

Medicare Advantage and Part D Fraud, Waste, and Abuse Compliance Training 2010

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Overview

- This Medicare Advantage and Part D Fraud, Waste, and Abuse Compliance Training for first-tier, downstream and related entities has been prepared by FamilyCare to provide an easily accessible process for you to complete your annual training requirements for Medicare regulations 42 CFR 422.504(b)(4) and/or Section 423.504 (b)(4)(vi)(c).
- The Centers for Medicare and Medicaid Services (CMS) requires annual fraud, waste and abuse training for organizations providing health, prescription drugs, or administrative services to Medicare Advantage (MA) or Prescription Drug Plan (PDP) enrollees on behalf of a health plan.
- As an MA and PDP sponsor, FamilyCare Health Plans is committed to following all applicable laws, regulations, and guidance that govern these programs.

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Objectives

- What:** Federal Requirements you need to know
- Why:** To detect, prevent, and correct fraud, waste and abuse and to raise awareness about the issue.
- How:** Medicare Advantage Plans and Part D, Prescription Drug Plans must implement an effective compliance plan including measures to detect, prevent , and correct fraud, waste and abuse and they are required to provide this training to first-tier, downstream and related entities.
- When:** This training must be completed annually by December 31st of each calendar year.
- Who:** You must train your organization, but FamilyCare is here to help with this training program.

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Definitions

- **Plan Sponsor:** An entity that has a contract with CMS to offer one or more of the following Medicare products: Medicare Advantage (MA), Medicare Advantage Part D Prescription Drug Plans and 1876 Cost Plans.
- **First Tier Entity:** A party that enters into a written agreement, acceptable to CMS, with a PLAN Sponsor to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs. Examples include Pharmacy Benefits Manager (PBM), contracted hospitals, clinics, and allied providers.
- **Downstream Entity:** A party that enters into a written arrangement, acceptable to CMS, with persons or entities involved in the MA or Part D benefit, below the level of the arrangement between a Plan Sponsor and first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include pharmacies, marketing firms, quality assurance companies, claims processing firms, and billing agencies.
- **Related Entity:** An entity that is related to the Plan Sponsor by common ownership or control and performs some of the Plan Sponsor's management functions under contract or delegation; furnishes services to Medicare enrollees under an oral or written agreement; leases rental property or sells materials to the Plan Sponsor at a cost of more than \$2,500 during the contract period

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Regulations

- Federal regulations require Medicare Advantage and PDP Sponsors to have a Compliance Plan
- An MA or PDP Sponsor's plan must
 - include measures to detect, prevent, and correct fraud, waste and abuse.
 - include training, education, and an effective communication plan.
 - apply this training, education, and communication requirements to all entities which provides benefits or services under MA or PDP programs.
 - produce proof (attestations and copies of training logs) from first tier, downstream and related entities to show compliance with these requirements.

What is a Compliance Plan?

An effective Compliance Plan includes seven core elements:

1. **Written Standards of Conduct:** development and distribution of written Standards of Conduct and Policies and 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.

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Compliance Plan (continued)

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.
- Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality.
 - First tier, downstream and related entities must report compliance concerns and suspected or actual misconduct involving the MA or Part D programs to the Plan Sponsor.
7. **Procedures for Responding to Detected Offenses and Corrective Action:** policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry

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Why Focus on Fraud, Waste and Abuse?

- Scams alone cost the health care industry more than \$100 billion annually.
- Fraud, waste and abuse programs save Medicare dollars and that benefits taxpayers, government, health plans, and beneficiaries.
- Detecting, correcting and preventing fraud, waste and abuse requires collaboration between:
 - Health Plans
 - Providers of Services, such as physicians, nurses and pharmacies
 - State and Federal agencies
 - Patients.

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Fraud, Waste and Abuse Defined

- **Fraud:** an intentional act of deception, misrepresentation, or concealment in order to gain something of value. Examples include:
 - Billing for services that were never rendered
 - Billing for services at a higher rate than actually justified
 - Deliberately misrepresenting services, resulting in unnecessary cost to the Medicare program, improper payments to providers, or overpayments.
- **Waste:** over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse:** excessive or improper use of service or actions that are inconsistent with acceptable business or medical practices. This refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. Examples include:
 - Charging in excess for services or supplies
 - Providing medically unnecessary services
 - Billing for items or services that should not be paid for by Medicare.

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Fraud, Waste and Abuse Prescriber Examples

- **Illegal Payment Schemes**
 - Prescriber is offered, paid, solicits, or receives unlawful payment to induce or reward the prescriber to write prescriptions for drugs or products .
- **Script Mills**
 - Prescribers write 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 prescriber.
- **Theft of Prescriber's Drug Enforcement Agency (DEA) Number or Prescription Pad.**
 - Prescription pads and/or DEA numbers stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications.

