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

Committed to Integrity
Dear Provider:

The Centers for Medicare & Medicaid Services (CMS) has mandated that all Medicare Advantage (MA) and Part D providers, their employees, first tier, downstream, and related entities complete mandatory Fraud, Waste, and Abuse (FWA) training on an annual basis beginning 1/1/2009. Please see slides 5 & 6 for definitions of key terms used in this presentation. This presentation includes important information regarding the FWA training content and how to attest that the presentation was received and reviewed. The attestation form is available on the Community Health Plan (CHP) website at: http://www.chpw.org/en/provider/training/. The training should take about 25 minutes and is offered at no charge.

CHP recognizes that this requirement may be cumbersome for providers, first tier, downstream, and related entities because these entities often contract with multiple Part D Sponsors.

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CHP Introductory Statement (continued)

In order to help reduce the burden of completing training requirements for multiple Sponsors, CHP will accept any of the following in place of our FWA training course as meeting this requirement:

- Completion of a FWA training program offered by another MA or Part D Sponsor
- Completion of a FWA training program developed in-house or by a third party, as long as the training includes the following elements:
  - Resources and references for applicable federal laws related to FWA
  - Required completion of training by employees, first tier, downstream and related entities
  - Information on how to report potential FWA violations
  - Protections for individuals and/or organizations who report suspected FWA
  - Examples of FWA that can occur in first tier, downstream and related entities

Please complete the attestation form listed below the training document link on the CHP website or provide verification of receiving and reviewing another Part D Sponsor’s training materials. We recommend keeping records of participation as you would for other staff training. CMS and/or CHP may request additional information to substantiate the statements made in the attestations.
Training Objectives

- Understand the MA and Part D Sponsor FWA training requirements
- Recognize examples of FWA
- Know how to prevent FWA
- Understand that FWA impacts everyone including providers, practitioners, members, health plans, and the Government
- Understand the impact FWA has on the quality of patient care
- Know how and where to report FWA
- Know how to contact the Community Health Plan Compliance Officer
Key Terms

- **Medicare Part A** - Part A covers hospice, home health care, and inpatient care in skilled nursing facilities and hospitals.
- **Medicare Part B** - Part B covers outpatient care, doctor's services, physical and occupational therapy, and home health care.
- **Medicare Part C** (also referred to as Medicare Advantage) combines Part A and Part B benefits.
- **Medicare Part D** is stand-alone prescription drug coverage.
- A **Part D Plan** provides stand-alone prescription drug coverage and is known as PDP. Part D may also be offered in conjunction with Medicare Advantage. When combined with Medicare Advantage, Part D plans are known as MA-PD plans.
- A **Medicare Advantage Plan (MA)** provides health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area.
Key Terms

• A **Part D Sponsor** refers to a PDP sponsor, a MA organization offering a MA-PD plan, a PACE organization offering a PACE plan including qualified prescription drug coverage, and a cost plan offering qualified prescription drug coverage.

• The **PACE** program is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

• A **downstream entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Part D benefit, below the level of the arrangement between a Part D plan sponsor (or applicant) and a first tier entity.

• A **first tier entity** means any party that enters into a written arrangement, acceptable to CMS, with a Part D plan sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under Part D.
CMS FWA Training Guidance

Comprehensive Medicare Fraud, Waste & Abuse (FWA) prevention, detection, and reporting guidance may be found in the CMS Prescription Drug Benefit Manual, Chapter 9. The Manual provides guidelines for MA and Part D Plan Sponsors on how to implement the regulatory requirements under 42 CFR §423.504(b)(4)(vi)(H). The regulations require that providers, provider staff, first tier contractors, downstream contractors, and related entities have in place a comprehensive plan to detect, correct and prevent FWA as an element of a comprehensive compliance plan.

