

MedicareBlueSM Solutions



Blue Cross Agent Training | Fall 2013

Medicare Compliance and Fraud, Waste and Abuse Training

Introduction



This training module consists of three parts:

- Northern Plains Alliance (NPA) Training, including a brief overview of its structure and products;
- CMS' Medicare Parts C & D Fraud, Waste, and Abuse (FWA) Training; and
- CMS' Medicare Parts C & D General Compliance Training.

All persons who provide health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements within 90 days of hire/contract and annually thereafter.

Except for slides containing the NPA logo, the slides in this presentation were taken directly from CMS' *Medicare Parts C & D Fraud, Waste, and Abuse Training* and *General Compliance Training*, issued in February 2013. Some slides were reformatted to fit this slide presentation.



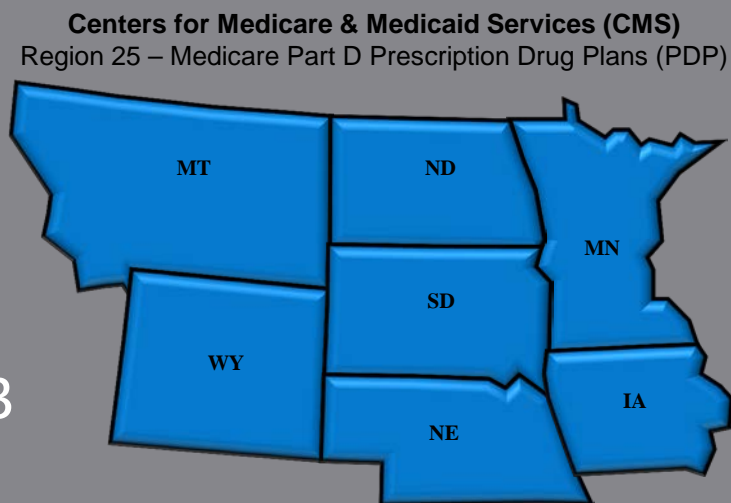
Part 1

The Northern Plains Alliance (NPA)

The Northern Plains Alliance



- Six independent Blue Cross and Blue Shield plans in our 7-state region (Medicare Prescription Drug Plan Region 25) created a contractual joint enterprise called the Blue Cross Blue Shield Northern Plains Alliance (NPA)
- The NPA plans (“Alliance Plans”) jointly sponsor MedicareBlue Rx and Group MedicareBlue Rx
 - A stand-alone Prescription Drug Plan
 - Offered to individuals and to employer/union groups
 - CMS Contract Number S5743





Part 2

Medicare Parts C & D Fraud, Waste and Abuse Training

Why Do I Need Training?



Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse.

It affects everyone. Including **YOU**.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.

Objectives



Meet the regulatory requirement for training and education

Provide information on the scope of fraud, waste, and abuse

Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse

Provide information on how to report fraud, waste, and abuse

Provide information on laws pertaining to fraud, waste, and abuse

Requirements



The Social Security Act and CMS regulations and guidance govern the Medicare program, including parts C and D.

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- Sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Where Do I Fit In?



As a person who provides health or administrative services to a Part C or Part D enrollee you are one of the following:

- Part C or D Sponsor Employee
- First Tier Entity
 - Examples: PBM, a Claims Processing Company, contracted Sales Agent
- Downstream Entity
 - Example: Pharmacy
- Related Entity
 - Example: Entity that has a common ownership or control of a Part C/D Sponsor

An Effective Compliance Program



Is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste and abuse.

Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

What are my responsibilities?



You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

How Do I Prevent Fraud, Waste, and Abuse?



Make sure you are up to date with laws, regulations, policies.

Ensure you coordinate with other payers.

Ensure data/billing is both accurate and timely.

Verify information provided to you.

Be on the lookout for suspicious activity.

Policies and Procedures



Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse.

These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with your entity's policies and procedures.

Understanding Fraud, Waste and Abuse



In order to detect fraud, waste, and abuse you need to know the Law

Criminal Fraud



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 (*18 United States Code §1347*).

- In other words...intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse



Waste

- Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.
- Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

- Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program.
- Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

Differences Between Fraud, Waste and Abuse



There are differences between fraud, waste, and abuse.

