2026 Compliance Training

Compliance Committee Approved: 11/25/25

IMPERIAL HEALTH PLAN OF CALIFORNIA

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IMPERIAL HEALTH PLAN OF CALIFORNIA

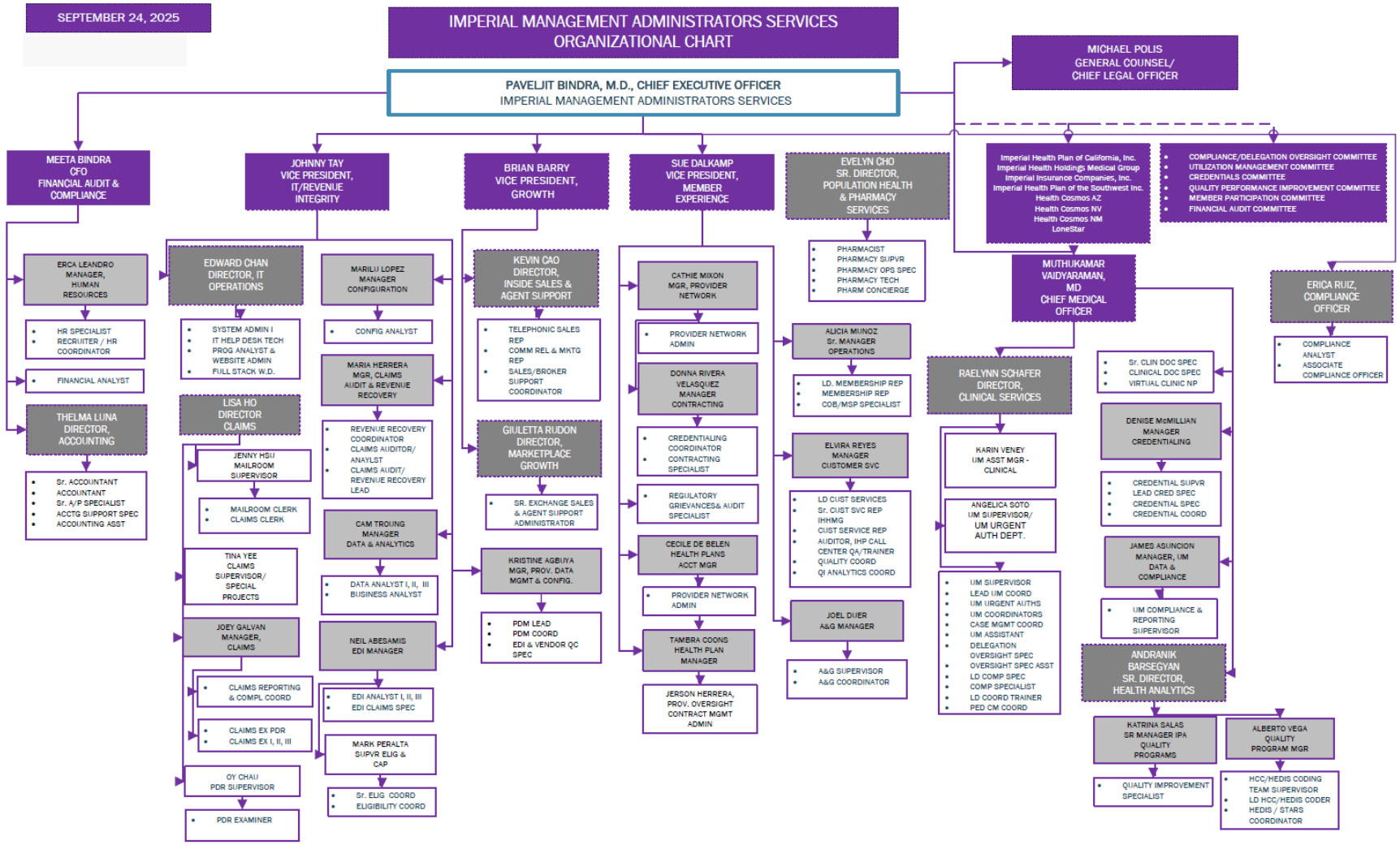
Who is Imperial?

At Imperial, we're passionate about helping communities receive the health care they deserve.

Imperial was established by a physician, we are dedicated to our mission to deliver valuable care so that our members are healthy in mind, body, and spirit to achieve their inherent potential.

Imperial offers full service, Medicare Advantage coverage, including a prescription drug plan and a chronic special needs plan in numerous counties.