Some examples of first tier, downstream, and related entities include:

- Home Health Agencies
- Pharmacies and Pharmacists
- Primary Care Practitioners
- Subcontractors
- Specialist Practitioners
- Ancillary Providers
- Claims Processing subcontractors
- Home Health Agencies
- Hospitals
- Dentists
- Billing Agencies
CMS Requirements (continued)

A final rule entitled, “Revisions to the Medicare Advantage (MA) and Part D Prescription Drug Contract Determinations, Appeals, and Intermediate Sanctions Processes,” Federal Register Document 07-5946 (72 Federal Register 68700 through 68741, published December 5, 2007), changed the compliance plan requirements for MA organizations and Part D Sponsors. This rule went into effect January 1, 2009. As of December 2009, Federal Rules are pending that will eliminate this training requirement for the MA Program.

The compliance regulation states that a compliance plan must include measures to detect, correct, and prevent FWA and must consist of training, education and effective lines of communication.

This change clarifies that MA organizations and Part D Sponsors must apply these training and communication requirements to all staff, first tier, downstream, and related entities affiliated with their respective organizations.
Practitioner and Provider Responsibilities

Practitioners and providers, their respective staff, first tier, downstream, and related entities must:

- Complete an annual FWA training designed for MA Programs and Medicare Prescription Drug Benefit Programs (Part D)
- Submit an annual attestation to Community Health Plan indicating the training materials have been reviewed and are understood
FWA Prevention

Elements of FWA Prevention

- Cooperation and coordination between providers, practitioners, vendors, contractors, government agencies, and law enforcement officials
- Ensuring fair and consistent enforcement policies are in place
- Early detection through medical review and data analysis
- Developing program compliance requirements that protect beneficiaries and public funds
- FWA training for providers, practitioners, beneficiaries, vendors and contractors
- Maintaining written Policies and Procedures
- Checking Federally Maintained Exclusion Lists
FWA Defined

Definition of Fraud
• An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Definition of Waste
• An overutilization of services or improper billing practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather through the misuse of resources.

Definition of Abuse
• Gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit and unnecessary costs either directly or indirectly.
### What is Considered Fraud?

**Fraud is Determined Both by Intent and Action**

Examples of fraud include:
- Misrepresenting a diagnosis to justify higher payments
- Falsifying certificates of medical necessity
- Knowingly submitting duplicate claims for reimbursement
- Soliciting, offering, or receiving kickbacks
- Unbundling of services to increase reimbursement
- Changing, forging or falsifying a prescriptions

**Example:** A billing clerk in a provider’s office might accidentally misread a code and submit a claim for a service that was not provided to that patient. Because the billing clerk did not have the intent to deceive the insurance company, this is not considered to be fraud. However, if the provider of service deliberately requests that the insurance company be billed for services not rendered, that provider would be committing fraud.
What is considered Waste?

- An organization’s culture that fails to identify waste vulnerabilities and protect company resources
- Inaccurate claims data submission causing unnecessary rebilling, or claims reprocessing
  - Sending employees to conferences that are unrelated to their work or unnecessary to perform their job function
  - Health care spending that can be eliminated without reducing the quality of care
  - Overuse, underuse, and ineffective use of services
  - Redundancy, delays, and unnecessary process complexity in providing treatment
What is Considered Abuse?

An overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

Examples of abuse may include:

• Billing Medicare patients at a higher rate than non-Medicare patients
• Visiting several doctors to obtain multiple prescriptions
• Providing excessive or unnecessary services
• Routinely waiving coinsurance and deductibles
MA Organization & Part D Sponsor FWA

- Failure to authorize the provision of medically necessary services
- Marketing schemes such as offering beneficiaries a cash payment as an inducement to enroll in Part D
- Selecting or denying coverage to beneficiaries based on their illness profile or other discriminating factors
- Inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness
- Offering inducements to deny medically necessary care
Pharmacy Benefit Manager (PBM) FWA

- Unlawful remuneration, such as remuneration for steering a beneficiary toward a certain plan or drug, or a formulary placement
- Inappropriate formulary decisions
- Prescription drug splitting or shorting
- Failure to offer negotiated prices
- Prescription drug switching
- Authorizing refills prematurely
Prescription Drug FWA

- **Illegal remuneration schemes** - Prescriber is offered, or paid or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products

- **Prescription mills** - Prescriber 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

- **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
Prescription Drug FWA (continued)

• **Theft of prescriber’s DEA number, prescription pad, or e-prescribing information** - Prescription pads and/or DEA numbers can be stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications often sold on the black market. In the context of e-prescribing, includes the theft of the provider’s authentication (log in) information.

