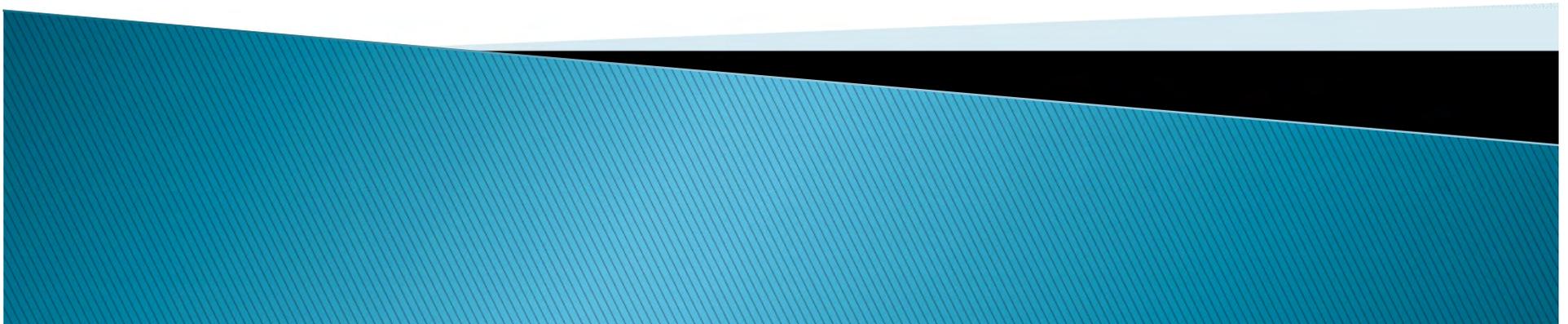


FRAUD, WASTE, & ABUSE TRAINING

FOR FIRST TIER, DOWNSTREAM, & RELATED
ENTITIES



OVERVIEW

The Center for Medicare & Medicaid Services (CMS) requires Medicare Advantage organizations (MAD) and Part A sponsors to provide annual compliance and fraud, waste, and abuse (FWA) training to first tier, downstream and related entities.

As per 42 CFR Parts 422 and 423 of the Medicare Advantage Program and Prescription Drug Benefit Program the plan sponsor must:

- ▶ Maintain appropriate oversight and develop a compliance plan that includes measures to detect, prevent and correct fraud, waste and abuse.
- ▶ Establish fraud, waste and abuse training and effective lines of communication between the Medicare Advantage or Part D plan and its first tier, downstream and related entities.



FWA TRAINING

- ▶ Although there is no exact measure of health care fraud, those who are intent on abusing the system can cost taxpayers billions of dollars and put beneficiaries health and welfare at risk
- ▶ To combat fraud and abuse, you need to know what to watch for to protect your organization and HealthCare Partners from potential abusive practices, civil liability, and perhaps criminal activity



FDR ROLES & RESPONSIBILITIES

- ▶ First Tier, Downstream and Related entities provide health care services or assist in the administration of the Medicare program on behalf of HealthCare Partners
- ▶ As an FDR for HealthCare Partners, you are required to comply with all applicable statutory, regulatory, and other Part C and/or Part D requirements
- ▶ You have a duty and obligation to both WellPoint and the Medicare Program to detect, prevent, and correct fraud, waste, and abuse in the Medicare Part C and Part D programs



COMPLIANCE PLAN

A compliance plan is a series of internal controls and measures to ensure the plan sponsor follows applicable laws and regulations that govern Federal programs like Medicare.

Organizations contracting directly or indirectly with the Federal government are obliged to:

- ▶ Report fraud, waste, and abuse;
- ▶ Demonstrate their commitment to eliminating fraud, waste, and abuse; and
- ▶ Implement internal policies and procedures to identify and combat health care fraud.



STANDARDS

The Compliance Department has constructed the below items to ensure that HCP complies with Federal and State Standards:

- Code of Conduct
- Policies and Procedures
- Compliance Officer
- Compliance Committee
- Compliance Hotline
- Education for Employees/Contractors
- Antifraud Monitoring/Risk Assessment
- Discipline and Enforcement



SPONSORS AND ENTITIES

Plan Sponsor:

An entity that has a contract with CMS to offer a Medicare Advantage Plan, Medicare Prescription Drug Plans or 1876 Cost Plans.

First Tier Entity:

An entity that enters into a written arrangement, acceptable to CMS, with a Plan Sponsor to provide health care or administrative services for a Medicare eligible individual under the MA or Part D programs. Examples include:

- ▶ Pharmacy Benefits Manager (PBM)
- ▶ Provider Organization (IPA)
- ▶ Hospitals



SPONSORS AND ENTITIES (cont.)