Organizational Structure – H5496



IMPERIAL HEALTH PLAN OF CALIFORNIA

Service Area – H5496

H5496 - Imperial Health Plan of California, Inc. (HMO) (HMO SNP) - 2026 Effective: 01/01/2018 (51 counties)			
Plan Name	Imperial Senior Value (HMO C-SNP) 005	Imperial Dynamic Plan (HMO) 012	Imperial Courage Plan (HMO) - 016
Service Area	Alameda, Amador, Butte, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Tehama, Tulare, Tuolumne, Ventura, Yolo, Yuba	Alameda, Amador, Butte, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Tehama, Tulare, Tuolumne, Ventura, Yolo, Yuba	Alameda, Amador, Butte, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Tehama, Tulare, Tuolumne, Ventura, Yolo, Yuba
Qualifiers	Must have: Cardiovascular Disorder, Chronic Heart Failure and/or Diabetes	-	Part C ONLY NO PART D

Compliance Program Description

Mandatory Compliance Training

Upon hire and annually thereafter, the following is a condition of continued employment and included in the employee evaluations

- Fraud, Waste and Abuse Training (FWA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Compliance Program
- Code of Conduct

**Reference Compliance Program Description embed here:

2026 Compliance Program

What is a Compliance Program?

- A compliance program is a company's set of internal policies and procedures put into place to comply with laws, rules, and regulations or to uphold the business's reputation.
- Medicare Part C & D Plan sponsons are required to have a compliance program.
- There are 7 Core Compliance Elements, for an effective compliance program. Per CMS Guidance Chapter 21.

Compliance Program - 7 Compliance Elements

CMS considers a Compliance Program Effective if it includes the 7 core Compliance Elements as follows:

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 Conduct
7. Procedures and System for Prompt Response to Compliance Issues

Element 1 - Policies and Procedure (P&P)

These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct. Compliance is everyone's responsibility, from the top of the organization to the bottom.

That is why we have made policies available to every department and First-Tier, Downstream, and Related Entity (FDR) (IPA, MSO, Supplemental vendor etc.). These procedures should help you detect, prevent, report, and correct FWA as well as HIPAA, Compliance, Standards of Conduct and operational P&Ps.

You can locate Imperial Policy & Procedures (P&P)

- S:\Imperial Health Plan of California\P&Ps
- If you see there is a missing P&P let Compliance know

Knowing Imperials Policies and Procedures will help you with the following.

- Conduct yourself in an ethical manner
- Identify and report areas of noncompliance and potential FWA

Element 2 - Compliance Officer

- Imperial must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.
- Imperial Compliance Officer is Erica Ruiz.
- The Compliance Officer engages with senior management and governing body and oversees compliance program.

Compliance Officer: Erica Ruiz
(562) 239-5675
eruiz@imperialhealthplan.com

Element 3 – Training and Education

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

- You are receiving this Compliance Training today as part of the 7 Compliance Elements required by regulatory requirements.
- The Compliance Training must include all items within this training such as
  - General Compliance Training
  - Standards of Conduct
  - Fraud, Waste, and Abuse (FWA)
  - Health Insurance Portability and Accountability Act (HIPAA)

Element 4 - Communication

Compliance must make 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.

Communication from Compliance comes in a variety of forms. The below is a list of some examples of communication efforts the Compliance team comminates with the Imperial team and its delegated entities.

- New or updated regulatory requirements.
- Any risk areas identified.
- Corrective Action Plans (CAP) needed.
- Required Compliance Trainings.
- Code of Conduct.
- Compliance Program.
- Compliance Policies and Procedures.
- Disciplinary action process.
- Ways to report suspected or detected noncompliance or potential FWA. How to report and how to report without fear of retaliation.

Element 5 – Disciplinary Process

The Compliance team has a disciplinary process that enforces standards.

- The process is listed in the Compliance Program provided to you at the time of hire and annually thereafter with this Compliance Training you are taking now.

Disciplinary Process is as follows

- After 2 untimely responses to deliverables, disciplinary action will occur
- A written warning
- Written warning placed in employees Human Resource file

Element 6 – Monitoring and Auditing

- Imperial creates a risk assessment of internal and delegated areas.
- Based on the risk, an annual audit calendar is created to audit internal and delegated areas.
- Compliance Team performs a formal review (audit) of internal areas and delegates to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.
- Other areas that are a lower risk are added to the Monitoring Dashboard where activities are monitored by the operational areas and reported to Compliance.