One of the primary differences is intent and knowledge.

- Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong.
- Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

Indicators of Potential Fraud, Waste and Abuse



Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in the Part C and/or Part D programs.

Key Indicators: Potential *Beneficiary* Issues



Does the prescription look altered or possibly forged?

Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?

Is the person receiving the service/picking up the prescription the actual beneficiary(identity theft)?

Is the prescription appropriate based on beneficiary's other prescriptions?

Does the beneficiary's medical history support the services being requested?

Key Indicators: Potential *Provider* Issues



Does the provider write for diverse drugs or primarily only for controlled substances?

Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?

Is the provider writing for a higher quantity than medically necessary for the condition?

Is the provider performing unnecessary services for the member?

Is the provider's diagnosis for the member supported in the medical record?

Does the provider bill the sponsor for services not provided?

Key Indicators: Potential *Pharmacy* Issues



Are the dispensed drugs expired, fake, diluted, or illegal?

Do you see prescriptions being altered (changing quantities or Dispense As Written)?

Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?

Are generics provided when the prescription requires that brand be dispensed?

Are PBMs being billed for prescriptions that are not filled or picked up?

Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

Key Indicators: Potential *Wholesaler* Issues



Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?

Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

Key Indicators: Potential *Manufacturer* Issues



Does the manufacturer promote off label drug usage?

Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

Key Indicators: Potential *Sponsor* Issues



Does the sponsor offer cash inducements for beneficiaries to join the plan?

Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?

Does the sponsor use unlicensed agents?

Does the sponsor encourage/support inappropriate risk adjustment submissions?

Reporting Fraud, Waste and Abuse



Everyone is required to report suspected instances of fraud, waste, and Abuse.



Your sponsor's Code of Conduct and Ethics should clearly state this obligation.



Sponsors may not retaliate against you for making a good faith effort in reporting.

Reporting Fraud, Waste and Abuse



Do not be concerned about whether it is fraud, waste, or abuse.

Just report any concerns to your compliance department or your sponsor's compliance department.

Your sponsor's compliance department area will investigate and make the proper determination.

Reporting Fraud, Waste and Abuse



Every MA-PD and PDP sponsor is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities.



Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting.

- Review your sponsor's materials for the ways to report fraud, waste, and abuse.



When in doubt, call the MA-PD or PDP fraud, waste, and abuse Hotline or the Compliance Department.

Reporting Fraud, Waste and Abuse



- We all have the right and obligation to report possible fraud, waste and abuse
- Report any fraud, waste or abuse issues or concerns to:
 - RAS Compliance
 - the RAS Compliance Officer, Paul Happe, at 651-662-1234, or toll free 888-878-0139 extension 21234
 - the RAS Compliance Hotline at 866-311-4216
 - your immediate supervisor, or your entity's Compliance Officer or Compliance Hotline

REMEMBER

- ❖ Reports are considered confidential
 - ❖ You may remain anonymous
 - ❖ Retaliation is prohibited when you report a concern in good faith
-
- We are committed to the compliance of our programs and strongly encourage you to report to the contacts listed on above; however, we understand that there may be circumstances in which you are not comfortable reporting to these contacts, so you may also report to:
 - 1-800-MEDICARE; or
 - The Office of the Inspector General Hotline 1-800-447-8477

Correction



Once fraud, waste, or abuse has been detected it must be promptly corrected.



Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements.

How Do I Correct Issues?



Once issues have been identified, a plan to correct the issue needs to be developed.

Consult your compliance officer or your sponsor's compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.

Laws



The following slides provide very high level information about specific laws.

- For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

Civil Fraud

Civil False Claims Act



Prohibits

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

Damages and Penalties

- Civil Money Penalty between \$5,000 and \$10,000 for each claim.
- The damages may be tripled.

Criminal Fraud Penalties



If convicted, the individual shall be fined, imprisoned, or both.

If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

Anti-Kickback Statute



Prohibits

- Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

Penalties

- Fine of up to \$25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute (Physician Self-Referral Law)



Prohibits

- A physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

Damages and Penalties

- Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a **\$15,000** fine for each service provided. Up to a **\$100,000** fine for entering into an arrangement or scheme.

