UNITED HEALTHCARE COMMUNITY & STATE
TENNCARE COMPLIANCE TRAINING 2018

MARCH® VISION CARE PROVIDERS

Presented by Provider Relations
844.966.2724 x7576

MARCH® Vision Care GROUP, INCORPORATED

keeping an eye on your health®

AGENDA

1. CULTURAL COMPETENCY
2. NON-DISCRIMINATION
3. LIMITED ENGLISH PROFICIENCY (LEP) & INTERPRETATION SERVICES
4. STATE LAW AND TENNCARE POLICY

PART 1: CULTURAL COMPETENCY

WHAT IS CULTURAL COMPETENCE?

- Understanding and respecting social and cultural perceptions and expectations other than your own.

WHAT IS OUR COMMITMENT?

- MARCH® shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. MARCH® shall exhibit congruent behaviors, attitudes and policies that come together in a system that enables effective work in cross-cultural situations.
  (MARCH® – Tennessee Provider Reference Guide – section 11.1)

WHAT IS YOUR RESPONSIBILITY?

- Providers are responsible for making sure that they and their office staff value diversity and strive to meet the culturally diverse needs of all members.

HOW TO PROMOTE CULTURAL COMPETENCY

- Understand the demographics of members in your service area.
- Strive to recruit, retain and promote a diverse staff that are representative of the demographics in your service area.
- Implement standards to provide culturally and linguistically appropriate services.
- Conduct cultural competency training for staff who have direct interaction with members.

PART 2: NON-DISCRIMINATION

ALL MARCH® VISION CARE PROVIDERS MUST OBEY FEDERAL LAWS AGAINST DISCRIMINATION INCLUDING:

- Title VI of the Civil Rights Act of 1964
- Title II of the Americans with Disabilities Act of 1990, and
- Other laws that apply to organizations who receive Federal funding

NON-DISCRIMINATION: TITLE VI – CIVIL RIGHTS ACT

FEDERAL AND STATE REQUIREMENT:

- No person, on the grounds of race, color, national origin, sex, age, disability or religion shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

FROM THE 2018 MARCH® VISION CARE — TENNESSEE PROVIDER REFERENCE GUIDE (SECTION 6.1):

- We do not allow unfair treatment in TennCare or UnitedHealthcare Community Plan. No one is treated in a different way because of race, language, birthplace, disability, religion, sex, color or age.

NON-DISCRIMINATION: TITLE II OF THE AMERICANS WITH DISBILITIES ACT (ADA)

No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. (Title II, section 202)

HEARING IMPAIRMENT

- Use of written materials
- TDD relay services
- Sign language interpreters

VISION IMPAIRMENT

- Large Font
- Accommodations for service animals
- Braille signage

OTHER DISABILITIES

- Wheelchair access to buildings and rooms
- Reasonable procedure modifications

PART 3: LIMITED ENGLISH PROFICIENT (LEP)

WHO IS A LEP MEMBER?

- Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered LEP.

HOW CAN YOU IDENTIFY A LEP MEMBER OVER THE PHONE?

- Member is quiet or does not respond to questions.
- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member self identifies as LEP by requesting language assistance.

WORKING WITH LEP MEMBERS

MEMBER DOES NOT SPEAK ENGLISH OR LANGUAGE YOU KNOW.

- Connect with contracted telephonic interpretation vendor to identify language needed.

MEMBER SPEAKS SOME ENGLISH.

- Speak slowly and clearly. Do not speak loudly or shout.
  Use simple words and short sentences.

HOW TO OFFER INTERPRETER SERVICES.

- "I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak? OR "May I put you on hold? I am going to connect us with an interpreter." (In the event you are having difficulty communicating with a member, using this statement is a good transition to initiating interpreter assistance.)

LEP RESOURCES

As a contracted provider, you are responsible for offering interpretation services, without charge to members. This is a requirement under Title VI and applies to any provider that accepts Federal funds.

More tips and resources for working with LEP members and on documenting interpretive services are located in the Tennessee Provider Reference Guide, Exhibits D - G.