Examples of Monitoring and Audit Areas

1. Organization Determinations – Pre-Service (UM)
2. Organization Determinations – Post Service (claims)
3. Organization Determinations – GRVC (Part C Grievances)
4. Organization Determinations – GRVD (Part D Grievances)
5. Organization Determinations – RECON (Part C Appeal)
6. Organization Determinations – RED (Part D Appeal)
7. Membership – Enrollment, Disenrollment, Cancellations, Retro, LIS, Late Enrollment Penalty, Coordination of Benefits
8. Sales – Sales Agents and Enrollment documents
9. Provider Adequacy – Provider Network/Contracting/Provider Relations

Internal Auditing Process

The below is an outline of the internal auditing process that is conducted by Imperial's Compliance Department.

- **Risk Assessment** – All audits are performed based on the risk assessment. The Compliance Team, performs a risk assessment to identify the level of risk and areas to be audited. Risk level are categorized a high, medium and low.
- **Audit Calendar** – is created listing the audit areas and scheduled audit dates.
- **Audit begins** – Engagement letter sent to audit area requesting documentation to fulfil the elements of the audits
- **Select Samples** – The Compliance team selects samples from the universe depending on the type of audit. The Compliance team, requests documents to fulfil the elements of the audit for the selected samples.
- **Compliance Audit Review** – After Compliance receives all required documentation, documents are reviewed and upon satisfaction, the audit will be closed.
- **Corrective Action Plan (CAP)** – In the event the elements are not met, Compliance will issue a CAP listing the deficiencies requiring CAP response within 30-days.
- **CAP Accepted** – If CAP addresses all deficiencies, Compliance accepts the CAP.
- **CAP Validation** – CAP deficiencies are validated that they were in fact corrected. If validated, CAP Validation is complete. Validation is only performed for internal areas and not FDRs.
- **Risk Assessment** – Upon audit completion the audit findings are recorded in the Risk Assessment for the following year.

**Note – Disciplinary action is taken for 2 consecutive past due notices anytime during the audit when requesting items to fulfil the elements of the audit.

Element 7 – Non-Compliance/CAP

- Imperial must have a process in place to respond promptly to non-compliance and undertake appropriate corrective action.
- Compliance receives questions, reports of suspected or detected noncompliance or potential FWA and investigates the issue to determine if there it involves non-compliance.
- Compliance monitors and audits internal and delegated FDRs to determine if there are any non-compliance issues.
- If non-compliance issues are identified, a corrective action plan (CAP) is requested, depending on the severity of the issue, regulatory agencies will be informed, disciplinary action may be warranted and up to termination.

Code of Conduct (COC)

- I will comply with the letter and spirit of all applicable federal, state and local laws and regulations
- I am responsible for the integrity of my own actions
- I may not justify a non-compliant, illegal, fraudulent, dishonest, or unethical act by claiming it was ordered or approved by another employee
- I am aware that no employee, regardless of level or position, is ever authorized by Imperial to commit or direct another employee to commit a non-compliant, illegal, fraudulent, dishonest or unethical act
- I am free to contact the Imperial Compliance Department, or the 24-hour Fraud and Abuse Compliance Hotline for guidance on the legality or ethics of any action under consideration or any action taken
- I will favorably represent Imperial through my proper conduct

**Reference Code of Conduct embed here:

2026 COC

The Foreign Corrupt Practices Act (FCPA) of 1977

The Foreign Corrupt Practices Act (FCPA) of 1977 prohibits companies and individuals from offering to pay or promise "anything of value" such as cash or gifts to retain business or gain an advantage.

- FCPA aims to prevent bribery and corruption in international business transactions.
- Strick rules against bribing officials to promote healthcare products or services.
- Payments to consultants or agents must be for legitimate services – no kickbacks for securing contracts
- Healthcare organizations must keep detailed and accurate financial records of all transactions related to foreign operations.

Enforcement and penalties

- Companies can face fines of millions.
- Individuals may face fines of up to $250,000 for anti-bribery violations.
- Penalties can include signification fines and up to five years in prison for anti-bribery violations.
- Companies and individuals can be required to give back all profits gained from illegal activity, plus prejudgment interest.

Resource: The Foreign Extortion Prevention Technical Corrections Act, 18 U.S.C. § 1352 ("FEPA"), was enacted in July 2024 and criminalizes the "demand side" of foreign bribery.
FEPA, see 18 U.S.C. § 1352(a)(1)), https://www.justice.gov/criminal/criminal-fraud/foreign-corrupt-practices-act

Anti-Bribery

Antibribery in healthcare involves preventing the abuse of power for private gain, such as offering or accepting money, gifts, or favors to influence decisions related to patient care, procurement or services.

