Fraud, Waste and Abuse Prevention Training

Fraud, Waste, and Abuse

- The Centers for Medicare & Medicaid Services (CMS) requires annual fraud, waste and abuse training for organizations providing health services to MA or Medicare clients.
- As an MA provider, we are committed to following all applicable laws, regulations and guidance that apply to our services.

CMS Role and Definition

- The Centers for Medicare & Medicaid Services (CMS) is a government agency within the U.S Department of Health and Human Services.

- CMS is responsible for oversight of the Medicare Program – including health plan sponsors of programs such as Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), and Prescription Drug Plans (PDP).

- The main or central office for CMS is located in Baltimore, MD. CMS also has 10 Regional Offices – in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, San Francisco, and Seattle.

- CMS publishes guidance on how to comply with the rules and regulations of MA, MAPD, and PDP plans through the Medicare Managed Care Manual and the Prescription Drug Benefit Manual. First tier, downstream, and related entities should refer to and be familiar with these materials to ensure compliance with the Medicare requirements related to their delegated functions.

Exclusion Lists

- Payment related to Medicare or Medicaid benefit programs must not be made for items or services furnished or prescribed by an excluded provider, person, or entity.

- First tier, downstream, and related entities must review federal exclusion lists at the time of hire/contracting and **MONTHLY** thereafter to ensure that none are excluded from participating in Federal health care programs.
- Review for excluded status is required for any:
  - First tier, downstream, and related entity employee (including temporary workers and volunteers), CEO, senior administrator or manager, governing body member, downstream entity or subcontractor.
  - We retain all documentation confirming the review activity was conducted and the results of the review.

- If we identify an excluded party or entity employed or contracted by our organization, we must report this to the appropriate authorities.

Contracted Entity Definitions:

- First Tier: Any party that enters into a written agreement with a plan sponsor to provide administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.
  - Examples include, but are not limited to: pharmacy benefit manager (PBM), contracted hospitals or providers.

- Downstream: Any party that enters into a written agreement below the level of the arrangement between a sponsor and a first tier entity for the provision of administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.
  - Examples include, but are not limited to: pharmacies, claims processing firms, billing agencies.

- Related: Any entity that is related to the sponsor by common ownership or control and 1) performs some of the sponsor's management of functions under a contract of delegation, 2) furnishes services to Medicare enrollees under an oral or written agreement, or 3) leases real property or sells materials to the sponsor at a cost of more than $2500 during a contract period.

Compliance Program Requirements

So what is a Compliance Program?

A Compliance Program is a series of internal controls and measures to ensure that the Plan Sponsor is following state and federal laws and regulations that govern the program.

It is comprised of the following seven elements and must incorporate measures to detect, prevent and correct fraud, waste, and abuse (FWA):

1. Compliance with Federal and State Standards and Written Policies and Procedures
2. Designation of Compliance Officer and Committee
3. Effective Compliance Training
4. Effective Lines of Communication
5. Disciplinary Guidelines and Enforcement
6. Internal Monitoring and Auditing Procedures
7. Response to Detected Offenses and Corrective Action Plan

This training is one way that we fulfill the training requirement above (#3).

Compliance Program Requirements:
7 Elements

1. **Written Standards of Conduct:** development and distribution of written Standards of Conduct and Policies & Procedures that promote the Plan Sponsor's commitment to compliance and that address specific areas of potential fraud, waste and abuse
2. **Designation of a Compliance Officer:** designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program
3. **Effective Compliance Training:** development and implementation of regular, effective education and training, such as this training.
4. **Internal Monitoring and Auditing:** use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem areas
5. **Disciplinary Mechanisms:** policies to consistently enforce standards and address dealing with individual or entities that are excluded from participating in CMS programs
6. **Effective Lines of Communication:** between the compliance officer and the organization's employees, managers and, directors and members of the compliance committee, as well as first tier, downstream and related entities.
    1. Includes a system to receive, record and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality
    2. First tier, downstream, and related entities must report compliance concerns and suspected or actual misconduct involving the MA or Part D programs to the Sponsor
7. **Procedures Responding to Detected Offenses and Corrective Action:** policies to respond to and to initiate corrective action to prevent similar offenses including a timely, reasonable inquiry

Compliance Program Requirements: Fraud, Waste and Abuse

- Fraud
  - is an intentional act of deception, misrepresentation, or concealment in order to gain something of value.
  - often involves billing for services that were never rendered or billing for services at a higher rate than is actually justified.
  - also occurs when services provided to members are deliberately misrepresented, resulting in unnecessary cost to the program, improper payments to providers, or overpayments.
- Waste
  - is over-utilization of services, (not caused by criminally negligent actions) and the misuse of resources
- Abuse
  - is the excessive or improper use of health care services or actions that are inconsistent with acceptable business and/or medical practice.
  - refers to incidents that, although not considered fraudulent, may directly or indirectly cause financial loss.

