FIRST TIER DOWNSTREAM AND RELATED ENTITIES (FDR) AND SUBCONTRACTOR COMPLIANCE GUIDE

2020 Edition
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INTRODUCTION FROM THE CHIEF COMPLIANCE OFFICER

For 25 years, AlohaCare has served the Hawaiian Islands with integrity and continues to work diligently to maintain the highest ethical standards. Our Core Values are based on the values surrounding “Aloha” in our culture and include: Fairness, Honesty, Loyalty, Respect/Dignity and Trust. We strive to act ethically, legally and with integrity in everything we do.

Your organization is contracted with AlohaCare as a First Tier, Downstream or Related Entity (FDR) for Medicare and Medicaid products. As a Medicare/Medicaid contractor, your organization is subject to federal and state laws related to the Medicare/Medicaid program as well as Centers for Medicare and Medicaid Services (CMS) rules, regulations and sub-regulatory guidance. This includes ensuring the FDR’s employees and downstream contractors must also abide by federal and state laws related to the Medicare/Medicaid program as well as CMS rules, regulations and sub-regulatory guidance.

AlohaCare knows that our FDRs and their cultural environments may be different from ours but they play a critical role in our success. AlohaCare aims to conduct business with companies who share similar ideas and values. We rely on our FDRs to maintain and strengthen our position as an ethical and compliant organization.

This FDR Compliance Guide is a resource designed to assist our FDRs with understanding and complying with the AlohaCare Compliance Program and State/Federal requirements. AlohaCare relies on our FDRs to help us meet the healthcare needs of our members. Your organization is a vital part of our business and has specific responsibilities under Medicare/Medicaid guidelines.

This Guide will:

- Demonstrate AlohaCare’s commitment to responsible corporate conduct;
- Set forth the FDRs’ compliance requirements;
- Publicize mechanisms for reporting Fraud, Waste, and Abuse (FWA), and compliance issues;
- Communicate information about the AlohaCare Business Conduct Guidelines and the compliance policies in place to detect, prevent, correct, and monitor FWA and compliance deficiencies;
- Define and provide examples of FWA; and
- Provide information about relevant laws and regulations that govern our business.

Thank you for partnering with us. If you have any questions, please do not hesitate to contact me at (808) 973-2476 or Monica Flitton at (808) 973-0851.

Francoise Culley-Trotman
Chief Compliance Officer
DEFINITIONS

AlohaCare uses CMS’ current definitions to define FDRs:

**First Tier Entity** is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage Program or Part D Program.

**Downstream Entity** is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D Plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

**Related Entity** means any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

1. Performs some of the Medicare Advantage Organization or Part D Plan Sponsor’s management functions under contract or delegation;
2. Furnishes services to Medicare members under an oral or written arrangement; or
3. Leases real property or sells materials to the Medicare Advantage Organization or Part D Plan Sponsor at a cost of more than $2,500 during a contract period.

AlohaCare uses the State of Hawaii, DHS/Med-QUEST current definition to define Subcontractor:

**Subcontractor** means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its managed functions or responsibilities of provider medical care to its patients OR an individual or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
ALOHACARE COMPLIANCE PROGRAM OVERVIEW

AlohaCare is committed to operating a health plan that meets the requirements of all applicable laws and regulations of the Medicare Advantage and Part D Program under CMS as well as State of Hawaii Medicaid guidelines. AlohaCare’s Compliance Program is designed to reduce or eliminate Fraud, Waste, Abuse, (FWA) and inefficiencies; ensure AlohaCare’s compliance with applicable regulations; and reinforce AlohaCare’s commitment to zero-tolerance for such activities. AlohaCare has a legal requirement to provide information and education to those individuals, entities, businesses, and providers that we work with.

Our commitment to operating a compliance health plan is reflected in our Business Conduct Guidelines which includes our Code of Ethics. This Code of Ethics is something each AlohaCare employee agrees to uphold in their job and those standards are reinforced with all employees, providers, and FDRs/Subcontractors.

According to CMS rules, each health plan must implement a compliance program that is effective in preventing, detecting, and correcting Medicare Advantage and Part D program noncompliance as well as a fraud, waste and abuse (FWA) program. AlohaCare’s Compliance Program is evaluated regularly based on CMS’ seven elements of an effective compliance program.