- Patient-provider bribery: A doctor accepts a bribe from a patient to prescribe unnecessary medication.
- Procurement and contractor bribery: A hospital administrator accepts a bribe to award a contract to a vendor, regardless of price or quality.
- Professional and regulatory bribery: A professional accepts money, gifts, or favors to approve a medication or medical services.

Enforcement and penalties

- Legal penalties: Fines, sanctions, or imprisonment under Bribery Act 2010
- Reputation damage: Loss of community's trust and public credibility.
- Operational Disruptions: Internal Investigations divert resources and affect productivity.

Resource: The Foreign Extortion Prevention Technical Corrections Act, 18 U.S.C. § 1352 (“FEPA”), FEPA complements the Foreign Corrupt Practices Act by making it a crime for any foreign official (as defined in FEPA, see 18 U.S.C. § 1352(a)(1)), https://www.justice.gov/criminal/criminal-fraud/foreign-corrupt-practices-act

Anti-Corruption

Anti-Corruption in healthcare is about preventing entities or people from misusing their power or position within the health system for personal gain.

- This means stopping actions like taking bribes, stealing money, medicines, or the misuse of power or resources for private gain.
- Ensuring all resources, money, medical supplies, and services are used fairly to benefit the public's health.
- Specific actions and systems designed to promote honesty, fairness, transparency, and accountability.
- The communities we serve know their rights and what services are covered or have an official cost.
- There are safe, independent, and confidential ways for both healthcare workers and patients to report suspicious activities or wrongdoing without fear of punishment.

Enforcement and penalties

- Health care fraud is defined under 18 U.S.C. § 1347 with a maximum penalty of 10 years in federal prison and significant fines (up to $250,000 for individuals, $500,000 for organizations.) If fraud result in serious bodily injury the maximum sentence increase to 20 years.
- The False Claims Act (FCA) 31 U.S.C. § § 3729-3733 filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim filed. Violations can result in a prison sentence of up to 5 years in prison per false claims.
- Civil Monetary Penalties Law 42 U.S.C. § 1320a-7a OIG (Office of Inspector General) seek civil monetary penalties to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation.

Resource: The Foreign Extortion Prevention Technical Corrections Act, 18 U.S.C. § 1352 ("FEPA"), was enacted in July 2024 and criminalizes the "demand side" of foreign bribery. FEPA complements the Foreign Corrupt Practices Act by making it a crime for any foreign official (as defined in FEPA, see 18 U.S.C. § 1352(a)(1)), https://www.justice.gov/criminal/criminal-fraud/foreign-corrupt-practices-act

Recognize Fraud, Waste and Abuse (FWA) in the Medicare Program

- Every year billions of dollars are improperly spent because of FWA. It affects everyone—including you. This training will help you detect, correct, and prevent FWA. You are part of the solution.

- Combating FWA is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

FWA Differences - Fraud

Fraud

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

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to $250,000. In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

Examples of actions that may constitute Medicare fraud include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep
- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment Examples of actions that may constitute Medicare waste include:
- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive laboratory tests
- Examples of actions that may constitute Medicare abuse include:
- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

FWA Differences - Waste

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.

Examples:

- Unnecessary medical tests or procedures that do not improve patient care.
- Overutilization of services due to lack of medical necessity.
- Administrative inefficiencies that result in unnecessary costs.
- Excessive prescription drug costs due to brand name drugs when generic alternatives are available.
- Inefficient handling of claims and paperwork that leads to delays and higher costs.

FWA Differences - Abuse

Abuse

Abuse describes practices that may directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care

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 that the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

Examples of Medicare abuse include:

- Excessive or unnecessary in-home care services.
- Charging for durable medical equipment (DME) that is not medically necessary.
- Billing for services provided by unlicensed or unqualified individuals.
- Failure to maintain accurate records or report cases of suspected fraud.
- Double-billing, where a healthcare provider bills both Medicare and Medicaid for the same service, resulting in overpayment.

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.

How to detect FWA

To detect FWA, you need to know the law.
The following pages provide high-level information about the following laws:

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

Penalties: Violating these laws may result in nonpayment of claims, Civil Monetary Penalties (CMP), exclusion from all Federal health care programs, and criminal and civil liability

Federal Civil False Claims Act (FCA)

The civil FCA, 31 United States Code (U.S.C.) Sections 3729–3733, protects the Federal Government from being overcharged or sold substandard goods or services. The civil FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government.