For more information on trained medical interpreters you can contact:

- www.languageline.com or
- (800) 752-6096 x4

PART 4: STATE LAW AND TENNCARE POLICY

- Background Check Requirements for Providers.
- Reporting Member Abuse & Neglect.
- Medicaid Program Integrity.
- Anti-Fraud Plan.

BACKGROUND CHECKS REQUIRED

Provider is responsible for conducting background checks and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the provider conducts background checks in accordance with state law and TennCare policy.

(MARCH® – Tennessee Provider Reference Guide (PRG) – section 1.8)

ABUSE & NEGLECT: STATE MANDATED REPORTER

- Health care providers are responsible for identifying and reporting suspected cases of abuse, neglect or exploitation.
- The protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of members who are adults, as well as suspected brutality, abuse, or neglect of members who are children, are outlined in section 8.2 of the MARCH® Vision Care Provider Reference Guide (PRG) for Tennessee.

ABUSE & NEGLECT: STATE MANDATED REPORTER

FOR ABUSE OR NEGLECT REPORTS CALL:

- Adult Protective Services:
  (888) APS-TENN (1-888-277-8366)
- Child Protective Services:
  (877) 237-0004 or
  (877) 54ABUSE (1-877-542-2873)
- Local Numbers for
  Adult Protective Services:
  - Knoxville: (865) 594-5685
  - Chattanooga: (423) 634-6624
  - Nashville: (615) 532-3492
  - Memphis: (901) 320-7220

*****CALLS ARE CONFIDENTIAL*****

- When you call, please be prepared to give:
  - Name of individual
  - Address
  - Age
  - Phone #
  - Specifics of abuse
- If the individual is at immediate risk, please contact 911 immediately.
- Penalties for failure to report:
  - Any person or institution required by law to report a case of suspected elder or child abuse/neglect who willfully fails to do so may be held criminally liable or civilly liable.

MEDICAID PROGRAM INTEGRITY: WHAT IS HEALTH CARE FRAUD?

HEALTH CARE FRAUD:

A general term for those practices in which either . . .

1. Health services are promised and/or paid for, but not provided at an appropriate standard of professionalism or skill. **OR**
2. Practices in which health care is provided — or allegedly provided, but reimbursement claims to Medicare, Medicaid or other 3rd party payer are fraudulent.

   (In other words, inappropriate billing by a health care provider.)

MEDICAID PROGRAM INTEGRITY: FRAUD AND ABUSE LAWS

FEDERAL FRAUD CIVIL REMEDIES ACT OF 1986:

- Government can impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which oversees Medicare and Medicaid Programs.

FEDERAL FALSE CLAIMS ACT:

- Providers are prohibited from knowingly submitting (or causing to be submitted) or making a false or fraudulent claim, record or statement to get a claim paid or approved by a state Medicaid program, the Federal government or its agents, such as a carrier or other claims processor.

MEDICAID PROGRAM INTEGRITY: CIVIL PENALTIES & WHISTLEBLOWER PROTECTION

CIVIL PENALTIES INCLUDE:

- $5,500 to $11,000

  and

- up to three times the federal government's damages for each false claim.

"QUI TAM" PLAINTIFF:

- Private citizens and employees with knowledge of fraud against the U.S. Government or state government are encouraged to file suit on behalf of the government against the person or business that committed the fraud by prohibiting retaliation against an employee for investigating, filing or participating in a whistleblower action.

ANTI-FRAUD PLAN REQUIREMENT

MARCH® Providers are required to either adopt and comply with the MARCH® anti-fraud plan, or to have their own anti-fraud plan/compliance program in place that meets or exceeds our standards.

Please review next four slides or MARCH® Provider Reference Guide section 8.1 for more details on our Anti-Fraud Plan:

- Step 1 – Identify Fraudulent Claims
- Step 2 – Reporting Incidents
- Step 3 – Investigate the Incident
- Step 4 – Remedial Measures

ANTI-FRAUD PLAN: STEP 1 – DETECT FRAUD

STEP 1 – IDENTIFY SUSPECTED FRAUDULENT ACTIVITY

- Fake or inaccurate license information
- Services billed do not match services rendered.
- Providers who advertise for free services.
- Significant amounts of patients in an unusually short period of time.
- High dollar claims shortly after coverage begins or before coverage ends.
- Low quality care.
- Discriminatory marketing.
- Kickbacks – these are a crime – and people go to jail.