A description of the seven elements of the AlohaCare Compliance Program is provided below:

1. **Written Policies, Procedures and Standards of Conduct** – The Business Conduct Guidelines describes the principles and values by which AlohaCare operates and is the foundation for compliance policies and procedures. AlohaCare makes its Business Conduct Guidelines available to FDRs/Subcontractors.

2. **Designation of Compliance Officer and Committee** – AlohaCare employs a full-time Chief Compliance Officer that oversees the day-to-day operations of the Compliance Program. The AlohaCare Internal Compliance Committee oversees the Compliance Program by supporting and advising the AlohaCare Chief Compliance Officer and Compliance staff. The Internal Compliance Committee meets regularly to discuss the status of the implementation of the Compliance Program. AlohaCare senior management, including the AlohaCare CEO and Board of Directors, receive regular reports of compliance activities, including identification of risk areas and strategies for mitigating those risks.

3. **Effective Training and Education** – Effective training and education ensures that everyone involved with providing healthcare or administrative services to Medicare/Medicaid members understands the rules and regulations that apply to their job. Effective training also prepares employees to identify and report Medicare/Medicaid program non-compliance or potential FWA. Medicare and Medicaid regulations require AlohaCare employees, including FDRs, to complete general Medicare and FWA training annually. This training supports AlohaCare’s strong commitment to conducting business in a legal and ethical manner.

4. **Effective Lines of Communication** – AlohaCare has several reporting methods for FDRs including a mechanism for anonymous reporting. Section IV of this Compliance Guide outlines the reporting methods. Any concerns, suspected misconduct, potential noncompliance, or possible FWA may be reported to AlohaCare and AlohaCare will promptly investigate the report.
AlohaCare policy prohibits retaliation or intimidation against anyone who reports suspected violations in good faith.

5. **Disciplinary Standards** – AlohaCare policies enforce standards when an investigation reveals noncompliance or unethical behavior. These standards may include re-training, specialized training, or disciplinary action up to and including termination of employment or termination of contract.

6. **Monitoring, Auditing and Identification of Risk** – AlohaCare performs regular risk assessments which includes ongoing monitoring and annual auditing of FDRs/Subcontractors. Monitoring activities are structured to regularly review normal operations and to confirm ongoing compliance. As a federally funded health plan, AlohaCare also monitors state and federal lists to identify providers and other individuals and entities for potential exclusion form participation in state and federal programs.

7. **Investigations** – Suspected FWA or compliance issues may be identified through AlohaCare’s Compliance Hotline, a member complaint, during routing monitoring or auditing of FDRs/Subcontractors, or by regulatory authorities. If misconduct is discovered or suspected, AlohaCare’s Special Investigation Unit will conduct an investigation. If the report is substantiated, appropriate corrective action is developed, implemented and tracked for compliance.

**ALOHACARE’S RESPONSIBILITY**

AlohaCare’s commitment to compliance includes ensuring that our FDRs/Subcontractors are in compliance with applicable state and federal regulations. AlohaCare contracts with these entities (also known as delegated entities) to provide administrative and healthcare services to our members. We are ultimately responsible for fulfilling the terms and conditions of our contract with the CMS and the State of Hawaii and meeting the Medicare and Medicaid healthcare program requirements. Therefore, AlohaCare requires each FDR/Subcontractor to comply with the compliance and FWA requirements within this Guide. Failure to meet the requirements may lead to:

- Corrective Action Plan,
- Re-training, or
- Termination of the contract and relationship with AlohaCare.

**FDR RESPONSIBILITIES AND HOW TO COMPLY**

**I. ANNUAL FDR/SUBCONTRACTOR COMPLIANCE ATTESTATION**

This attestation must be completed upon execution of contract and annually thereafter to attest to compliance with the Standards of Conduct, Compliance Policies, General Compliance / FWA training, Office of Inspector General (OIG) and General Services Administration (GSA) Exclusion Screening, and publication of FWA and compliance reporting mechanisms requirements.
An authorized representative is an individual who has responsibility directly or indirectly for all employees, contracted personnel, providers/practitioners, and vendors who provide healthcare or administrative services under Medicaid and Medicare. Authorized representatives may include, but are not limited to, a Compliance Officer, Chief Medical Officer, Practice Manager/Administrator, Provider, an Executive Officer, or similar related positions.

