig.hhs.gov/hotlineoperations/> 1-800-HHS-TIPS (1-800-447-8477)

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

<http://www.healthintegrity.org/contracts/nbi-medic> 1-877-7SafeRx (1-877-772-3379)Centers for Medicare & Medicaid Services (CMS)

1-800-MEDICARE (1-800-633-4227)

Also, since you are involved in the provision of care or the administration of care or government-sponsored plans, you will be required to participate in periodic mandatory training to help prevent, identify, report, and correct practices that may be fraudulent, wasteful, or abusive. Fraud, Waste, and Abuse and General Compliance Training are accessible on the Employee ADP Portal. Failure to complete mandatory training timely will result in disciplinary action

Definitions of FWA

Fraud. An intentional deception or misrepresentation made by a person knowing that the deception could result in some unauthorized benefit to themselves or others. It includes any act that constitutes fraud under applicable Federal or State law.

Waste. To use health care benefits or spend health care dollars carelessly or needlessly.

Abuse. Practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicare, Medicaid, or any health insurance programs.

Examples of FWA

Reporting phantom patient visits and improper cost reporting -- Providers submit inflated reports of patient traffic and treatment costs to induce payers to increase future per-patient capitation fees.

Encounter Data Falsification -- Knowingly submitting falsified claims encounter data to gain higher capitation revenue.

Inappropriate alteration of database entries or physical records --changing a date or time entry, erasing notes, falsification, fabrication, or alteration of any document.

Under-utilization -- Providers deliberately and systematically deter members from receiving medically necessary services to maximize service funds or capitation revenue.

Attestations/ Conditions of Participation -- Falsification of information provided to federal or state regulators to obtain government contracts or other business.

Quality Access -- Falsification of network adequacy reporting to obtain government contracts.

Identity Theft -- Use of a patient's health plan membership card to receive benefits for someone other than the patient.

The Federal False Claims Act

The Federal False Claims Act permits a person who learns of fraud against the United States Government to file a lawsuit on behalf of the government against the person or business that committed the fraud. If the action is successful, the person filing the lawsuit or the plaintiff is rewarded with a percentage of the recovery. These persons are often referred to as whistleblowers. Federal and state whistleblower laws and MedPOINT Management's non-retaliation policy protect all employees. The Federal False Claims Act establishes liability for any person who knowingly presents or causes to be given a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" means that a person, concerning information:

- Had actual knowledge that information in the claim was false
- Deliberately acted unaware the claim was false
- Reckless disregard for the validity of the claim

It is not necessary that the person had the intent to defraud the United States Government.

Frequently Asked Questions

What happens if I don't report something that turns out to be a compliance issue?

You are obligated to report. You will be subject to disciplinary action if you do not report a situation you reasonably should have identified as a compliance issue. That's why we make it as easy as possible for you to report potential compliance issues. As noted here, you have several ways to communicate and can even do so anonymously.

What happens after I report a potential compliance issue?

It may seem like nothing is happening to most of your co-workers and other employees. But every reported issue will be investigated. Documents are reviewed, the people involved are interviewed, and you may be asked for additional, clarifying information. The actions taken as a result of the investigation depend on the severity of the issue. It could be something as simple as implementing a new policy or procedure. Or it could include disciplinary action up to and including immediate termination of those

involved. Your involvement will be kept confidential to the extent possible.

Will I be treated differently if I report a compliance issue?

No. There should be no difference in your workplace duties, responsibilities, or relationships. MedPOINT Management has a policy against retaliation. We do not tolerate anyone retaliating against you or trying to intimidate you when you have reported something in good faith. (On the flip side, however, knowingly making a false report is a very serious issue that will be addressed through disciplinary action up to and including termination, so "in good faith" is the key here.)

More Questions?

Please see your Supervisor, Manager, Human Resources, or Compliance Officer for additional information.

Table of Statutes

Statute	Reference
AKS 42 U.S.C. 1320A-7b(b)	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7b.pdf
Regulatory Safe Harbors 42 Code of Federal Regulations (CFR) Section 1001.952	http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol5/pdf/CFR-2013-title42-vol5-sec1001-952.pdf
Physician Self-Referral Law 42 U.S.C. Section 1395nn	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
Criminal Health Care Fraud 18 U.S.C. Section 1347	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title18/pdf/USCODE-2012-title18-partI-chap63-sec1347.pdf
Exclusion 42 U.S.C. Section 1320a-7	http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapXI-partA-sec1320a-7.pdf

Ethics, Code of Conduct, and Compliance Attestation

1. I have received a copy of the Code of Conduct and acknowledge that I am expected to read, understand and adhere to this Ethics, Code of Conduct and Compliance Handbook, which includes the Conflict of Interest policy, Member Discrimination Policy, Utilization Related Incentives Policy, and Confidentiality Policy.
2. I will report potential compliance issues and will follow up on those reports as required.
3. I have no conflict of interests beyond those that I have already discussed with Human Resources.
4. I will follow all general guidelines and job-specific procedures related to protected health information, and company information.