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Fraud, Waste and Abuse Wholesaler Examples

- **Counterfeit, Impure Drugs through Black Market**
 - Black Market include fake, diluted, expired, illegally imported, illegally acquired drugs, etc.
- **Diverters**
 - Individuals who illegally gain control of discounted medicines and mark up the prices and move them to small wholesalers.
- **Inappropriate Documentation of Pricing Information**
 - Submitting false or inaccurate pricing or rebate information

Fraud, Waste and Abuse Beneficiary Examples

- **Identity Theft**

- Using a member's ID card that does not belong to that person to obtain prescriptions, services, equipment, supplies, doctor visits, and/or hospital stays.

- **Doctor Shopping**

- Visiting a number of doctors to obtain multiple prescriptions for pain killers or other drugs. This might point to an underlying scheme (stockpiling or black market resale)

Fraud, Waste, and Abuse Pharmaceutical Manufacturer Examples

- **Illegal Off-label Promotion**
 - Promotion of off-label drug use.
- **Illegal Usage of Free Samples**
 - Providing free samples to prescribers knowing and expecting prescribers to bill Medicare for the sample.
- **Kickbacks, Inducements, Other Illegal Payments**
 - Inappropriate marketing or promotion of products reimbursable by federal health care programs.
 - Inappropriate discounts or educational grants.

Fraud, Waste, and Abuse Plan Sponsor Examples

- **Payments for Excluded Drugs**
 - Receiving payment for drugs not covered by the Plan Sponsor's formulary.
- **Marketing Schemes**
 - Offering beneficiaries a cash payment as an encouragement to enroll in a Medicare Plan
 - Unsolicited door-to-door marketing
 - Use of unlicensed agents
 - Enrollment of individual in a Medicare Plan without such individual's knowledge or consent
 - Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or by CMS.

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Fraud, Waste and Abuse Pharmacy Benefit Manager (PBM) Examples

- **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.

Fraud, Waste and Abuse Billing Examples

- **Inappropriate Billing Practices**
 - Billing for services not provided
 - Misrepresenting the service that was provided
 - Billing for a higher level than the service actually delivered
 - Billing for non-covered services or prescriptions as covered items
 - Unbundling services billed

Federal Fraud, Waste and Abuse Laws

- **False Claims Act:** Prohibits any person from knowingly presenting or causing a fraudulent claim for payment.
- **Anti-Kickback Statute:** Makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a Federal Health Care Program.
- **Self-Referral Prohibition Statute (Stark Law):** Prohibits physician from referring Medicare patients to an entity with which the physician or physician's immediate family member has a financial relationship – unless an exception applies

Reporting Potential Fraud, Waste, and Abuse

- Everyone has the right and the responsibility to report possible fraud, waste, and/or abuse. Report issues or concerns to:
 - Your organization’s compliance officer or compliance hotline and/or;
 - The Compliance Officer or Compliance Hotline of the applicable Plan Sponsor(s) with whom you participate; compliance hotline numbers for FamilyCare are:
 - » 503-345-5777
 - » 800-335-3205 ext 5777
 - 1-800-Medicare

Remember:

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

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Fraud, Waste and Abuse Resources

Federal government web sites are sources of information regarding detection, correction, and prevention of fraud, waste, and abuse:

- Dept of Health & Human Services Office of Inspector General:
<http://oig.hhs.gov/fraud.asp>
- Centers for Medicare and Medicaid Services (CMS):
<http://www.cms.hhs.gov/MDFraudAbuseGenInfo/>.
- CMS Information About the Physician Self Referral Law:
www.cms.hhs.gov/PhysicianSelfReferral

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Training Completed!!!

- Congratulations! You have completed the compliance training.
- Please report back to FamilyCare that you have completed this training. FamilyCare is required to keep a log of those who complete the training annually.
- See attached attestation form.

Attestation of Training Completion

As a first tier, downstream or related entity, _____ (Organization Name) attests that it has administered appropriate education and training to detect, correct, and prevent potential fraud, waste, and abuse, as required by the final rule issued in the Federal Register for 42 CFR Parts 422 and 423 of the Medicare Program on December 5, 2007.

Your organization completed the education and training to comply with the final rule requirement. This completed Fraud, Waste and Abuse training and education was provided by FamilyCare Health Plan.

By signing below, you attest that your organization will furnish training logs and certifications from downstream entities upon request to FamilyCare to validate that training was completed.

Print Name of Organization Representative

Organization Name

Representative's Title

Signature

Date Signed

This attestation is valid through December 31 of the Calendar Year

(Sign and return by mail to FamilyCare Health Plans, Inc. 825 NE Multnomah Ste. 300 Portland, OR 97232 or via fax at 503-734-3163)

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FamilyCare Contacts

For questions or concerns, you may contact FamilyCare
Provider Relations Department at:

503- 222-3205

800- 335-3205

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for use of content used in preparation of this training.

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