How to Comply with the Attestation Requirement:

AlohaCare will send a notification to each FDR and Subcontractor to communicate the deadline for completion of the annual Attestation. All FDRs/Subcontractors must complete Attestations within the designated timeline.

II. STANDARDS OF CONDUCT AND COMPLIANCE INFORMATION

AlohaCare requires each FDR/Subcontractor to establish and sustain a culture of compliance. AlohaCare’s FDRs/Subcontractors must either (1) establish and publicize comparable Standards of Conduct that meet CMS requirements set forth in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) and reflect a commitment to preventing, detecting, and correcting non-compliance or (2) adopt and distribute to all employees and contractors AlohaCare’s Business Conduct Guidelines.

In addition to the Standards of Conduct, each FDR/Subcontractor must distribute compliance information to all employees and contractors within 90 days of hire/contract, when there are updates, and annually thereafter. Also, you must retain evidence of your distribution of the Standards of Conduct. AlohaCare provides compliance information in this Guide that can be used for this purpose. If an FDR opts to use different material, it must include at a minimum:

- Description of the Compliance Program;
- Instructions on how to report suspected non-compliance;
- Requirement to report potential non-compliance and FWA;
- Disciplinary guidelines for non-compliant behavior;
- Non-retaliation provision;
- FWA training requirement and
- Overview of relevant laws and regulations (such as the Deficit Reduction Act of 2005, False Claims Act, and HIPAA).

How to Comply with Standards of Conduct and Compliance:

FDRs/Subcontractors must maintain records (i.e., attestations, logs, etc.) to document that each employee and contractor has received, read, understood and will comply with the written standards of conduct and compliance policies upon hire/contract and annually thereafter.

Standards of Conduct Requirements:
42 CFR § 422.503(b)(4)(vi)(A) for MA
42 CFR § 422.504(b)(4)(vi)(A) for Part D
Manual, Chapter 21 § 50.1
III. GENERAL COMPLIANCE / FRAUD, WASTE AND ABUSE (FWA) TRAINING

FDRs/Subcontractors must have a system in place to receive, record, respond to, and track compliance questions or reports of suspected noncompliance or potential FWA from employees, members of the governing body, and members. Reporting systems must maintain confidentiality (to the greatest extent possible), allow anonymity if desired (e.g., through telephone hotlines) and emphasize the AlohaCare’s / FDR/Subcontractor policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns and participation in the Compliance Program.

All of the FDR’s/Subcontractor’s employees (including temporary or volunteer personnel), and downstream and related entities must complete required annual compliance training if any persons are involved in the administration or delivery of the Medicare Program benefits. All new hires should receive training within 90 days of initial hire and annually thereafter. In addition to having an established code of conduct, compliance policies and/or a compliance program within your organization, CMS suggests that some entities, particularly those which may have fewer resources, may wish to access CMS Compliance program training.

CMS developed a web-based compliance training module. The module provides separate content for compliance and FWA and provide both web-based and downloadable versions. Training courses are available on the CMS Medicare Learning Network (MLN): http://www.cms.gov/MLNProducts

Methods for Completing the Training

FDRs/Subcontractors will have three options for satisfying the general compliance training requirement:

1. FDRs/Subcontractors can complete the general compliance and/or FWA training modules located on the CMS MLN. Once an individual completes the training, the system will generate a certificate of completion. This MLN certificate must be accepted by AlohaCare.

2. FDRs/Subcontractors can download and incorporate the content of the CMS standardized training modules from the CMS website into their organizations’ existing compliance training materials/systems.

3. FDRs/Subcontractors can incorporate the content of the CMS training modules into written documents for providers (e.g. Provider Guides, Participation Modules, Business Associate Agreements, etc.)

How to Comply with General Compliance / Fraud, Waste, and Abuse Training:

FDRs/Subcontractors are required to complete General Compliance and FWA training within 90 days of contract/hire and annually thereafter. The training requirement extends to all employees and contractors. Each FDR and Subcontractor will be required to attest that all employees and contractors have satisfied the General Compliance and FWA training via one of the options listed below:

- CMS Fraud Waste and Abuse training: http://www.cms.gov/MLNProducts

- Another FWA Training which meets CMS requirements outlined in 42 CFR § 422.503(b)(4)(vi)(C) and 42 CFR § 423.504(b)(4)(vi)(C).