The terms "**knowing**" and "**knowingly**" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No specific intent to defraud is required to violate the civil FCA.

Examples: *A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than actually provided*

Penalties: Civil penalties for violating the civil FCA may include recovery of up to three times the amount of damages sustained by the Government as a result of the false claims, plus financial penalties per false claim filed. Criminal penalties for violating the civil FCA may include recovery of up to three times the amount of damages sustained by the Government as a result of the false claims. For any violations that occurred after November 2, 2015, but that are assessed after February 12, 2024, the adjusted penalties will be applied. The minimum False Claims Act penalty will increase from $13,508 to $13,946 per claim, and the maximum penalty will increase from $27,018 to $27,894 per claim.
Additionally, under the criminal FCA, 18 U.S.C. Section 287, financial penalties include up to $250,000 for individuals and $500,000 for organizations for submitting false, fictitious, or fraudulent claims, including fines, imprisonment, or both.

Anti-Kickback Statute (AKS)

The AKS, 42 U.S.C. Section 1320a-7b(b), makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS

Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies

Example: A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals

Penalties: Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participation in the Federal health care program. Under the CMPL, penalties for violating the AKS may include three times the amount of the kickback, plus up to $100,000 per kickback. Civil penalties include fines of up to $50,000 per violation and three times the amount of the kickback.

Whistleblower

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

- Whistleblower are protected by state and federal law. Any Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

- Those who spot such violations may be eligible for Medicare fraud rewards under the False Claims Act qui tam provision, which pays whistleblowers (also known as qui tam relators) between 15 and 25 percent of what the government collects based on their report of Medicare fraud (or Medicaid fraud).

Physician Self-Referral Law (Stark Law)

- The Physician Self-Referral Law, 42 U.S.C. Section 1395nn, often called the Stark Law, prohibits a physician from referring patients to receive “designated health services” payable by Medicare or Medicaid to an entity with which the physician or a member of the physician’s immediate family has a financial relationship, unless an exception applies

- Example: A physician refers a beneficiary for a designated health service to a clinic where the physician has an investment interest

- Penalties: Penalties for physicians who violate the Stark Law may include fines, repayment of claims, and potential exclusion from participation in the Federal health care programs.

Criminal Health Care Fraud

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie about the delivery of, or payment for. Health care benefits, items, or services to either:

- Defraud any health care benefit program
- Get (by means of false or fraudulent pretenses, representations, or promises) the money or property owned by, or under the custody or control of, a health care benefit program.

For more information, refer to 18 USC Section 1347.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both

Exclusion Statute

The Exclusion Statute, 42 U.S.C. Section 1320a-7, requires the OIG to exclude individuals and entities convicted of any of the following offenses from participation in all Federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances

Civil Money Penalties(CMP)

The Civil Monetary Penalties (CMP), 42 U.S.C. Section 1320a-7a, apply to a variety of health care fraud violations and assessment of the CMP depends on the type of violation. The CMP authorizes penalties up to $100,000 (in 2018) per violation, and assessments of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received. Violations that justify CMP's include:

- Presenting a claim you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent
- Violating the AKS
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs

Where Do I Fit In?

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

- Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- First-tier entity (Examples: Pharmacy Benefit Management [PBM]; IPA/MSO; dental vendor; vision vendor; telehealth vendor; Over the Counter vendor; hearing vendor; gym vendor; hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
- Downstream entity (Examples: pharmacies, doctor's office, firms providing agent/broker services, marketing firms, and call centers)
- Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider)

Where Do I Fit In? (continued)

- I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.
- The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Example

- Of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity.
- If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity.
- If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

Where Do I Fit In? (continued)

- I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.
- The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.
- Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

What Are Your Responsibilities?

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

How Do You Prevent FWA?

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS' guidance

How Do You Prevent FWA?

- Look for suspicious activity
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- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS' guidance

Report Compliance Issues & FWA or Submit Questions

Have Compliance related questions, want to report suspected or detected noncompliance or potential FWA. Report via the following ways without fear of retaliation.

- Anonymously call at 1-888-708-5377
- Anonymously send via https://imperialhealthplanca.navexone.com
- Fax at 1-626-380-9054
- Compliance Mailbox at complianceFWA@imperialhealthplan.com
- Mail to Compliance FWA, PO Box 60874 Pasadena, CA 91116

Reporting FWA Outside Your Organization

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

What is HIPAA

Health **I**nsurance **P**ortability & **A**ccountability **A**ct of 1996 (**HIPAA**), (45 C.F.R. parts 160 & 164).