Exclusion



No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

HIPAA



Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

- Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
- Safeguards to prevent unauthorized access to protected health care information.
- As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences of Committing Fraud, Waste, or Abuse



Actual consequences depend on the violation; however, the following are potential penalties:

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs



Part 3

Medicare Parts C and D Compliance Training

Why Do / Need Training?



Compliance is EVERYONE'S responsibility!

- As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare program, or the Medicare trust fund.

Training Objectives



To understand the organization's commitment to ethical business behavior

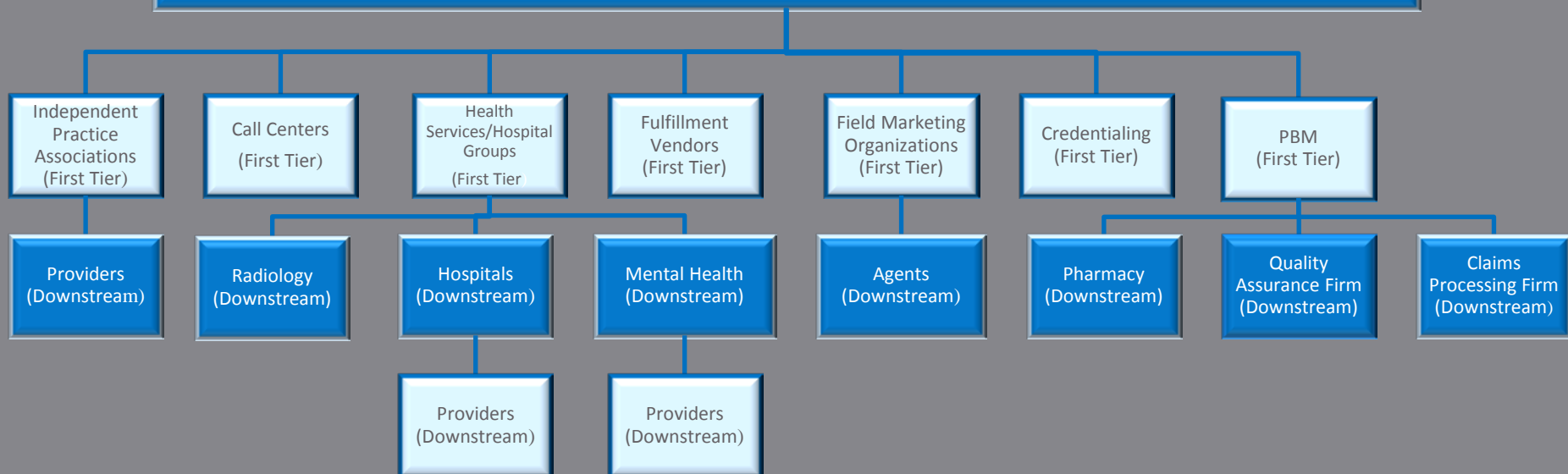
To understand how a compliance program operates

To gain awareness of how compliance violations should be reported

Where Do I Fit in the Medicare Program?



Medicare Advantage Organization, Prescription Drug Plan, and Medicare Advantage-Prescription Drug Plan