ANTI-FRAUD PLAN: STEP 2 – REPORT FRAUD

STEP 2 – REPORT FRAUD AND ABUSE

- Report TennCare fraud & abuse to the Office of Inspector General at:
  - www.tn.gov/tnoig/ReportTennCareFraud.html
  - or Call 800-433-3982
- The Office of Inspector General website is at:
  - www.oig.hhs.gov
- You can also report to UHCCP at:
  - 800-690-1606

ANTI-FRAUD PLAN: STEP 3 – INVESTIGATE

At MARCH®, the Chief Executive Officer or his/her designee, the law firm of Katten Muchin & Rosenman, LLP ("KMR") will investigate all credible incidents of suspected fraud that are reported and all credible incidents that are uncovered pursuant to the auditing and monitoring program. The investigation will involve interviews and document review.

The Chief Executive Officer shall record the progress of the investigation, including the results of the interview and document reviews.

ANTI-FRAUD PLAN: STEP 4 – REMEDIAL MEASURES

If fraudulent activity has occurred, the Chief Executive Officer will consult with the manager of the department in which the fraudulent activity has occurred to determine the appropriate action necessary to correct the matter. The following remedial measures will be taken, as applicable:

1. Deny/Recoup Payment – If the fraudulent activity involves payment to a provider or to a member, the payment will be denied if not yet made, and will be recouped if already made.
2. Terminate Provider Contract or/and Discipline Employee Appropriately.
3. File Appropriate Reports – If fraudulent behavior constitutes a reportable offense, a report will be made to the appropriate entity.
4. Notify Appropriate Government Agencies as applicable (i.e. State license board, District Attorney's Office, OIG, DOJ, Medicare, Medicaid, U.S. Attorney's Office).
5. Take Further Remedial Measures to avoid recurrence of fraud – undertake additional investigations or other actions if it appears there may be a continuing pattern of fraud.

COMPLIANCE QUIZ

1. What is one way you can promote cultural diversity at your practice?
   - **(A) Hire staff that reflect your service area.**
   - **(B) Conduct cultural competence training.**
   - **(C) Implement standards to meet needs of your culturally diverse population.**
   - **(D) All of the above.**

2. What services can you offer to patients with disabilities?
   - **(A) Provide sign language interpreter for hearing impaired patient.**
   - **(B) Provide large font for vision impaired patient.**
   - **(C) Provide wheelchair access for handicapped members.**
   - **(D) All of the above.**

COMPLIANCE QUIZ (continued)

3. How can you identify an LEP member over the phone?
   - **(A) You have a hard time understanding what they are saying.**
   - **(B) Member is quiet.**
   - **(C) Member only says yes or no.**
   - **(D) All of the above.**

4. (T or F) – Background checks are not required for sub-contractors, only providers and their staff are required to have background checks.

5. (T or F) – If a Provider fails to report a case of suspected elder or child abuse/neglect they may be held criminally liable or civilly liable.

6. (T or F) – It is ok to back-date service date on claim form in order to receive payment for servicing member within same month that insurance has been terminated.

7. (T or F) – Providers are required to adopt the MARCH Anti-Fraud Plan.

ANSWERS TO QUIZ

(1) **D-** All of the above.
(2) **D-** All of the above.
(3) **D-** All of the above.
(4) **False –** Background checks are required for Provider and all employees and agents.
(5) **True**
(6) **False –** This is fraud.
(7) **False –** Providers can choose to have their own anti-fraud plan that meets or exceeds the standards of MARCH's plan OR adopt and the MARCH Anti-Fraud Plan.

QUESTIONS???

Contact Provider Relations
at 844.966.2724 x7576

Thank you for completing the compliance training.
No further action is required.