- CMS Deemed FWA Training through enrollment into Parts A or B of the Medicare program or accreditation Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
IV. REPORTING FRAUD, WASTE AND ABUSE AND COMPLIANCE ISSUES

AlohaCare’s FDRs/Subcontractors have a responsibility to report any alleged compliance, FWA, and/or compliance issues that involve AlohaCare. FDRs/Subcontractors may anonymously report a potential violation of our compliance policies or any applicable regulation by using the following methods:

**Reporting to AlohaCare:**
- Confidential and anonymous hotline: **1-855-973-1852**
- Phone: (808) 973-2476
- Email: compliance@alohacare.org  
  fraud@alohacare.org
- Mail:  
  Attention: Chief Compliance Officer  
  1357 Kapiolani Boulevard  
  Suite 1250  
  Honolulu, HI  96814

**Reporting to Medicare:**
- Office of Inspector General at:  
  - Phone:  1-800-HHS-TIPS (1-800-447-8477)  
  - TTY:  1-800-377-4950  
  - Mail:  HHS Tips Hotline  
    P.O. Box 23489  
    Washington, DC  20026
- Centers for Medicare and Medicaid Services:  
  - Phone:  1-800-Medicare (1-800-633-4227)  
  - TTY:  1-800-486-2048  
  - Mail:  Beneficiary Contact Center  
    P.O. Box 39  
    Lawrence, KS  66044
- For additional information on how to detect and report Medicare fraud, you may access this link at [www.stopmedicarefraud.gov](http://www.stopmedicarefraud.gov)

**Hawaii QUEST Integration (Medicaid) Reporting**
- Medicaid Member Fraud: (808) 587-8444
- Medicaid Provider Fraud: (808) 692-8072

**What is Fraud, Waste and Abuse?**

**Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

**Waste** - The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

**Abuse** - Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet
professionally recognized standards of care. It includes enrollee practices that result in unnecessary cost.

Common Examples of Fraud, Waste and Abuse

- **Fabrication of Claims:** In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed.

- **Falsification of Claims:** In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for the purpose of obtaining a payment to which he or she is not entitled.

- **Unbundling:** Provider submits a claim reporting comprehensive procedure code (e.g., Restriction of small intestine) along with multiple incidental procedure codes (e.g., Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

- **Fragmentation:** Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (Antepartum care, Vaginal delivery and Obstetric care) which includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

- **Duplicate claim submissions:** Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

- **Fictitious Providers:** There has been fraud where perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the HCFA 1500 claim form.

All FDRs/Subcontractors must have a system in place to receive, record, respond to and track compliance questions or reports of actual or suspected noncompliance or FWA from employees, members of the governing body, and members. AlohaCare requires each FDR and Subcontractor to publicize confidential reporting mechanisms for all employees and downstream entities. If an FDR/Subcontractor does not maintain a confidential reporting mechanism, the AlohaCare Confidential Hotline and website information must be distributed to encourage reporting of potential compliance issues, FWA, conflict of interests, violations of compliance policies, and/or any applicable regulation.

**AlohaCare Investigations**

It is AlohaCare’s policy to thoroughly and objectively investigate any reported allegation of misconduct, fraud, or abuse involving AlohaCare employees, FDRs/Subcontractors, accounts, or operations. AlohaCare holds individuals responsible for violations of AlohaCare’s policies, breaches of ethical behavior, or illegal acts committed against AlohaCare, on AlohaCare’s behalf, on AlohaCare premises, or during hours of, or within the scope of AlohaCare business operations. AlohaCare will investigate any allegation of wrongdoing regardless of the source of the report. AlohaCare will conduct all
investigations in a manner that protects the rights of those who may be the subject of allegations of wrongdoing as well as those who, in good faith, make such allegations. AlohaCare requires the cooperation of FDRs/Subcontractors during any investigations that may involve (directly or indirectly) their organization or individuals associated with their organization. The investigation will be initiated by a representative of AlohaCare and continue until the investigation is completed. Coordination of investigations which involve any regulatory agency will be handled in accordance with their requests.