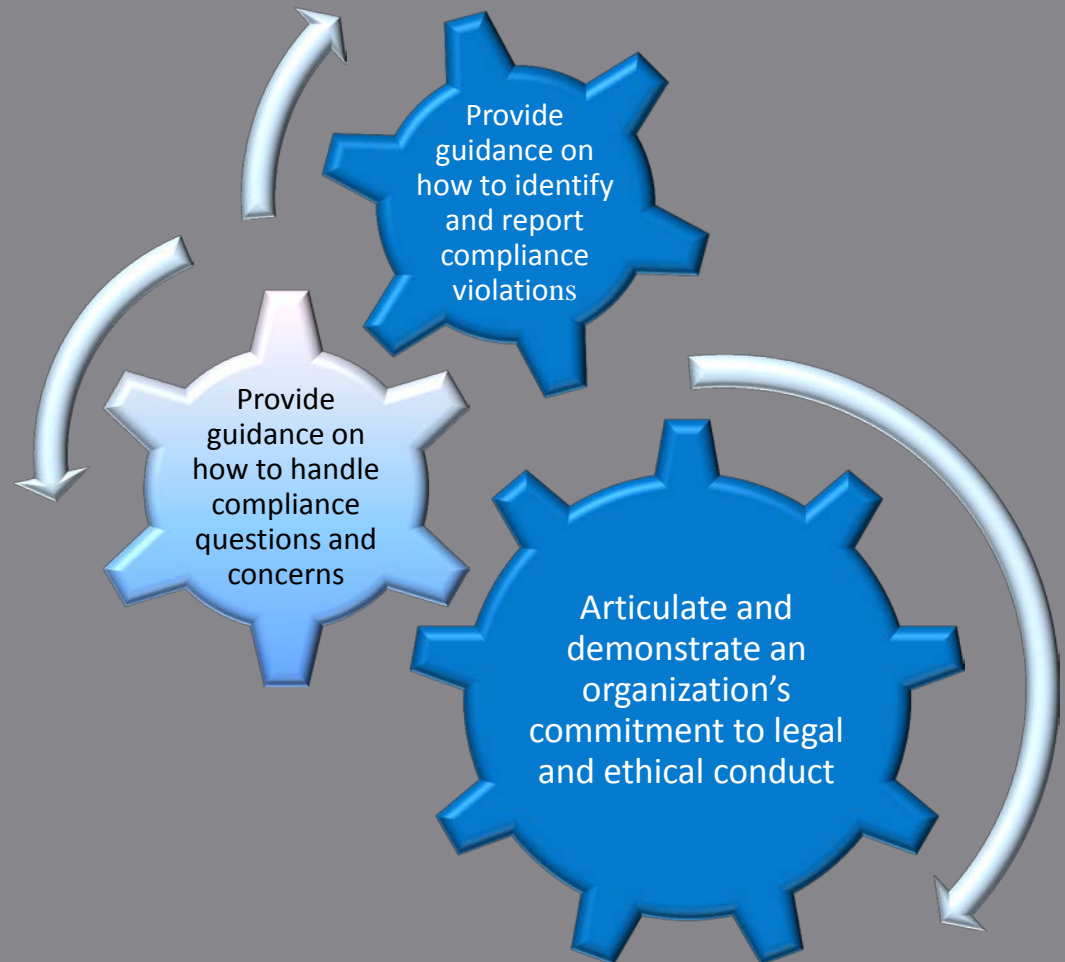


Background



CMS requires Medicare Advantage, Medicare Advantage-Prescription Drug, and Prescription Drug Plan Sponsors (“Sponsors”) to implement an effective compliance program.

An effective compliance program should:



Compliance



A culture of compliance within an organization:

- Prevents noncompliance
- Detects noncompliance
- Corrects noncompliance

Compliance Program Requirements



At a minimum, a compliance program must include the 7 core requirements:

- Written Policies, Procedures and Standards of Conduct;
- Compliance Officer, Compliance Committee and High Level Oversight;
- Effective Training and Education;
- Effective Lines of Communication;
- Well Publicized Disciplinary Standards;
- Effective System for Routine Monitoring and Identification of Compliance Risks; and
- Procedures and System for Prompt Response to Compliance Issues

Compliance Training



CMS expects that all Sponsors will apply their training requirements and “effective lines of communication” to the entities with which they partner.

- Having “effective lines of communication” means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

Ethics – Do the Right Thing!



As a part of the Medicare program, it is important that you conduct yourself in an ethical and legal manner.

- Act fairly and honestly
- Comply with the letter and spirit of the law
- Adhere to high ethical standards in all that you do
- Report suspected violations

It's about doing the right thing!

How Do I Know What is Expected of Me?



Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates.

Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations.

Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report.