• **Provision of false information** - Prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage.
Pharmacist and Pharmacy FWA

- 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
- Dispensing expired or adulterated prescription drugs
- True Out-of-Pocket (TrOOP) manipulation
- Prescription splitting
- Prescription drug shorting
- Bait and switch pricing
- Prescription forging or altering
Provider & Practitioner FWA

- Unnecessary treatment - Providing treatment not warranted by type of or severity of illness
- Billing for services not rendered and/or supplies not provided
- Coding medical services at a level that isn’t supported by medical record documentation
- Misrepresentation - Misrepresenting the identity of the individual who received the services
- Double billing - Billing for the same service multiple times
- Misrepresenting the date services were rendered
- Billing non-covered services as covered items
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Offering inducements to patients for overutilization of services
Medicare Beneficiary FWA

• **Resale of drugs on black market** - Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market

• **Prescription stockpiling** - Beneficiary attempts to game their drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against periods of non-coverage (i.e., by purchasing a large amount of prescription drugs and then disenrolling), or for purposes of resale on the black market

• **Doctor shopping** - Beneficiary or other individual consults 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

• **Improper Coordination of Benefits** - Improper coordination of benefits where beneficiary fails to disclose multiple coverage policies, or leverages various coverage policies to game the system
Medicare Beneficiary FWA

- **Misrepresentation of status** - A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive the drug benefit.

- **Identity theft** - Perpetrator uses another person’s Medicare card to obtain prescriptions.

- **True out of Pocket (TrOOP) manipulation** - A beneficiary manipulates TrOOP to push through the coverage gap, so the beneficiary can reach catastrophic coverage before they are eligible.

- **Prescription forging or altering** - Where prescriptions are altered, by someone other than the prescriber to increase quantity or number of refills, especially narcotics.

- **Prescription diversion and inappropriate use** - Beneficiaries 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 beneficiary’s medications by a caregiver or anyone else.
Patient Safety and Quality of Care

FWA Can Cause Serious Personal Harm

- Unnecessary procedures may cause injury or death
- Falsely billed procedures and medical identity theft can create an erroneous record of the patient’s medical history
- Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addiction, and perpetuates criminal activity
Important Federal Laws

The **False Claims Act** (31 U.S.C §3729-3733) is a federal law which allows people who are not affiliated with the government to file actions against contractors claiming fraud against the government for:

- Presenting to the government a false claim for payment
- Causing someone else to submit a false claim for payment to the government
- Making or using a false record or statement to get a claim paid by the government
- Conspiring to get a false claim paid by the government
- Making or using a false record to avoid or decrease an obligation to pay or reimburse the government
Important Federal Laws

False Claims Act (continued)

• A **Whistleblower** - is a person who raises a concern about wrongdoing occurring in an organization or body of people, usually this person would be from that same organization

Whistleblower protection is a provision in the False Claims Act that:

• Allows individuals to report fraud anonymously

• Allows individuals to sue an entity on behalf of the government and collect a portion of any resulting settlement

• Prohibits employers from threatening, intimidating, or retaliating against employees, who in good faith report misconduct or wrongdoing
Important Federal Laws

False Claims Act (continued)

- **Penalties**
  - Fines up to $11,000 for each false claim
  - Exclusion from participating in the Medicare & Medicaid programs
  - Plus treble damages suffered by the government
  - Possible criminal prosecution and imprisonment
  - Trial costs

- **Social and Business Consequences**
  - Irreparable damage to one’s reputation
  - Loss of business
Important Federal Laws

Federal Anti-Kickback Law

• In 1972, Congress passed the anti-kickback statute which made it illegal for providers, including doctors, to knowingly and willfully accept bribes or other forms of remuneration in return for generating Medicare, Medicaid or other federal healthcare program business.