AlohaCare is required to refer suspected fraud or misconduct related to the Medicare program to the HHS-OIG and the Medicare Drug Integrity Contractor (MEDIC) for fraud and misconduct related to the Medicare Prescription Drug Program. Suspected fraud, waste, and abuse related to the Hawaii state funded programs (QUEST Integration) are reported to the Investigations Office of the Benefits Employment and Support Services Division or the Medicaid Investigator at the MedQUEST Division.

Non-Retaliation

AlohaCare is committed to a culture that promotes the prevention, detection, investigation, and remediation of violations of the AlohaCare Business Conduct Guidelines, as well as all applicable laws. To support this culture, AlohaCare has established a strict non-retaliation policy to protect employees, FDRs, and Subcontractors who, in good faith, report known or suspected Misconduct, Fraud, Waste and/or Abuse. Each FDR and Subcontractor must adopt a policy of non-retaliation and publicize the policy to all employees and contractors.

**How to Comply with Reporting Compliance Issues:**

In addition to publicizing your organization’s confidential reporting mechanisms, you may also distribute the AlohaCare FDR and Subcontractor Reporting Poster to your employees/contractors or post it in your facility. The AlohaCare FDR and Subcontractor Reporting Poster provides different anonymous reporting methods. AlohaCare policy prohibits retaliation or retribution against anyone who reports suspected violations in good faith.

**Reporting Requirement:**

*Medicare Managed Care Manual Ch. 21 §50.4.2*

**V. OIG EXCLUSION SCREENING**

Federal law prohibits the payment by Medicare, Medicaid or any other federal/state healthcare program for any item or service furnished by a person or entity excluded from participation in these federal/state programs. Therefore, prior to hire and/or contract and monthly thereafter, each FDR and Subcontractor must perform a check to confirm that employees and contractors are not excluded from participation in federal/state funded healthcare programs according to the OIG and GSA exclusion lists.
Medicaid Provider Responsibilities:

Any provider participating or applying to participate in the Medicaid program must search Hawaii’s excluded provider list monthly and the List of Excluded Individuals and Entities (LEIE) on an annual basis to determine if any existing employee or contractor has been excluded from participation in the Medicaid program. In addition, any provider participating or applying to participate in the Medicaid program must search both lists prior to hiring staff to ensure that any potential employees or contractors have not been excluded from participating in the Medicaid program. Monthly screening is essential prevent inappropriate payment to providers, pharmacies, and other entities that have been added to exclusions lists since the last time the list was checked.

For further information regarding State of Hawaii Medicaid Exclusion List please visit: http://www.med-quest.us/providers/ProviderExclusion_ReinstatementList.html

Upon discovery of an excluded individual, the FDR/Subcontractor must provide immediate disclosure to AlohaCare. No payment will be made by Medicare, Medicaid or any other Federal or State of Hawaii health care programs for any item or service furnished on or after the effective date specified in the notice period, by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion. To assist you with implementation of your OIG/GSA Exclusion process, links to the OIG and GSA exclusion websites and descriptions of the lists are below.

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**How to Comply with Exclusion Screening:**

The websites below should be used to perform the required screening:

- OIG List of Excluded Individuals/Entities (LEIE): [http://oig.hhs.gov/exclusions](http://oig.hhs.gov/exclusions)
- General Services Administration (GSA) database of excluded individuals/entities: [https://www.sam.gov/portal/public/SAM#1](https://www.sam.gov/portal/public/SAM#1)

FDRs/Subcontractors must maintain evidence of exclusionary checks (i.e., logs or other records) to document that each employee and contractor has been screened in accordance with current regulations and requirements.

**Exclusion Screening Requirement:**

42 CFR § 1001.1901

Medicare Managed Care Manual Ch. 21 §50.6.8

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**VI. DOWNSTREAM ENTITIES**

AlohaCare’s FDRs/Subcontractors are responsible for the administration of the Medicare Parts C and D benefits and the State of Hawaii Medicaid QUEST Integration (Medicaid), regardless of whether AlohaCare has delegated some of that responsibility. AlohaCare monitors and audits its FDRs/Subcontractors who are identified as high risk at least annually, or as necessary, to ensure that they are in compliance with all applicable laws and regulations. AlohaCare also must ensure that FDRs/Subcontractors are monitoring the compliance of any entities with which they contract (AlohaCare’s “downstream” entities).
Monitoring of first tier entities for compliance program requirements must include an evaluation to confirm that the first tier entities are applying appropriate compliance program requirements to downstream entities with which the first tier contracts.