RAS' Code of Conduct and Compliance Policies & Procedures (P&Ps)



RAS' Code of Conduct and P&Ps show how the NPA complies with applicable standards

NPA employees, including senior managers, are expected to conduct themselves in accordance with RAS' Code of Conduct

- First tier, downstream and related entities (FDRs) are also expected to conduct themselves in accordance with RAS's Code or to be familiar with the RAS Code and use a similar set of standards of conduct

Topics covered in our Code include, but are not limited to:

- RAS' commitment to ethics and compliance with Medicare requirements;
- conflict of interest disclosures;
- gifts and gratuities;
- interacting with government employees;
- responding to government inquiries;
- remediation and disciplinary actions; and
- how to report violations

Code of Conduct



Conflict of Interest (COI)

- A COI is any financial, business, or other relationship which puts you at odds with RAS' interests or conflicts with your assigned duties
- Any COI must be disclosed upon hiring, and annually thereafter
- Any changes to a COI Disclosure Statement during the year should be immediately reported to your local compliance team or the RAS Compliance Officer
- Upon disclosure, each COI Disclosure Statement is reviewed to determine appropriate steps to mitigate the associated risk

Gifts and gratuities, in general, may not be

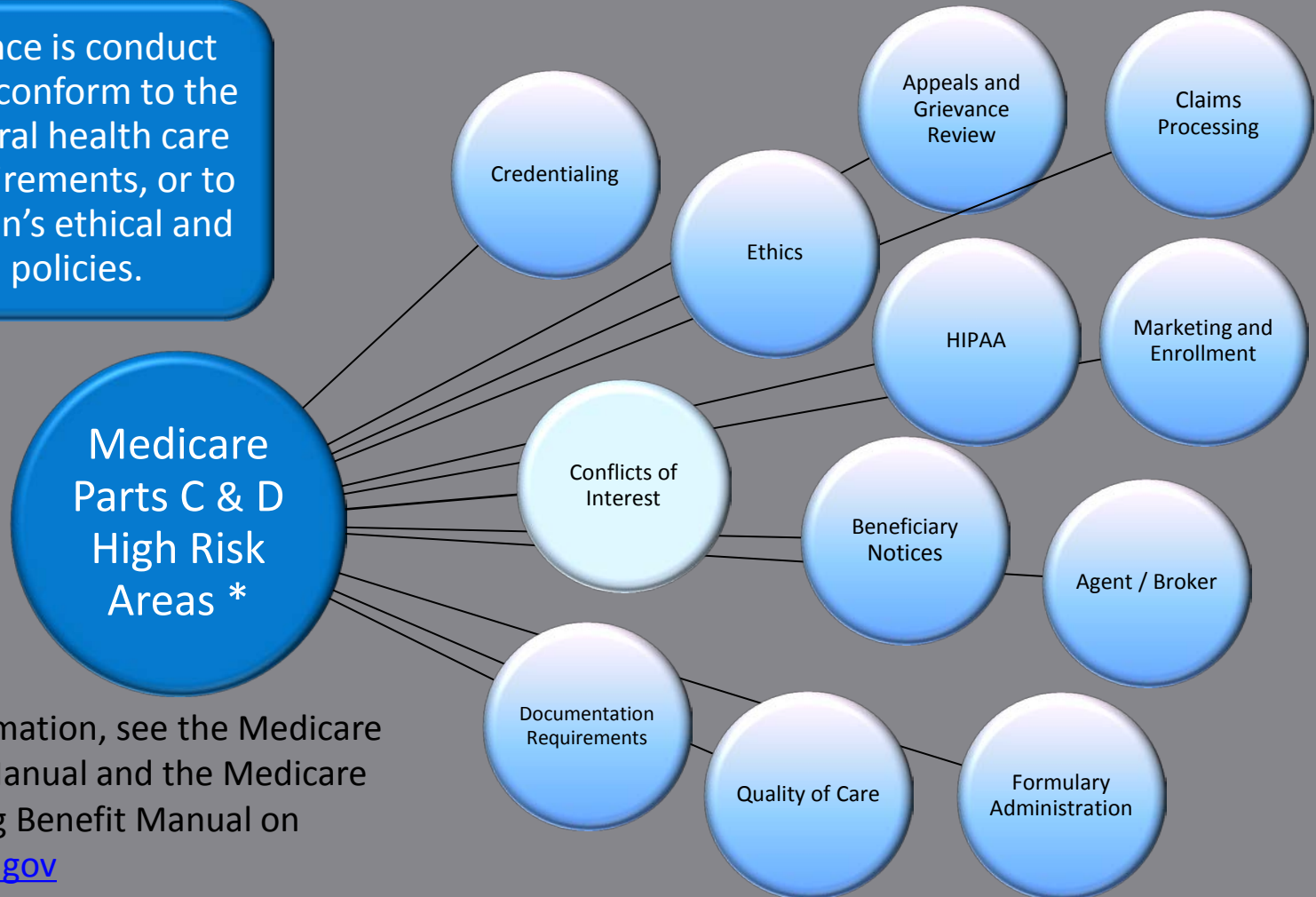
- requested or accepted from government employees or contractors
- provided or offered to government employees or contractors

The RAS Code and Compliance P&Ps are available for your review. Refer to the "Resources" section located on the MedicareBlue Online Training Center.

