Medicare Advantage and Part D Fraud, Waste, and Abuse Compliance Training 2011

Overview

- This Medicare Advantage and Part D fraud, waste, and abuse compliance training for first-tier, downstream and related entities has been developed by Blue Cross and Blue Shield of Minnesota, First Plan of Minnesota, HealthPartners, Metropolitan Health Plan, Medica, and UCare in collaboration with the Minnesota Council of Health Plans Fraud, Waste, and Abuse Training Workgroup.*

- The Centers for Medicare and Medicaid Services (CMS) requires annual fraud, waste, and abuse training for organizations providing health, prescription drug, or administrative services to Medicare Advantage (MA) or Prescription Drug Plan (PDP) enrollees on behalf of a health plan.**

- As MA and PDP Sponsors, Minnesota health plans are committed to following all applicable laws, regulations, and guidance that govern these programs.

*Other plan sponsors may use this training with permission of the Minnesota Council of Health Plans.

**See 42 CFR Section 422.504(b)(4)(vi)(c) and/or Section 423.504(b)(4)(vi)(c).

Overview and Objectives

- **What:** New federal requirements you must know.
- **Why:** Detect, prevent, and correct fraud, waste, and abuse; raise awareness about the issue.
- **How:** Plan Sponsors must implement an effective compliance plan including measures to detect, prevent, and correct fraud, waste, and abuse.
- **When:** Complete this training now and yearly thereafter.
- **Who:** You.

Definitions

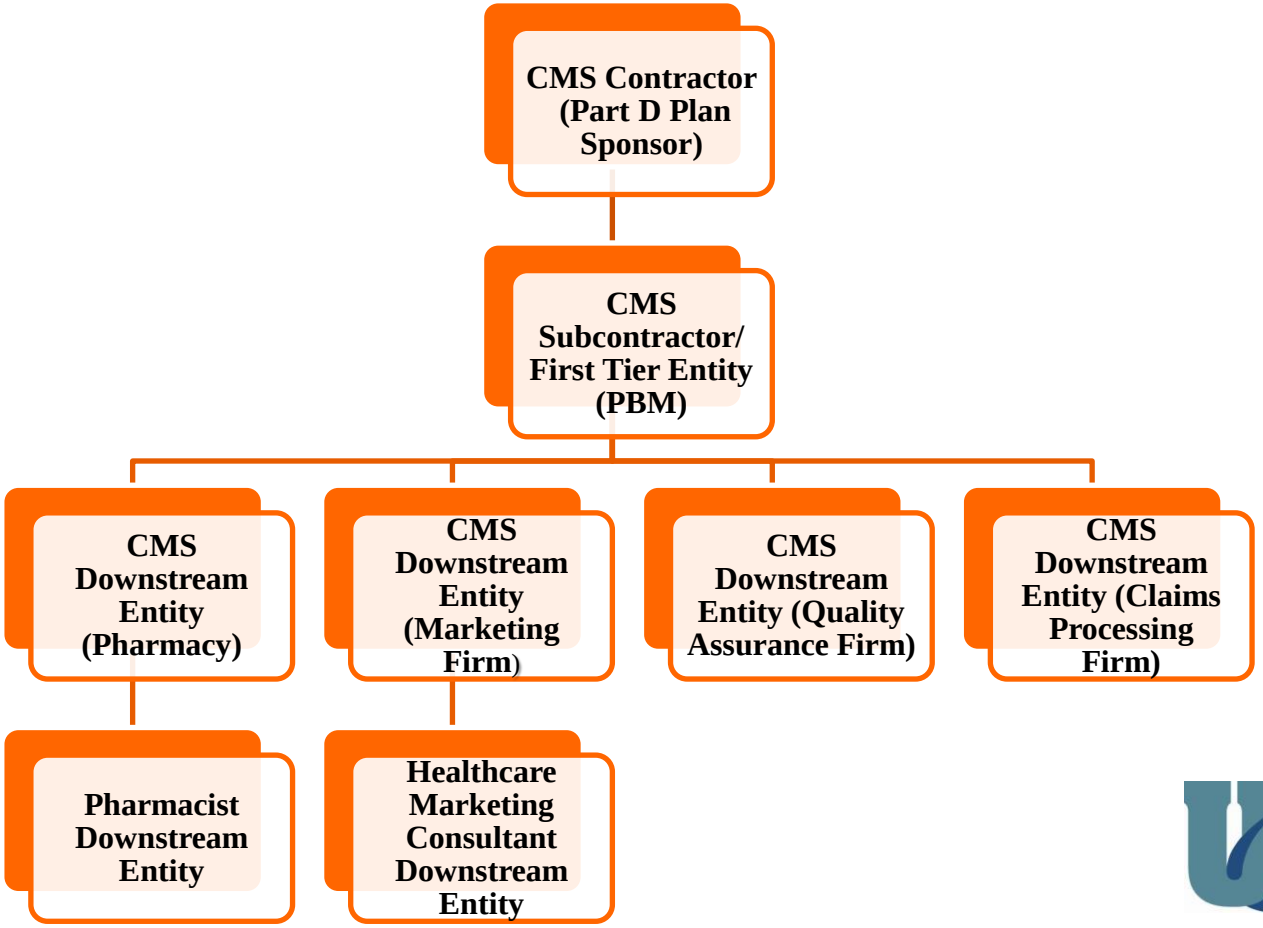
- **Plan Sponsor:** An entity that has a contract with CMS to offer one or more of the following Medicare products: Medicare Advantage (MA), Medicare Advantage Prescript Drug plans, Prescription Drug Plans (PDP), and 1876 Cost Plans.