Examples of FWA

- Double billing: Charging more than once for the same service.
- Using another person's Medicare card to get medical care, supplies, equipment, or prescription drugs.
- Soliciting, offering or receiving bribes, rebates or kickbacks.
- Dispensing expired drugs.
- Prescription forging.
- Resale of drugs on the black market.
- Billing for services that were not furnished and/or supplies not provided.
- Altering claim forms and/or receipts in order to receive a higher payment amount.
- Charging in excess for services or supplies.
- Providing medically unnecessary services.
- Billing for items or services that should not be paid for by Medicare.

Fraud, Waste, and Abuse Policies

- First tier, downstream, and related entities are obligated to establish and implement policies and procedures to address fraud, waste, and abuse.
- Examples of policies include but are not limited to:
  - Policies providing guidance to employees on how to request compliance assistance or report suspected non-compliance or potential fraud, waste, and abuse.
  - Policies expressly prohibiting retaliation against employees who, in good faith, report or participate in the investigation of compliance concerns.
  - Procedures to conduct timely and reasonable inquiries to detected offenses, including applying corrective actions as necessary.

False Claims Act

- The federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. In addition to the Federal False Claims Act, the State of Minnesota passed its own False Claims Act in 2010.
  - A "claim" is broadly defined to include any submissions that results, or could result, in payment.
- Under the False Claims Act, 'knowing' or 'known' means that a person:
  - Has actual knowledge;
  - Acts in deliberate ignorance of truth or falsity; or,
  - Acts in reckless disregard of truth or falsity.

- Proof of specific intent to defraud is not required to fall within the definition of knowledge.

- Claims "submitted to the government" includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.

False Claims Act, cont.

- Liability can also be created by the improper retention of an overpayment.
- The Patient Protection and Affordable Care Act of 2010 (PPACA) or Health Care Reform Law expanded a provision of the False Claims Act referred to as a reverse false claim.
- Overpayments or any funds received or retained under Medicare or Medicaid that a person or organization is not entitled to, must be reported and returned within 60 days of identification.
- Whistleblower and Whistleblower Protections:
  - The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.
  - Individuals who file such suits are known as 'whistleblowers'. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

False Claims Act, cont.

Examples include:

- A physician who submits a bill to Medicare for medical services not provided.
- A government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.
- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor.

Additional Compliance Considerations

- **Anti-Kickback Statute**
  - Prohibits the offering or giving of remuneration (payments) or anything of value to:
    - Induce the referral of a Medicare or Medicaid beneficiary.
    - Induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare or Medicaid program.
  - Applies to Plan Sponsors employees and all first tier, downstream, and related entities.

- **Civil Monetary Penalties**
  - Sanctions may be applied to organizations that offer or give something of value to a Medicare beneficiary, such that the organization knows or should know is likely to influence the person's selection of a particular provider, practitioner, or supplier of any item or service which may be paid entirely or in part by Medicare.

- **Self-Referral Prohibition Statute (Stark Law)**
  - Prohibits physicians from referring Medicare patients to an entity with which the physician or a physician's immediate family member has a financial relationship — unless an exception applies.

Anti-Kickback Statute

- The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs.
- The Anti-Kickback law is intended to ensure that referrals for health care services are based on medical need and not based on financial or other types of incentives to individuals or groups.
- The Patient Protection and Affordable Care Act of 2010 (PPACA) or Health Care Reform Law has added a provision to the Anti-Kickback Statute where “knowingly and willfully” does not mean the individual had the intent to specifically violate the statute. In addition, violations of the Anti-Kickback statute can now be considered a false and fraudulent claim under the False Claims Act.

Anti-Kickback Statute

- Examples include:
  - A frequent flyer campaign in which a physician may be given a credit toward airline frequent flier mileage for each questionnaire completed for a new patient placed on a drug company's product.
  - Free laboratory testing offered to health care providers, their families and their employees to induce referrals.
- In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to the prevention of health care fraud and abuse.
- HIPAA Privacy
  - The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.
- HIPAA Security
  - The Security Rule outlines specific protections and safeguards for electronic PHI.
    - If you become aware of a potential breach or inappropriate disclosure of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

HIPAA

Example of HIPAA provisions related to the prevention of health care fraud and abuse:

- The creation of the Fraud Abuse and Control Program for coordination of state and federal health care fraud investigation and enforcement activities.
- The expansion of the exclusion authority so that any health care fraud conviction, even if the fraud is not related to Medicare or Medicaid, results in mandatory exclusion from participation in the Medicare or Medicaid programs.
- The creation of a new series of federal crimes, together referred to as “health care fraud”, which make it a federal crime to defraud health care benefit programs – any benefit program, not just Medicare or Medicaid.