How to Comply with Monitoring Downstream Entities:

If your organization contracts with other entities external to your organization to perform any of the services contractually delegated to your organization on behalf of AlohaCare, you must distribute materials and information to those downstream entities and monitor and audit the downstream entities’ performance to ensure they also comply with all applicable Medicare and Medicaid requirements.

Requirement:
*Medicare Managed Care Manual Ch. 21 §50.6.6*

VII. RECORD RETENTION AND RECORD AVAILABILITY

AlohaCare is accountable for maintaining training records for a period of 10 years of the time, attendance, topic, certificates of completion and test scores of any tests administered to their employees and must require FDRs/Subcontractors to maintain records of the training of their employees. AlohaCare must be able to demonstrate that its employees and FDRs/Subcontractors have fulfilled these training requirements. Examples of proof of training include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training. Please see: *Medicare Managed Care Manual Chapter 21 §50.3.2.*

FDRs/Subcontractors must comply with all Medicare/Medicaid laws, regulations and CMS instructions (422.504(i)(4)(vi)) and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records for a minimum of 10 years. Please see: *Medicare Managed Care Manual Chapter 21 §100.4.*

AlohaCare shall ensure that all medical records are maintained, in accordance with Sections 622-51 and 622-58, HRS, for a minimum of seven (7) years from the last date of entry in the records. For minors, the health plan shall preserve and maintain all medical records during the period of minority plus a minimum of seven (7) years after the age of majority. All providers shall maintain and retain records of members according to the standards stated in the contract and the HRS. During the period that records are retained under this section, the health plan and any subcontractor shall allow the state and federal government full access to such records, to the extent allowed by law. Please see 71.100 Retention of Medical Records (MedQUEST).

CMS has the discretionary authority to perform audits under 42 C.F.R. 4 422.504(e)(2) and 42 C.F.R. 4 422.505(e)(2), which specify the right to audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of AlohaCare or FDRs that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract or as the Secretary of Health and Human Services may deem necessary to enforce the contract.
AlohaCare and FDRs/Subcontractors must provide records to CMS or its designee. AlohaCare and FDRs/Subcontractors should cooperate in allowing access as requested. Failure to do so may result in a referral of AlohaCare and/or FDR/Subcontractor to law enforcement and/or implementation of other corrective actions, including intermediate sanctioning in line with 42 C.F.R. Subpart O. Please see: Medicare Managed Care Manual Ch. 21 §50.6.11

The above recommendations are suggestions and should not replace analysis by your organization regarding your compliance obligations. Additionally, the above recommendations are not intended to encompass all of your compliance obligations as they relate to the function(s) your organization may be performing under the Medicare Advantage program or State of Hawaii Medicaid program.

How to Comply with Record Retention and Availability:

- Maintain all records, reports, and supporting documentation that relate to the functions your organization is performing or providing under the applicable AlohaCare program for 10 years.
- Maintain records of general compliance and fraud, waste, and abuse training and education taken by your employees for 10 years. The records must demonstrate the date of the training, the topic, attendance, and cert of completion and/or test scores, if applicable. Examples of proof of training include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training.
- Be prepared to make your records available to AlohaCare as part of an AlohaCare audit or monitoring activity.

AUDITING AND MONITORING OF FDRs/SUBCONTRACTORS

CMS requires that we develop a strategy to monitor and audit our FDRs/Subcontractors. This helps ensure compliance with all applicable laws and regulations and that our FDRs/Subcontractors monitor the compliance of their Downstream Entities. Therefore, if you choose to subcontract with other individuals/parties to provide administrative and/or healthcare services for AlohaCare’s Plans, you must make sure that these Downstream Entities abide by all laws and regulations that apply to you as a FDR/Subcontractor. This includes all Compliance Program requirements described in this guide.

Also, your organization must conduct sufficient oversight to test and ensure that your employees and Downstream Entities are compliant with applicable laws, retain evidence of completion, conduct root cause analysis and implement corrective action plans or take disciplinary actions, as necessary, to prevent recurrence of non-compliance with applicable laws.