What Is Noncompliance?

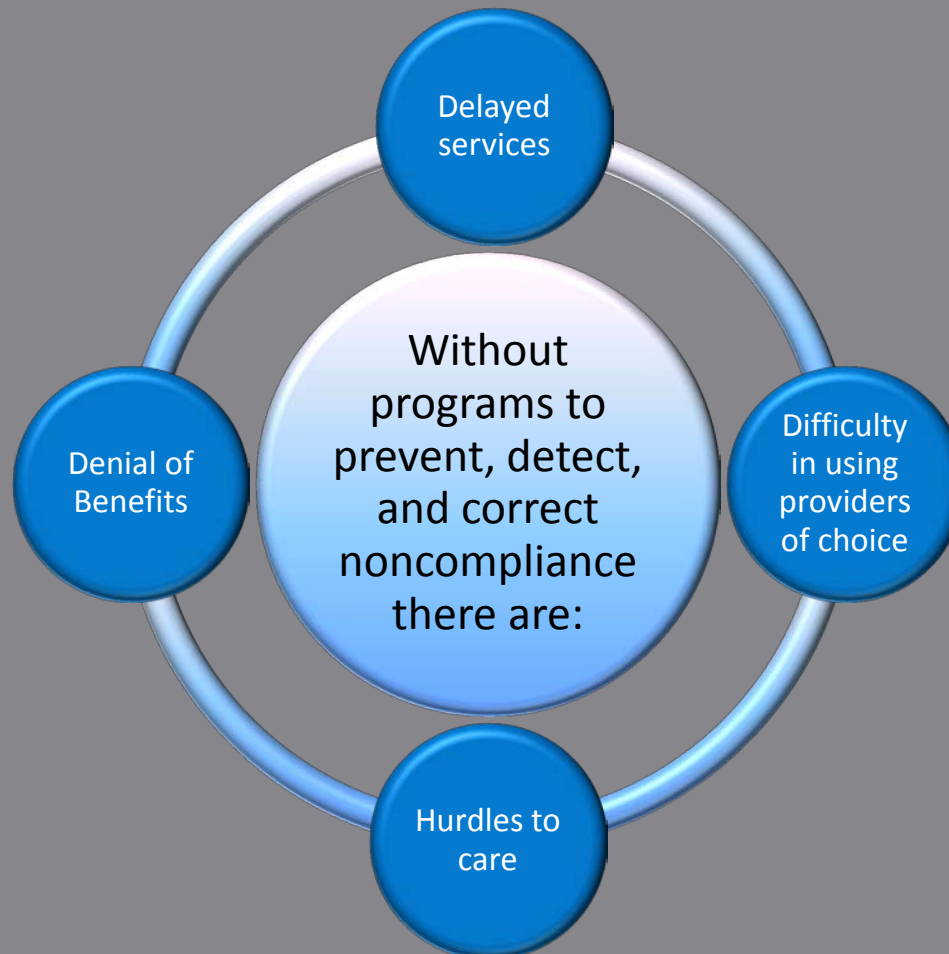


Noncompliance is conduct that does not conform to the law, and Federal health care program requirements, or to an organization's ethical and business policies.



* For more information, see the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit Manual on <http://www.cms.gov>

Noncompliance Harms Enrollees



Noncompliance Costs Money



Without programs to prevent, detect, and correct noncompliance you risk:

- Higher premiums
- Higher insurance copayments
- Lower profits
- Lower Star ratings
- Lower benefits for individuals and employers

Non-compliance affects EVERYBODY!