Criminal Health Care Fraud Statute

- The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits 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

- In connection with the delivery of or payment for health care benefits, items, or services.

- Proof of actual knowledge or specific intent to violate the law is **not** required. Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Consumer or Member Fraud, Waste, and Abuse:

- **Doctor Shopping –** Consumer or other individual consults with a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- **Prescription diversion and inappropriate use –** Consumers obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and give or sell this medication to someone else. Also can include the inappropriate consumption or distribution of a consumer's medications by a caregiver or anyone else.
- **Identity Theft or Medical Identity Theft –** A person uses another person's Medicare card to obtain services or prescriptions – OR – another person's information is used to bill for procedures that were never done or for supplies that were never received.

Pharmacy Fraud, Waste, and Abuse

- **Prescription Drug Switching –** The Pharmacy or pharmacy benefit manager (PBM) receives a payment to switch a consumer from one drug to another or influence the prescriber to switch the patient to a different drug.
- **Prescription Drug Shorting or Splitting –** A pharmacy or PBM's mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the patient or make arrangements to provide the balance, but bills for the fully-prescribed amount. The pharmacy splits original prescription to receive additional dispensing fees.
- **Inappropriate billing practices such as:**
  - Billing for brand when generics are dispensed
  - Billing for non-covered prescriptions as covered items
  - Billing for prescriptions that are never picked up

Prescriber Fraud, Waste and Abuse

- **Script mills –** Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- **Illegal remuneration schemes –** Prescriber is offered, paid, solicits, or receives unlawful remuneration (payment or items of value) to induce or reward the prescriber to write prescriptions for drugs or products.
- **Prescription drug switching –** Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.

How to Ask Questions, Request Clarification and Report Issues

- Everyone has the right and responsibility to report possible fraud, waste or abuse. Report issues or concerns to:
  - Your organization's compliance officer:
    - Tim McGuire, LICSW
    - 651-288-3443
    - tim.mcguire@peopleincorporated.org
  - 1-800-MEDICARE
  - Health and Human Services Office of Inspector General Hotline 1-800-447-8477
- Surveillance and Integrity Review Section of MN DHS

  SIRS Hotline: (651) 431-2650 or 1-800-657-3750 (anonymous)

  Fax: (651) 431-7569

  Email: DHS.SIRS@state.mn.us

You may report anonymously and retaliation is prohibited when you report a concern in good faith.

Please answer the following questions and then check your answers on the next slide. If you **cannot** answer these questions correctly without referring to the answers, please review the training materials again:

1. Which of the following is **NOT** an essential element of an effective compliance program?
   (A) Written Standards of Conduct
   (B) High Level Oversight
   (C) Effective Lines of Communication
   (D) Conference Calls

2. True or False? CMS is the part of the Federal government that oversees the Medicare program.

3. True or False? If I identify or am made aware of potential misconduct or a suspected fraud, waste, or abuse situation, I should keep this information to myself and not tell anyone else.

1. **(D) Conference calls**. Conference calls are not an essential element of an effective compliance program.

The government has said that the following elements <u>are</u> part of an effective compliance program:

1. Written Standards of Conduct,
2. High Level Oversight,
3. Effective Compliance Training,
4. Effective Lines of Communication,
5. Disciplinary Mechanisms,
6. Monitoring and Auditing,
7. Procedures for Responding to Detected Offenses.

2. **TRUE**. CMS – the "Centers for Medicare & Medicaid Services" – is a government entity within the U.S. Department of Health and Human Services that is responsible for oversight of the Medicare Program – including health plans such as Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), and Prescription Drug Plan (PDP).
3. **FALSE**. If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, you should NOT keep this information to yourself. Instead, it is your right and responsibility to report it.

Important

- Print and complete the form on the next slide (only print slide 27)
- Send to Madeline North, admin assistance at the Centre Pointe office. She will input your information in ADP.

2014 ATTESTATION OF FWA TRAINING COMPLETION

As a first-tier entity, downstream entity or related entity, People Incorporated attests that it has obtained or conducted fraud, waste and abuse compliance education and training for its personnel (including managers and directors), as required for the **2014** calendar year by the final rule issued in the Federal Register for 42 C.F.R. Parts 422 and 423 on 12/5/07. Upon request, People Incorporated attests that it will furnish training logs, and training content, to validate that the required fraud, waste and abuse compliance training was completed.

_____	People Incorporated
Print Name	Organization Name
_____	41-09622916
Title	Tax ID
_____	_____
Signature	Date training was completed

People Incorporated
2060 Centre Pointe, Blvd. Suite #3
Saint Paul, MN 55120