Expect routine monitoring and audits

We routinely monitor and periodically audit FDRs/Subcontractors. This helps us ensure compliant administration of our contracts with CMS and the State of Hawaii, as well as applicable laws and regulations. Each FDR/Subcontractor must cooperate and participate in these monitoring and auditing
activities. Also, we expect FDRs/Subcontractors to routinely monitor and periodically audit their Downstream Entities.

If we determine that an FDR/Subcontractor doesn’t comply with any of the requirements in this guide, we’ll require the FDR/Subcontractor to develop and submit a Corrective Action Plan (CAP). We can help the FDR/Subcontractor address the identified compliance issues.

These Monitoring and Auditing requirements are noted in 42 C.F.R. § 422.503(b)(4)(vi)(F) for Medicare Advantage and 42 C.F.R. § 423.504(b)(4)(vi)(F) for Part D, and further described in the Manual, Chapter 9 § Section 50.6.6.

### FDR/SUBCONTRACTOR TIMELINE

<table>
<thead>
<tr>
<th>REQUIREMENT / RESOURCE</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>OIG EXCLUSION</td>
<td>Before (hire or contract)</td>
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<tr>
<td></td>
<td>Monthly thereafter</td>
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<tr>
<td>COMPLIANCE POLICIES DISTRIBUTION</td>
<td>Within 90 days (execution of contract)</td>
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<tr>
<td></td>
<td>Annually thereafter</td>
</tr>
<tr>
<td>CMS GENERAL COMPLIANCE / FWA TRAINING</td>
<td>With 90 days (upon hire or execution of contract)</td>
</tr>
<tr>
<td></td>
<td>Annually thereafter</td>
</tr>
<tr>
<td>MONITORING CHECKLIST</td>
<td>Regular (monthly, quarterly, semi-annually, annually)</td>
</tr>
<tr>
<td></td>
<td>Pursuant to contractual requirements</td>
</tr>
<tr>
<td>AUDITING</td>
<td>Annually</td>
</tr>
<tr>
<td>ANNUAL ATTESTION</td>
<td>Annually</td>
</tr>
<tr>
<td>RECORD RETENTION</td>
<td>10 years (or more)</td>
</tr>
<tr>
<td>REPORTING FWA / NONCOMPLIANCE</td>
<td>Immediately if FWA / Noncompliance is suspected or detected</td>
</tr>
</tbody>
</table>

### APPLICABLE LAWS

**Deficit Reduction Act**

As a participant in the Medicaid Program, we must comply with the terms of the Deficit Reduction Act (DRA) of 2005. The DRA, specifically Section 6033, entitled “Employee Education About False Claim Recovery”, which was effective January 1, 2007, requires any organization that receives $5 million or more in Federal Medicaid funds annually, (including payments from managed care companies such as AlohaCare), to adopt a compliance program in accordance with Federal law and to inform its employees and any contractor or agent of the terms of the False Claims Act. Any organization that does not comply with the requirements may be denied Medicaid reimbursement. You should carefully consult with your attorney to determine if you are subject to this requirement.

**False Claims Act**

31 U.S.C. 3729-3733  
P.L. 2007, Chapter 265, (as amended by P.L. 2009, Chapter 265)
The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the FCA, private citizens (i.e., whistleblowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

The state of Hawaii also enacted a state law regarding the reporting of false claims, which is very similar to the federal law. The primary difference between the Hawaii FCA and the federal FCA is that the Hawaii FCA applies to false claims made to the state, or to any contractor, grantee, or other member of state funds as opposed to the federal government.

For the purposes of this policy, “knowing” and/or “knowingly” means that a person, with respect to the information, has actual knowledge of the information; acts in a deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

Both state and federal False Claims Acts apply when a company or person:

- Knowingly presents (or causes to be presented) to the state or federal government a false or fraudulent claim for payment
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the state or federal government
- Conspires with others to get a false or fraudulent claim paid by the state or federal government
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state or federal government

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicare or QUEST Integration program for Members not actually served by AlohaCare
- Knowingly failing to provide Members with access to services for which AlohaCare has received premium payments
- Knowingly submitting inaccurate, misleading, or incomplete Medicare or Medicaid cost reports

**False Claims Act Penalties**

Those who defraud the government can end up paying triple (or more than) the damage done to the government or a fine (between $5,500 and $11,000) for every false claim, in addition to the claimant’s costs and attorneys’ fees. These monetary fines are in addition to potential incarceration, revocation of licensures, and/or becoming an excluded individual which prevents an individual from being employed in any job that receives monies from the Federal Government, the State Government, or both.