I'm Afraid to Report Noncompliance



There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

Each Sponsor must offer reporting methods that are:

- Confidential
- Anonymous
- Non-retaliatory

How Can I Report Potential Noncompliance?



Employees of an MA, MA-PD, or PDP Sponsor

- Call the Medicare Compliance Officer
- Make a report through the Website
- Call the Compliance Hotline

FDR Employees

- Talk to a Manager or Supervisor
- Call Your Ethics/Compliance Help Line
- Report through the Sponsor

Beneficiaries

- Call the Sponsor's compliance hotline
- Make a report through Sponsor's website
- Call 1-800-Medicare

Reporting Non-Compliance and FWA



We all have the right
and obligation to
report possible non-
compliance or FWA

Reports are
considered
confidential

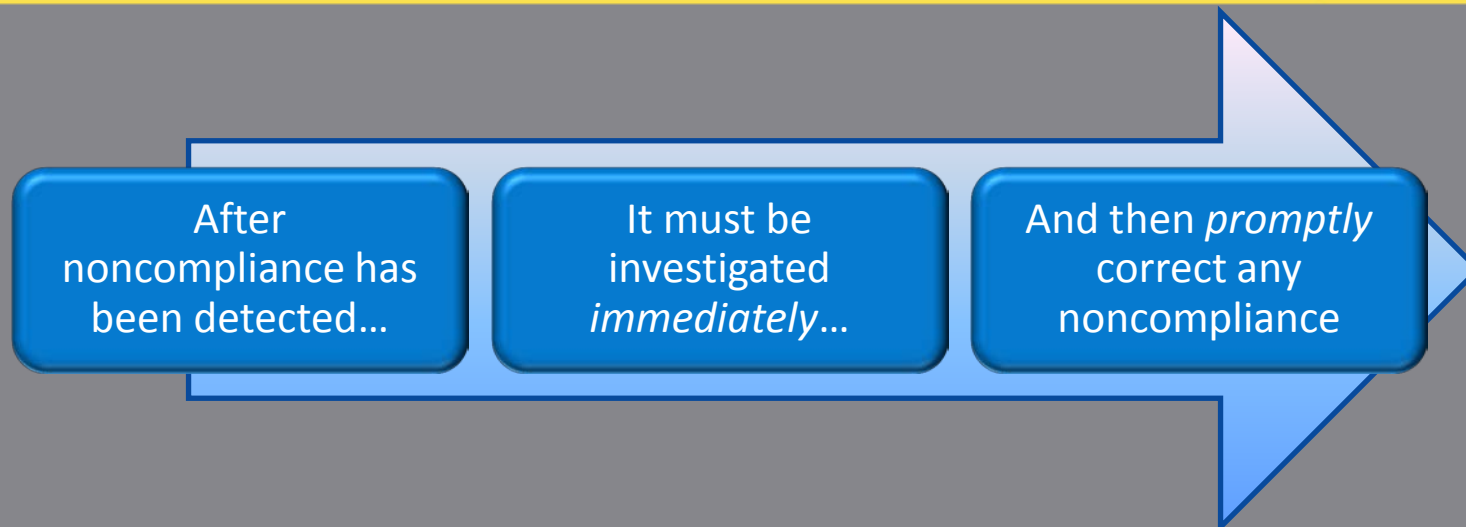
You may remain
anonymous

Retaliation is
prohibited when
you report a
concern in good
faith

Remember, you don't need to determine if an issue is non-compliance or FWA before you report it; just report any issues or concerns to:

- RAS Compliance
 - the RAS Compliance Officer, Paul Happe, at 651-662-1234, or toll free 888-878-0139 extension 21234
 - the RAS Compliance Hotline at 866-311-4216
- your immediate supervisor
- your entity's Compliance Officer or Compliance Hotline

What Happens Next?



Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
- Promotes efficiency and effective internal controls
- Protects enrollees
- Ensures ongoing compliance with CMS requirements

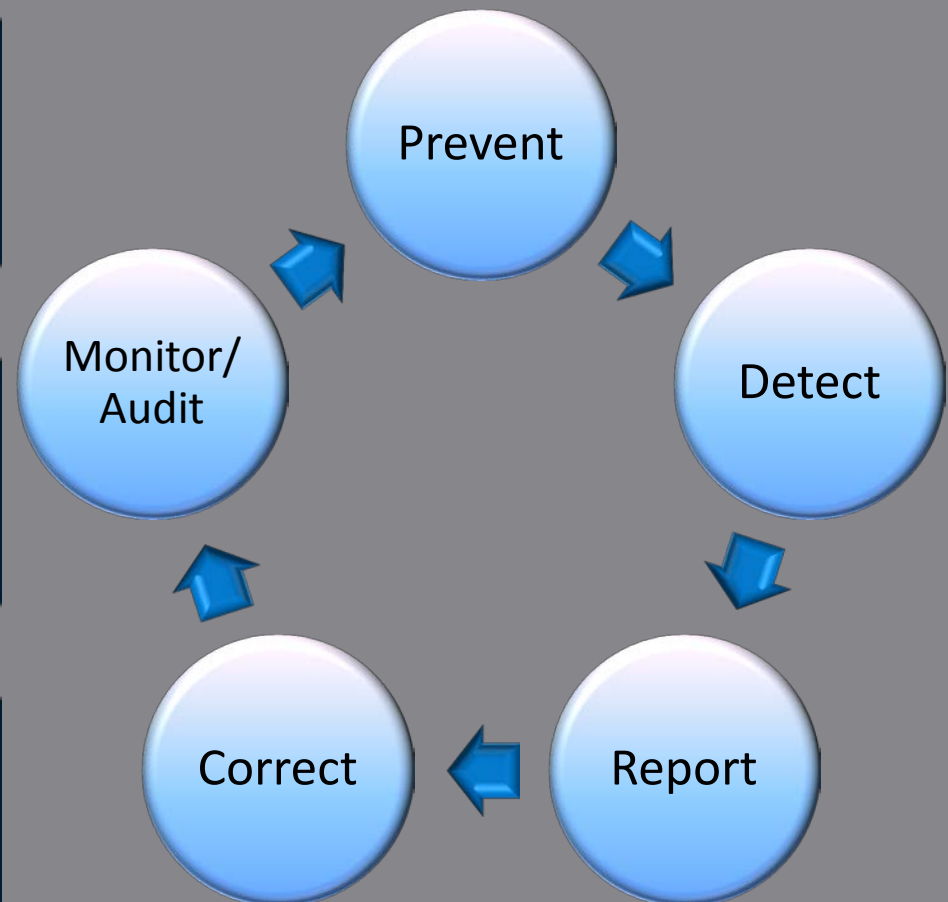
How Do I Know the Noncompliance Won't Happen Again?



Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.

Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures



Know the Consequences of Noncompliance



Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-Compliant behavior may be subject to any of the following:



Compliance is Everyone's Responsibility!!



PREVENT

- Operate within your organization's ethical expectations to PREVENT noncompliance!



DETECT & REPORT

- If you DETECT potential noncompliance, REPORT it!



CORRECT

- CORRECT noncompliance to protect beneficiaries and to save money!

What Governs Compliance?



- **Social Security Act:**
 - Title 18
- **Code of Federal Regulations*:**
 - 42 CFR Parts 422 (Part C) and 423 (Part D)
- **CMS Guidance:**
 - Manuals
 - HPMS Memos
- **CMS Contracts:**
 - Private entities apply and contracts are renewed/non-renewed each year
- **Other Sources:**
 - OIG/DOJ (fraud, waste and abuse (FWA))
 - HHS (HIPAA privacy)
- **State Laws:**
 - Licensure
 - Financial Solvency
 - Sales Agents

** 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)*

Additional Resources



- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
 - Title XVIII of the Social Security Act
 - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
 - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
 - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
 - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
 - Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
 - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
 - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
 - OIG Compliance Program Guidance for the Healthcare Industry:
<http://oig.hhs.gov/compliance/compliance-guidance/index.asp>

IMPORTANT NOTICE



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CMS' developed the *Medicare Parts C & D Fraud, Waste, and Abuse Training and General Compliance Training* to assist Medicare Parts C and D Plan Sponsors in satisfying the Compliance training requirements of the Compliance Program regulations at 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi) and in Section 50.3 of the Compliance Program Guidelines found in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

The original CMS training can be located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