Downstream Entity:

Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between the MAD and the first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity:

Any entity that is related to the MAD by common ownership or control and (1) performs some of the MAD management under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAD at the cost of more than \$2,500 during a contract period.



FRAUD

FRAUD

Fraud is the intentional misrepresentation of data for financial gain. Fraud occurs when an individual knows or should know that something is false and makes a knowing deception that could result in some unauthorized benefit to themselves or another person.

Examples of fraud:

- ▶ Billing for services not furnished
- ▶ Billing for services of a higher rate than is actually justified
- ▶ Violations of the physician self-referral “Stark” prohibition



WASTE

WASTE:

Waste is the extravagant, careless or needless expenditure of healthcare benefits or services that results from deficient practices or decisions.

Examples of waste:

- ▶ Over-utilization of services
- ▶ Misuse of resources



ABUSE

ABUSE:

Abuse involves payment or services where there was no intent to deceive or misrepresent but the outcome of poor insufficient methods results in unnecessary costs to the Medicare program.

Examples of abuse:

- ▶ Providing medically unnecessary services
- ▶ Billing Medicare based on a higher fee schedule than is used for patients not on Medicare



FRAUD & ABUSE TYPES

There are several common ways fraud and abuse can occur. Examples include:

- ▶ False claims
- ▶ Kickbacks
- ▶ Identity theft
- ▶ Identity swapping
- ▶ Marketing schemes
- ▶ Duplicate billing



FRAUD & ABUSE USUAL SUSPECTS

Who can commit fraud and abuse?

- ▶ Beneficiaries
- ▶ Providers, pharmacies
- ▶ Plan sponsors
- ▶ Employees
- ▶ Employer groups
- ▶ Brokers/agents
- ▶ Pharmacy benefit management (PBMs)



BENEFICIARY EXAMPLES

Examples of Potential FWA: Beneficiary

- ▶ Use of another's insurance card to obtain prescription drug benefits or medical services
- ▶ Adding ineligible dependents to the plan
- ▶ Loaning one's card to someone else to obtain benefits
- ▶ Falsifying information on the application
- ▶ Identity theft
- ▶ Excessive trips to the emergency room to obtain controlled substances
- ▶ Resale of drugs on the black market



PROVIDER MEDICAL SERVICES EXAMPLES

Examples of Potential FWA: Provider (or billing company) – Medical Services

- ▶ Billing for services not rendered
- ▶ Unnecessary treatments (rent-a-patient schemes)
- ▶ Unbundling, upcoding
- ▶ Soliciting, altering or receiving a kickback, bribe or rebate
- ▶ Eligibility fraud (misrepresenting the date services were rendered or the individual who received the services)
- ▶ Misrepresentation of services (misrepresenting who rendered the service or billing of non-covered services as covered items)



PROVIDER PRESCRIPTION DRUGS EXAMPLES

Examples of Potential FWA: Provider (or billing company) – Prescription drugs

- ▶ Prescription drug shorting—providing less than the prescribed quantity but billing for the fully-prescribed amount
- ▶ Inappropriate billing practices
 - Billing for brand when generics are dispensed
 - Billing for non-covered prescriptions as covered items
- ▶ Dispensing expired or adulterated drugs
- ▶ Forging or altering an existing prescriptions



PHARMACY BENEFITS MANAGER EXAMPLES

Examples of Potential FWA: Pharmacy Benefits Manager (PBM)

- ▶ Prescription drug switching—PBM receives a payment to switch a beneficiary from one drug to another or influence prescriber to switch patient to a different drug
- ▶ Prescription drug splitting or shorting—PBM mail order pharmacy intentionally provides less than the prescribed quantity, does not inform the patient or make arrangements to provide the balance and bills for the fully-prescribed amount. Splits prescription to receive additional dispensing fees.
- ▶ Inappropriate formulary decisions
- ▶ Failure to offer negotiated prices



PLAN SPONSOR EXAMPLES

Examples of Potential FWA: Plan Sponsor

- ▶ Fails to provide medically necessary items or services that the organization is required to provide and that failure adversely affects (or is substantially likely to affect) the enrollee
- ▶ Inappropriate enrollment/disenrollment—example, fails to affect timely disenrollment of beneficiary upon request
- ▶ Marketing schemes
 - Offering beneficiaries a cash payment to enroll in a Medicare plan
 - Unsolicited door-to-door marketing
 - Use of unlicensed agents



