



SECTION 08

Compliance, Fraud, Waste, and Abuse

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Overview

As a Medicare Advantage organization, eternalHealth is required to maintain a comprehensive compliance program that promotes adherence to federal and state laws, Centers for Medicare & Medicaid Services (CMS) regulations, contractual obligations, and ethical business practices. Participating providers are important partners in helping ensure compliance with these requirements and maintaining the integrity of the Medicare program.

Providers are expected to conduct business in an ethical manner, comply with applicable laws and regulations, report suspected misconduct, and cooperate with compliance-related activities conducted by eternalHealth, CMS, or other regulatory agencies.

Compliance with Federal and State Laws

Participating providers must comply with all applicable federal, state, and local laws and regulations governing the delivery of healthcare services and participation in the Medicare Advantage program. This includes requirements established by CMS, the U.S. Department of Health and Human Services (HHS), state regulatory agencies, and other governmental authorities.

Providers are responsible for ensuring that services rendered to eternalHealth members are delivered in accordance with:

- Medicare Advantage regulations
- Medicare coverage policies
- State licensing requirements
- Provider contract requirements
- Privacy and security laws
- Anti-fraud and abuse requirements
- Nondiscrimination requirements

eternalHealth may monitor provider compliance through audits, reviews, education programs, credentialing activities, and regulatory oversight processes.

Fraud, Waste, and Abuse (FWA)

Fraud, Waste, and Abuse can negatively impact the Medicare program, healthcare costs, and member access to care. Participating providers are expected to remain vigilant in identifying and preventing activities that may constitute Fraud, Waste, or Abuse.

Fraud

Fraud is the intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in an unauthorized benefit. Examples may include:

- Billing for services not rendered
- Falsifying medical records
- Misrepresenting diagnoses or procedures
- Submitting false claims for reimbursement

Waste

Waste includes the overutilization or misuse of healthcare resources that directly or indirectly results in unnecessary costs to the Medicare program. Examples may include:

- Excessive testing
- Unnecessary services
- Inefficient healthcare practices

Abuse

Abuse includes actions that are inconsistent with sound medical, business, or fiscal practices and result in unnecessary costs or improper reimbursement. Examples may include:

- Improper billing practices
- Inappropriate coding
- Failure to maintain adequate documentation
- Services that do not meet accepted standards of medical necessity

Reporting Fraud, Waste, and Abuse

Providers have an obligation to report suspected Fraud, Waste, or Abuse involving providers, facilities, members, vendors, employees, or other individuals associated with Medicare benefits or healthcare services.

Suspected Fraud, Waste, and Abuse may be reported through the following channels:

Office of Inspector General (OIG)

Phone: 1-800-HHS-TIPS (1-800-447-8477)

TTY: 1-800-377-4950

Website: oig.hhs.gov/fraud/report-fraud

eternalHealth Compliance Hotline

Phone: 1-857-557-6007

Email: compliance@eternalhealth.com

Providers are encouraged to report concerns promptly. Reports may be made without fear of retaliation for good-faith reporting of suspected misconduct.

Compliance and FWA Training Requirements

CMS requires Medicare Advantage organizations to provide education regarding compliance and Fraud, Waste, and Abuse requirements. Participating providers are strongly encouraged to ensure that employees, contractors, and applicable workforce members receive appropriate compliance, FWA, and HIPAA training.

Training topics may include:

- General compliance requirements
- Medicare Advantage regulations
- Fraud, Waste, and Abuse prevention
- HIPAA Privacy and Security requirements
- Code of conduct expectations
- Reporting obligations

Providers may utilize compliance training resources available through the CMS Medicare Learning Network® and other approved compliance education programs.

Nondiscrimination Requirements

eternalHealth prohibits discrimination in the delivery of healthcare services and administration of health plan benefits. Participating providers must comply with all federal and state nondiscrimination laws and regulations.

Providers may not discriminate against any individual on the basis of:

- | | | |
|-------------------|---------------------|--|
| • Race | • Gender | • Genetic information |
| • Color | • Age | • Veteran status |
| • National origin | • Disability | • Geographic location |
| • Religion | • Health status | • Plan membership |
| • Sex | • Source of payment | • Any other characteristic protected by applicable law |

Providers must ensure members receive equitable access to services and are treated with dignity and respect regardless of protected status.

Providers must also comply with Section 1557 of the Affordable Care Act, the Americans with Disabilities Act (ADA), the Civil Rights Act of 1964, and other applicable civil rights laws.

Treatment of Immediate Relatives and Household Members

eternalHealth follows Medicare guidance regarding reimbursement for services provided to immediate relatives and members of the provider's household. Certain services may not be eligible for reimbursement when provided to individuals who meet Medicare's definition of immediate relatives or household members.

Examples of immediate relatives include:

- Spouse
- Parent
- Child
- Sibling
- Grandparent
- Grandchild
- Stepparent
- Stepchild
- In-law relationships recognized under Medicare guidance

Providers should refer to applicable Medicare guidance for additional details regarding these restrictions.

Balance Billing and Prohibited Billing Practices

Participating providers may not balance bill members for covered services except for applicable member cost-sharing amounts specifically authorized under the member's benefit plan.

Examples of prohibited billing practices include:

- Billing members for the difference between billed charges and contracted reimbursement amounts
- Billing members for claims denied due to provider timely filing failures
- Billing members for covered services denied because required documentation was not submitted
- Billing members for covered services when authorization requirements were not followed by the provider

- Billing members for payment reductions resulting from claims editing or reimbursement methodologies permitted under the Provider Agreement

Providers who engage in prohibited billing practices may be subject to corrective action, regulatory reporting, recovery actions, credentialing review, or network termination.

Provider Responsibilities

Participating providers are responsible for:

- Complying with all applicable laws, regulations, and contractual obligations.
- Maintaining an effective compliance culture within their organization.
- Reporting suspected Fraud, Waste, and Abuse.
- Cooperating with compliance investigations and audits.
- Ensuring workforce members receive appropriate compliance education.
- Protecting member privacy and confidentiality.
- Adhering to nondiscrimination requirements.
- Avoiding prohibited billing practices and balance billing.

Failure to comply with compliance requirements may result in corrective action, repayment obligations, sanctions, credentialing review, termination from the network, or referral to appropriate regulatory authorities.