- It provides a framework for establishment of nationwide protection of patient confidentiality, security of electronic systems, and standards and requirements for electronic transmission of health information.

Protected **H**ealth **I**nformation (**PHI**) is individually identifiable health information that is:

- Created or received by a health care provider, health plan, employer, or health care clearinghouse and that
- Relates to the past, present, or future physical or mental health or condition of an individual;
- Relates to the provision of health care to an individual
- The past, present or future payment for the provision of health care to an individual.

What Does PHI Include? Information in the health record, such as:

- Encounter/visit documentation
- Lab results
- Appointment dates/times
- Invoices
- Radiology films and reports
- History and physicals (H&Ps)
- Patient Identifiers

The Rules

Privacy Rule

- Privacy Rule went into effect April 14, 2003
- Privacy refers to protection of an individual's health care data
- Defines how patient information used and disclosed
- Gives patients privacy rights and more control over their own health information
- Outline's ways to safeguard Protected Health Information (PHI)

Security Rule

- Security (IT) regulations went into effect April 21, 2005
- Security means controlling:
  - Confidentiality of electronic protected health information (ePHI)
  - Storage of electronic protected health information (ePHI)
  - Access into electronic information

Electronic Data Exchange (EDI) Rule

- Defines transfer format of electronic information between providers and payers to carry out financial or administrative activities related to health care.
- Information includes coding, billing and insurance verification.
- Goal of using the same formats is to ultimately make billing process more efficient.

Minimum Necessary Rule

- Healthcare entities are required to ensure the uses and disclosure of PHI is limited to the minimum necessary information to perform one's job duties.
- The minimum necessary rule applies to all forms of PHI, including physical documents, spreadsheets, printed images, electronic protected health information (ePHI), any form of media that is stored, and information that is communicated verbally.

Why Comply With HIPAA?

- To show our commitment to protecting privacy
- As an employee, you are obligated to comply with Imperial's privacy and security policies and procedures
- Our patients/members are placing their trust in us to preserve the privacy of their most sensitive and personal information
- Compliance is not an option, it is required.

If you choose not to follow the rules:

- You could be put at risk, including **personal** penalties and sanctions
- You could put Imperial at risk, including financial and reputational harm

HIPAA Regulations

HIPAA Regulations require we protect our member's' PHI in all media including, but not limited to, PHI created, stored, or transmitted in/on the following media areas:

- **Verbal Discussions** (i.e., in person or on the phone)
- **Written** on paper (i.e., chart, progress notes, encounter forms, prescriptions, x-ray orders, referral forms and explanation of benefit (EOBs) forms)
- **Computer Applications and Systems** (i.e., electronic health record (EHR), Practice Management, Lab and X-Ray)
- **Computer Hardware/Equipment** (i.e., PCs, laptops, PDAs, pagers, fax machines, servers and cell phones)

How are HIPAA Regulations Enforced?

- The Public. The public is educated about their privacy rights and will not tolerate violations! They will take action.
- Office For Civil Rights (OCR). The agency that enforces the privacy regulations providing guidance and monitoring compliance.
- Department of Justice (DOJ). Agency involved in criminal privacy violations. Provides fines, penalties and imprisonment to offenders.

Who or What Protects PHI?

1. Federal Government protects PHI through HIPAA regulations
   - Civil penalties up to $1,500,000/year for identical types of violations.
   - Willful neglect violations are mandatory!

   Criminal penalties:
   - $50,000 fine and 1 year prison for knowingly obtaining and wrongfully sharing information.
   - $100,000 fine and 5 years prison for obtaining and disclosing through false pretenses.
   - $250,000 fine and 10 years prison for obtaining and disclosing for commercial advantage, personal gain, or malicious harm.

2. Our organization, through the Notice of Privacy Practices (NPP) on the plan's website

3. You, by following our policies and procedures.

Compliance Issues/FWA/HIPAA Internal Process

- Issue reported to Special Investigation Unit (SIU)/Compliance Team.
- All issues address within two weeks of reported incident.
- SIU reviews/investigates.
- Case is closed within 45 – 60 days from date of incident depending on the complexity of the case.
- All issues reported are considered an allegation until proven otherwise.
- All cases are reported to the Compliance Committee and Board of Directors.

Action

- Sign attestation (must be your actual signature (wet signature))

- Return attestation to regulatorycompliance@imperialhealthplan.com