BROKER EXAMPLES

Examples of Potential FWA: Broker

- ▶ Encouraging a member to disenroll from a plan
- ▶ Offering cash to enroll in a MA or MA-PA plan
- ▶ Offering a gift worth more than the allowed amount to sign up for MA or MA-PD plan
- ▶ Making false statements to an individual or member



EMPLOYER EXAMPLES

Examples of Potential FWA: Employer

- ▶ Misrepresenting who is actually eligible for coverage by representing them as an employee of the group
- ▶ Changing dates of hire or termination to expand dates of coverage
- ▶ Providing false employer or group eligibility information to secure health care coverage



FRAUD, WASTE, & ABUSE LAWS

THE FALSE CLAIMS ACT

The False Claims Act makes it illegal to:

- ▶ Knowingly present, or cause to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval.
 - ▶ Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government
 - ▶ Conspiring to defraud the Government by getting a fraudulent claim allowed or paid
 - ▶ Has actual knowledge of the information
 - ▶ Acts in deliberate ignorance of the truth or falsity of the information
 - ▶ Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required
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THE FALSE CLAIMS ACT (cont.)

The False Claims Act imposes two sorts of liability:

- ▶ The submitter of the false claim/statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the Government any damages and even if the claim is rejected.
- ▶ The submitter of the claim is liable for damages that the government sustains because of the submission of the false claim
- ▶ Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government are liable for three times the Government's damages plus civil penalties of \$5,000 to \$10,000 per false claim. In New York State the penalties are \$6,000 to \$12,000.



ANTI-KICKBACK STATUTE

The Anti-kickback Statute makes it a criminal offense to knowingly and willfully solicit, receive, offer or pay remuneration (including any kickback, bribe or rebate) in return for:

- ▶ Referrals for the furnishing or arranging of any items or service reimbursable by a Federal Health Care Program
- ▶ Purchasing, leasing, ordering or arranging for any items or service reimbursable by a Federal Health Care Program
- ▶ Remuneration is defined as the transfer of anything of value, directly for indirectly, overtly or covertly in cash or in kind.
- ▶ If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute.
- ▶ Criminal penalties for violating the anti-kickback statute may include fines, imprisonment, or both.



STARK LAW

PHYSICIAN SELF-REFERRAL LAW

The Physician Self-Referral Law prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Penalties for Stark Law violations include fines and exclusion from participation in all Federal Health Care Programs.



WHISTLEBLOWER (QUI TAM) PROTECTION

The whistleblower provision protects employees who assist the federal government in investigation and prosecution of violations of False Claims Act. The provision prevents retaliation against employees assisting in the investigation and prosecution. If any retaliation does occur, the employee has a right to obtain legal counsel to defend the actions.

A whistleblower is someone such as an employee who reports suspected misconduct that would be considered an action against company policy or federal laws or regulations.



NYS LABOR LAWS

Under NY's Labor Laws, employers are prevented from taking any retaliatory actions against an employee who discloses or threatens to disclose to a supervisor or a public body an activity, policy or practice of the employer that is in violation of a law, rule or regulation the violation of which creates and presents a substantial and specific danger to public health or safety or which constitutes health care fraud.

Retaliatory actions include discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment.



REPORTING SUSPECTED FRAUD, WASTE, & ABUSE

Everyone has the responsibility to report suspected fraud, waste, or abuse.

To report suspected fraud, please contact:
Lisa Katz, Chief Compliance Officer, 516-515-8804

You may also report anonymously:
Hotline: 888-475-8376



FRAUD, WASTE, & ABUSE RESOURCES

RESOURCES

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.gov>

Medicare Learning Network (MLN)

<http://www.cms.gov/MLNGenInfo/>

OIG and fraud

<http://oig.hhs.gov/fraud>

Office of Inspector General (OIG) list of excluded individuals

<http://oig.hhs.gov/exclusions>

Health Care Fraud Prevention & Enforcement Action Team (HEAT)

<http://www.stopmedicarefraud.gov>

More information on Anti-Kickback Statute

<http://oig.hhs.gov/compliance/safe-harbor-regulations>

More information on Stark Law

<http://www.cms.gov/PhysicianSelfReferral>

Health Insurance Portability and Accountability Act (HIPAA)

<http://www.cms.hhs.gov/HIPAAGenInfo/>

National Health Care Anti-Fraud Association

<http://www.nhcaa.org>

Part D Prescription Drug Benefit Manual

http://www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#

