Medicare Compliance Training and Fraud, Waste, and Abuse Training

Producer Training 2012-2013
• Providence Health Plans (PHP) contracts with the Centers for Medicare & Medicaid Services (CMS) to provide Providence Medicare Advantage Plans that provide health care and prescription drug benefits to Medicare beneficiaries. As a part of these contracts, CMS requires us to oversee our first tier, downstream and related entities (FDRs) that assist us in providing services for our Medicare beneficiaries.

• Examples of FDRs include providers, agents and brokers, pharmacies, claims processors, healthcare facilities and other vendors who help us deliver benefits.
The Partnership

• As an FDR in Medicare Advantage Plans, you are an important partner in the continued success of our Medicare program. As such, Medicare requires FDRs to participate in our Medicare compliance program.
• PHP is committed to providing you with the tools needed to ensure you meet the obligations under our Medicare compliance program.
• We provide our Providence Medicare Advantage Plans Standards of Conduct, trainings, resources for reporting concerns or issues, and more, on a public website for you.
Medicare Compliance Training and Fraud, Waste, and Abuse Training

• CMS requires our FDRs to complete Medicare compliance training, and fraud, waste, and abuse training on an annual basis.
• To fulfill the compliance training requirement, we are providing this training.
• Please complete this training and the post-test following this training.
Learning Objectives

• Describe the Medicare Advantage-Prescription Drug Fraud, Waste, and Abuse (FWA) training requirements

• Recognize examples of health care FWA

• Describe steps taken to prevent and combat FWA

• Describe how you can prevent health care FWA

• Report suspected health care FWA
What is Fraud, Waste and Abuse?

• **Health Care Fraud**
  – Is intentionally, or knowingly and willfully attempting to execute a scheme to falsely obtain money from any health care benefit program (as defined in Title 18, US Code § 1347).

• **Abuse in the Health Care System**
  – Involves actions that are inconsistent with accepted, sound medical, business or fiscal practices. Abuse directly or indirectly results in unnecessary costs to the Medicare program through improper payments.

• **Waste in the Health Care System**
  – Over-utilization of services and misuse of resources.
What Does it Look Like?

• Examples of Ways that Fraud, Waste & Abuse can Occur
  – Enrolling a beneficiary without their knowledge or consent.
  – Encouraging a member to disenroll.
  – Offering beneficiaries a cash payment as an inducement to enroll.
  – Stating the agent/broker works for or is contracted with the Social Security Administration or CMS.
  – Misrepresenting the MA or Prescription Drug Plan being marketed (i.e., enrolling a beneficiary in an MA-PD plan when they wanted a PDP).
  – Discouraging a beneficiary from enrolling based on their illness profile or other discriminating factors.
Examples of Health Plan Fraud Waste and Abuse

• Failing to provide medically necessary services
• Marketing schemes such as offering beneficiaries a cash payment as an inducement to enroll in Part D
• Selecting or denying 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
The Cost of Healthcare Fraud

• The U.S. spent $2.47 trillion on health care in 2009
• Estimates suggest that 3% - 10% of health care dollars are lost to fraud¹
• Prescription drugs constitute approximately 10% of all health care spending²

²http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=56280
Risk to Individuals

• Unnecessary procedures may cause injury or death
• Falsely billed procedures 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
How does CMS combat Fraud

1. Close coordination with contractors, providers, and law enforcement agencies
2. Developing Medicare Program compliance requirements that protect stakeholders
3. Applying fair and firm enforcement policies
4. Early detection through Medical Review and data analysis
5. Effective education of health insurers, physicians, providers, suppliers, and beneficiaries
   • Among other things, the fifth strategy led to the development of this FWA training requirement.
What is PHP doing?

- Establishing a highly effective SIU
- Data Mining using sophisticated software
- Publishing internal/external reporting methods
- Educating internal and external customers
- Conducting claim reviews, pends, denials, edits, and audits
- Investigating and responding to potential fraud, waste, and abuse
What Can You Do?

- CMS requires all first tier, downstream and related entities to have appropriate policies and procedures to address fraud, waste and abuse.

  - *First tier entity* includes a broker/agent or agency that contracts directly with an MA organization [or Part D plan sponsor] to provide marketing services.

  - *Downstream entity* includes a broker/agent who contracts with an agency that has a contract with an MA organization [or Part D plan sponsor]. These contract arrangements continue down to the level of the ultimate provider of marketing services.

  - For brokers/agents this means either the agency or the agent must have such a policy.
Know Relevant Laws

• **False Claims Act:**
  – Prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or 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 federal government or its agents, like a carrier, other claims Processor, or state Medicaid program.

• **Anti-Kickback Statute:**
  – Makes it a criminal offense to knowingly or willfully offer, pay, solicit, or receive any remuneration to induce or reward referral of items or services reimbursable by a Federal health care program. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
Avoid Business with Excluded Persons

• Exclusions and Debarment
  – Individuals or entities that participate in or bill a Federal health care program may not employ or contract with an excluded or debarred individual or entity.
  – No payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed, directly or indirectly, by an excluded or debarred individual or entity.
  – Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

• Do you know someone who is excluded? Find out here:
  – OIG List of Excluded Individuals/Entities (LEIE):
    • http://exclusions.oig.hhs.gov/search.html
  – General Services Administration (GSA) database of excluded individuals/entities:
    • http://epls.arnet.gov
Report Suspected Fraud, Waste and Abuse to PHP

• For cases involving our members call us:
  – Contact Providence Health Plan’s Special Investigations Unit at (503) 574-8505 or the toll free number is 1-888-233-4101

• Or mail your letter to:
  Special Investigations Unit
  PO Box 3150
  Portland, OR  97208-3150
Confidential Methods for Reporting to Medicare/Medicaid

- 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

- Centers for Medicare & Medicaid Services (CMS)
  - By Phone: 1-800-MEDICARE (1-800-633-4227)
  - By TTY: 1-877-486-2048

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

- **Whistleblower**: An employee, former employee, or member of an organization who reports misconduct to people or entities that have the power to take corrective action.

- A provision in the False Claims Act allows individuals to:
  - Report fraud anonymously
  - Sue an organization on behalf of the government and collect a portion of any settlement that results
  - Employers cannot threaten or retaliate against whistleblowers
Summary: What you should know now.

• Understand Fraud, Waste, and Abuse definitions

• Understand how to report suspected Fraud, Waste and Abuse

• Understand relevant state, and federal Statues, and regional policies apply

• Understand what Providence Health Plans and the Government are doing to combat Fraud, Waste, and Abuse