**FCA: Whistleblower Protections**

The False Claims Act allows everyday people to bring suits against organizations or individuals who are defrauding the government (not including tax fraud). These individuals are commonly known as Whistleblowers. If the government moves forward with a case, the individual who brings the suit is generally entitled to receive a percentage of any recovered funds once a decision has been made. If the
government decides not to pursue it, then the individual must pursue the issue on his or her own and, if successful, then he or she would be entitled to percentage of any recovered funds as well.

Federal statutes and related State and Federal laws shield employees from retaliation for reporting illegal acts of employers. An employer cannot retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer does retaliate, the employee may be entitled to file a charge with a government agency, sue the employer, or both.

To report information about fraud, waste, or abuse involving Medicare or any other healthcare program involving only federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is 1-800-HHS-TIPS (1-800-447-8477).

For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to: https://oig.hhs.gov/fraud/report-fraud/index.asp

**Stark Law**

The Stark Law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he or she has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain diagnosed health services to an entity with which the physician, or a member of the physician’s immediate family, has a financial relationship, unless an exception applies. It also prohibits an entity from presenting, or causing to be presented, a bill or claim to anyone for a health service furnished as a result of a prohibited referral.

Violations of the Stark Law and the practice of Physician self-referral are to be reported to the Centers of Medicare and Medicaid Services via their self-disclosure process.

**Anti-Kickback Statute**

The Medicare and Medicaid Patient Projection Act of 1987, provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other Federal or State funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital, and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any goods or services from any healthcare facilities, programs, or providers.
Federal Program Fraud Civil Remedies Act

31 U.S.C. 3801-3812

For a copy of this citation, please visit: https://www.federalregister.gov/articles/2009/06/04/E9-12170/program-fraud-civil-remedies-act

This act provides federal administrative remedies for false claims and statements, including those made to federally funded healthcare programs. Current civil penalties are $5,500 for each false claim or statement and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

HIPAA Privacy

The Health Insurance Portability and Accountability Act (HIPAA) Privacy rule requires providers to take reasonable steps to protect and safeguard the Protected Health Information (PHI) of members/patients. A member’s PHI is subject to the protections established by the Privacy Rule and under the contractual relationship between AlohaCare and the member, and between AlohaCare and the provider or FDR. PHI includes information regarding enrollment with AlohaCare, medical records, claims submitted for payment, etc. Such PHI must be safeguarded and held in strict conformance, so as to comply with applicable privacy provisions of State and Federal laws, including the HIPAA. Ways in which a provider can protect member/patient PHI include:

- Ensuring that only authorized provider office employees have access to member/patient charts;
- Including limited information on member/patient sign-in sheets; and
- Restricting nonemployees from being in areas of the office that contain member/patient records.

HIPAA Security

The HIPAA Security rule requires covered entities to adopt national standards for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information (e-PHI) that is collected, maintained, used or transmitted by a covered entity. As a covered entity, you must ensure that you have the appropriate administrative, technical, and physical safeguards in place to protect the data that is being electronically accessed by our workforce. You must:

A. Ensure the integrity and confidentiality of the information;
B. Protect against any reasonably anticipated-
   i. Threats or hazards to the security or integrity of the information; and
   ii. Unauthorized uses or disclosures of the information.

This can be accomplished by establishing appropriate policies and procedures that outline your compliance with the Rule and your expectations of your workforce in complying with the Rule. Compliance with the Security Rule is not a one-time goal, but instead an ongoing process that requires periodic risk analyses and audits of covered entities’ employees’ devices to confirm their compliance with your established policies.
A member’s PHI must be safeguarded and only those employees of the covered entity who have a business need to access the information should be permitted to do so. Access to member PHI should be role-based. This means that access should only be granted to a covered entity’s employees based on their job duties and responsibilities within the organization.

Please consider the relevant laws and regulations listed below:

- Title XVIII of the Social Security Act
- Medicare regulations governing Parts C and D found at 42 C.F.R. §§ 422 and 423 respectively.
- Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119)
- Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191)
- Anti-Kickback Statute (42 U.S.C. § 1320a-7(b))
- The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))
- 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
- All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos, and guides