• Likewise, a physician cannot offer anything of value to induce federal healthcare program business.

• Since its creation, the anti-kickback statute has been revised to allow more than 20 exceptions or “safe harbors” such as for investments in group practices.
Important Federal Laws

Federal Anti-Kickback Law

- Safe harbors include:
  - Investments in large publicly held health care companies
  - Investments in small health care joint ventures
  - Space rental
  - Equipment rental
  - Personal services and management contracts
  - Sales of retiring physicians' practices to other physicians
  - Referral services
  - Warranties
  - Discounts
  - Employee compensation
  - Group purchasing organizations
  - Waivers of Medicare Part A inpatient cost-sharing amount
  - Increased coverage
Important Federal Laws

Federal Anti-Kickback Law

- **Safe harbors include (continued):**
  - Reduced cost-sharing amounts or reduced premium amounts offered by health plans to beneficiaries
  - Price reductions offered to health plans by providers
  - Investments in ambulatory surgical centers
  - Joint ventures in underserved areas
  - Practitioner recruitment in underserved areas
  - Sales of physician practices to hospitals in underserved areas
  - Subsidies for obstetrical malpractice insurance in underserved areas
  - Investments in group practices
  - Specialty referral arrangements between providers
  - Cooperative hospital services organizations
Anti Kickback Law (continued)

Examples of anti-kickback schemes
• Drug “switching” programs-if structured incorrectly
• Drug rebate programs-if structured incorrectly
• Pharmacy paid to “steer” patients to specific Part D plan

Penalties
• Exclusion from participation in federally health care programs
• Violations of the law are punishable by up to five years in prison
• Administrative civil money penalties up to $50,000
• Criminal fines up to $25,000
Important Federal Laws

The Stark Law (42 U.S.C. 1395 §1877) is a broad statute in the Social Security Act that prohibits physicians from referring Medicare and Medicaid patients to entities with which the referring physician or members of his or her immediate family have a financial relationship for services identified in the statute as “designated health services.” It also prohibits an entity from billing or filing a claim for a designated health service as a result of a prohibited referral. The Stark Law is made of three separate provisions:

- The Stark Law
- Stark II
- Stark III
Important Federal Laws

Federal “Stark” Law

- Physician refers patients to a pharmacy to have Rx filled and the physician (or immediate family member) has a financial relationship with that pharmacy, the pharmacy cannot bill Medicare or Medicaid unless a statutory exception applies
  - Example: physician’s spouse owns the pharmacy

Stark II

- One purpose of this regulation is to prohibit physician self-referrals

Stark III

- This regulation provides further clarifications and modifications to Stark II regarding physicians in group practice and the relationships between physicians and hospitals
Important Federal Laws

Stark and Anti-kickback legislation

- These two laws are separate but also integrated into each other
- One big difference between the laws is that to be found guilty of an Anti-kickback violation, prosecutors must prove criminal intent. By contrast, no proof of criminal intent is necessary to be found guilty of a Stark violation

Penalties

- Both laws carry stiff penalties for violations including large monetary penalties, exclusion from federal health care programs and in the case of an Anti-kickback violation, imprisonment up to five years
Important Federal Laws

Beneficiary Inducement Civil Monetary Penalty Law
(42 U.S.C. § 1320a-7a)

• Prohibits any payment, discount, or other “remuneration”
• Applies to beneficiaries enrolled in government health care programs
• Prohibits any incentive likely to influence beneficiaries to patronize a particular provider
• Rationale: discourage over-utilization of health care supplies and services
• Applies to all government programs

Penalties

• Fines up to $10,000 per violation plus treble damages
• Potential Exclusion from Medicare & Medicaid
Important Federal Laws

Some exceptions to beneficiary inducement:

• Providers may offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services that have a retail value of no more than $10 individually, and no more than $50 in the aggregate annually per patient.