- **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 a 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; or leases real property or sells materials to the Plan sponsor at a cost of more than $2,500 during a contract period.

First Tier and Downstream Example



Source: Based on Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 40

Requirements

- Federal law requires MA and PDP Sponsors to have a Compliance Plan.

- An MA or PDP Sponsor must:
  - Create a Compliance Plan that incorporates measures to detect, prevent, and correct fraud, waste, and abuse.
  - Create a Compliance Plan that must consist of training, education, and effective lines of communication.
  - Apply such 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.

Source: Federal Register, Part V Department of Health and Human Services Centers for Medicare and Medicaid Services 42 CFR 422 and 423, Wednesday, December 5, 2007.

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 & 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 impltementation 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.

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.

Why Focus on Fraud, Waste, and Abuse?

- Scams alone cost the health care industry more than $100 billion annually.
- Fraud, waste, and abuse programs saves Medicare dollars and that benefits taxpayers, government, health plans, and beneficiaries.
- Detecting, correcting, and preventing fraud, waste, and abuse requires collaboration between:
  - You.
  - Providers of services, such as physicians, nurse, and pharmacies.
  - State and federal agencies.
  - Beneficiaries.

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 is 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 services or actions that are inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. Examples include:
  - Charging in excess for services of supplies.
  - Providing medically unnecessary services.
  - Billing for items or services that should not be paid for by Medicare.

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.

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 70.1.4

Fraud, Waste, and Abuse *Wholesaler* Examples

- **Counterfeit, Impure Drugs through Black Market**
  - Black Market include fake, diluted, expired, illegally imported 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.

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 70.1.5

Fraud, Waste, and Abuse *Beneficiary* Examples

- **Identity Theft**
  - Using a member's I.D. 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 painkillers or other drugs. Might point to an underlying scheme (stockpiling or black market resale).

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 70.1.7

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.

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 70.1.6

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 CMS.

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 70.1.1

Fraud, Waste, and Abuse Pharmacy Benefits 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.

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006), Section 70.1.2

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.

Source: Prescription Drug Benefit Manual, Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse (Rev.2, 04-25-2006) Section 70.1.3

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 physicians 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 responsibility to report possible fraud, waste, or abuse. Report issues or concerns to:

- Your organization's compliance office or compliance hotline and/or,
- The compliance officer or compliance hotline of the applicable Plan Sponsor(s) with whom you participate; compliance hotline numbers are available on each Plan Sponsor's web sites and/or,
- 1-800-MEDICARE.

Remember:

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

Fraud, Waste, and Abuse Resources

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

- **Department of Health and 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/PhysicanSelfReferral.

Training Completed

- **Congratulations!** You've completed the compliance training.

- Please report back to your organization that you have completed this training. This step is important. Your organization is required to keep a log of who completed the training.

Attestation of Training Completion

As a first tier, downstream or related entity, _____ (Organization Name and NPI) 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 _____ (Organization Name).

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

_____ _____

Print name of organization representative Organization

_____

Representative's title

_____ _____

Signature Date signed

This attestation is valid through Dec. 31 of the calendar year.

Sign and return by mail to:
UCare
P.O. Box 52
Attention: Steve Martin
Minneapolis, MN 55440-0052

OR

Fax to UCare at: (612) 676-6597

Sample Training Log

Employee Name	Title of Training	Date	Employee Signature

UCare Contacts

- For questions or concerns, you may contact:
  - UCare's Provider Assistance Center
    - 612-676-3300 (metro area)
    - 1-888-531-1493 (toll free)
  - UCare's Corporate Compliance
    - E-mail: compliance@ucare.org