OIG/SAM/Medi-Cal Exclusions – All Lines of Business (LOBs)

OIG/SAM/Medi-Cal Exclusions Screening Attestation

MedPOINT Management is committed to ensuring that our first-tier, downstream and related entities (FDR) are in compliance with applicable state and federal regulations, including regulations concerning the Office of the Inspector General (OIG) and General Services Administration (GSA). Specifically, the regulations require that all FDRs that participate in the delivery of governmental funded health care programs must review the OIG, GSA System for Awards Management ("SAM") and Medi-Cal Exclusion Lists upon initial hiring of or contracting with personnel and monthly thereafter to ensure that any employee, manager or downstream entity is not on any such list. FDRs must retain documentation to support results. Screen prints of negative results are sufficient.

In order to validate that each FDR has met the requirements, we must obtain a completed Attestation from an authorized representative of every FDR (i.e. Compliance Officer, CEO, CMO, Practice Manager Provider, Owner, etc.). Please be advised that pursuant to the terms of your agreement with IPA/Medical Group or an affiliated entity, you are required to comply with all applicable federal, state, and municipal rules and regulations and that this request is directly related to such provision. Please also be advised that such screenings are required under the contract between IPA/Medical Group or an affiliated entity, on the one hand, and the health plan, on the other hand.

To assist you with the implementation of your OIG_GSA Exclusion process, we are providing links to the relevant exclusions lists in order to comply with the regulations:

<http://exclusions.oig.hhs.gov/>
<https://sam.gov/content/exclusions>
<https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx>

Please note that these three lists do not necessarily overlap and thus all three lists must be checked as to each employee, manager or downstream entity. For example, an employee could be listed on the Medi-Cal exclusion list but not listed on the OIG and SAM exclusion lists.

Please execute and return the included Attestation Form at your earliest opportunity.

If you have any questions, please contact the Compliance department at 818-702-0100, ext. 1813.

Thank you.

Anne Rohr
Compliance Officer
MedPOINT Management

Critical Incident Training – EAE D-SNP

Overview

- A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or wellbeing of a member.
- Members of EAE D-SNP are adults (age 21 or older) may be vulnerable to abuse or neglect due to medical or mental health condition or disability, age and frailty, social isolation, and poverty.
- Reportable Critical Incidents
- Critical Incident Report Form

Reportable Critical Incidents

Abuse	Death
Neglect	Medical Psychiatric Emergency
Exploitation	Restraints/Seclusion
Rights Violations	Medical Errors
Missing Person/Disappearance	Suicide Attempt
Serious, life-threatening event requiring immediate emergency evaluation	

Reporting

Staff identifying the Critical Incident is required to report the incident immediately upon awareness to their immediate supervisor who will follow-up with the appropriate authority in accordance with departmental policies and procedures.

- If the employee/supervisor is not sure how to report or categorize the Critical Incident, they may contact the Quality Improvement (QI) Nurse Specialist in the Quality Management (QM) Department to discuss.
- Critical incidents may be reported to the QM Department:
 - Email: QM_Leadership@medpointmanagement.com
 - Call 818-702-0100, ext.1353 for the Quality Management department
 - Email Quality Management QM_Leadership@medpointmanagement.com
- The QI Nurse will determine if there is an immediate need for:
 - Activating emergency assistance if required
 - Provision of medical assistance if required
 - Provision of relevant support services
 - Endorsement to the State Agency(s) responsible for overseeing responding directly to critical incidents

Critical Incident Report Form

Critical Incident Report			
Date of incident:	____/____/____	Time of incident	____ am/pm
Location: (include address, where applicable)			
Name of person completing form:			
Position of person completing form:		Contact number:	
Employees, Volunteers or Directors involved in incident:			
Name:		Contact number:	
1.			
2.			
3.			
4.			
Clients or community members involved in incident:			
Name:		Contact number:	
1.			
2.			
3.			
4.			
Description of incident and background:			
(Include all relevant circumstances and information leading up to the incident, whether the incident was witnessed, and any other relevant issues.)			

Critical Incident Report Form	
Who was informed of the incident? (For example, CEO, manager, mental Health Services, police, fire department, Mental health, family members, and so on.)	
1.	4.
2.	5.
3.	6.
Actions taken to date: (Including date and time of contact, contact number, and other contact numbers of agencies or people who were informed, as well details of support provided.)	
1.	
2.	
3.	
4.	
5.	
Follow up actions planned:	
1.	
2.	
3.	
4.	
5.	
Critical Incident Report Form received by:	
_____ (Signature of Employee)	Date: ____/____/____
_____ (Signature of Manager)	Date: ____/____/____

Additional Resources

- Medicare Managed Care Manual (MMCM), Ch.5 “Quality Assessment,” Section 30.1.1
- California Health & Safety Code, Section(s) 1368-1368.03
- Title 42 Code of Federal regulations (CFR)§422.152 (1) (3)
- The Centers for Medicare and Medicaid (CMS) and the State of California: California Readiness Review Criteria

Documentation Requests & Modifications

Requests & Modification Updates

- To request a Policy & Procedure related to the materials covered, including but not limited to the following:
 - Services (e.g., Provider Education, Panel Status Changes, etc.)
 - Policies (e.g., Prior Authorization, Pre-Natal Services, Member Satisfaction, etc.)
 - Procedures (e.g., DHCS Recommended Care Standards, Continuity of Care, Special Needs Plan (SNP), etc.)
- Please email: CompliancePNO@medpointmanagement.com
- Please note, any modifications to Policies & Procedures related to the information presented will be communicated via the MedPOINT Management website [News feed](#).