• Providers may offer beneficiaries more expensive items or services that fit within one of the five statutory exceptions:
  • Waivers of cost-sharing amounts based on financial need
  • Properly disclosed copayment differentials in health plans
  • Incentives to promote the delivery of certain preventive care services
  • Any practice permitted under the federal anti-kickback statute pursuant to 42 CFR 1001.952
  • Waivers of hospital outpatient copayments in excess of the minimum copayment amounts
Preventing & Combating FWA

Ways to prevent FWA:
• Develop and maintain a compliance program
• Monitor claims for accuracy—ensure coding reflects services provided
• Monitor medical records—ensure documentation supports services rendered
• Perform regular internal audits
• Maintain open lines of communication with colleagues and staff members
• Ask about potential compliance issues in exit interviews
• Take action if you identify a problem

Caution! - Providers, Practitioners, Pharmacists, and Pharmacies are ultimately responsible for claims bearing your name, regardless of whether a claim was submitted by a provider or the claim was submitted on their behalf.
Administrative Sanctions for FWA

Administrative sanctions means the formal official imposition of a penalty or fine and may include:

- Assessment of damages, reimbursement, restitution, compensation
- Denial or revocation of Medicare and/or Medicaid provider application
- Addition to the OIG List of Excluded Individuals/Entities (LEIE)
- License revocation or suspension
- Suspension of provider payments
- Civil Monetary Penalties
OIG & GSA Exclusion Lists and FWA

Check the OIG and General Services Administration (GSA) exclusion lists for all employees at the time of hire and annually thereafter to ensure that employees and other entities that assist in the administration or delivery of services to Medicare beneficiaries are not included on such lists.


- General Services Administration (GSA) database of excluded individuals/entities: [https://www.epls.gov/](https://www.epls.gov/)
Reporting FWA
Confidential Methods for Reporting FWA

Office of the Inspector General
• By Phone: **1-800-HHS-TIPS (1-800-447-8477)**
• By TTY: **1-800-377-4950**
• By E-mail: [HHSTips@oig.hhs.gov](mailto:HHSTips@oig.hhs.gov)
• Website: [http://oig.hhs.gov/fraud/hotline/](http://oig.hhs.gov/fraud/hotline/)

Department of Social and Health Services of Washington
• Toll Free: (800) 562-3022
• Web Site: [www.adsa.dshs.wa.gov](http://www.adsa.dshs.wa.gov)

Callers are encouraged to provide information on how they can be contacted for additional information, but they may remain anonymous if they choose.
Resources

- CMS Prescription Drug Benefit Manual
- Code of the Federal Regulations (see CFR 422.503 and CFR 423.504)
- Office of the Inspector General
  - http://www.oig.hhs.gov/fraud.asp
- Medicare Learning Network (MLN) Fraud & Abuse Job Aid
- Safe Harbor Regulations
  - http://oig.hhs.gov/fraud/safeharborregulations.asp
Community Health Plan Resources

For questions, comments, or additional resource information please contact the Community Health Plan Compliance Officer at:

Community Health Plan
Attn: Compliance Officer
720 Olive Way, Suite 300
Seattle, WA 98101
206-521-8833 Main number
1-800-440-1561 Toll free
TTY at 1-866-816-2470 Toll free
Compliance.officer@chpw.org Email
Community Health Plan Resources

Community Health Plan Provider Manual:

Medical Coding Training from Community Health Plan with CME/CEU for Participating Provider Staff and Billing Office Staff can be found at: http://www.chpw.org/en/provider/training/

Thank you for your time and attention.
Community Health Plan Presentation

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