



Network Health Insurance
Corporation (NHIC)
Contracted Entity Fraud, Waste
and Abuse Compliance
Training Program

Overview

- This Medicare Advantage and Part D Fraud, Waste & Abuse compliance training for first-tier, downstream and related entities has been developed by Network Health Insurance Corporation
- The Centers for Medicare & Medicaid Services (CMS) requires annual fraud, waste and abuse training for organizations providing health, prescription drug or administrative services to enrollees receiving Medicare Advantage without prescription drug coverage (MA) or Medicare Advantage with prescription drug coverage (MAPD) on behalf of the health plan
- As an MA and MAPD sponsor, Network Health Insurance Corporation is committed to complying with all applicable laws, regulations and guidance that govern these programs

Fraud, Waste and Abuse Defined

Fraud:

Intentional deception, misrepresentation or concealment in order to gain something of value:

- 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

Fraud, Waste and Abuse Defined

Abuse:

Excessive/improper use of services or actions that are inconsistent with acceptable business or medical practices. Refers to incidents that, although not fraudulent, may cause direct or indirect 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

Purpose & Objectives

- WHAT :** 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 annually thereafter

Definitions

- **Plan Sponsor:**

Refers to any of the following organizations offering prescription drug coverage: stand alone Prescription Drug Plan (PDP), MA or MAPD organization, and PACE organization or cost plan

- **First Tier Entity:**

A party that enters into a written arrangement, acceptable to CMS, with a Plan Sponsor to provide administrative or health care services for a Medicare eligible individual under the MA or Part D programs. Examples: Pharmacy Benefit Managers (PBMs), contracted hospitals, clinics and allied providers

Definitions (Continued)

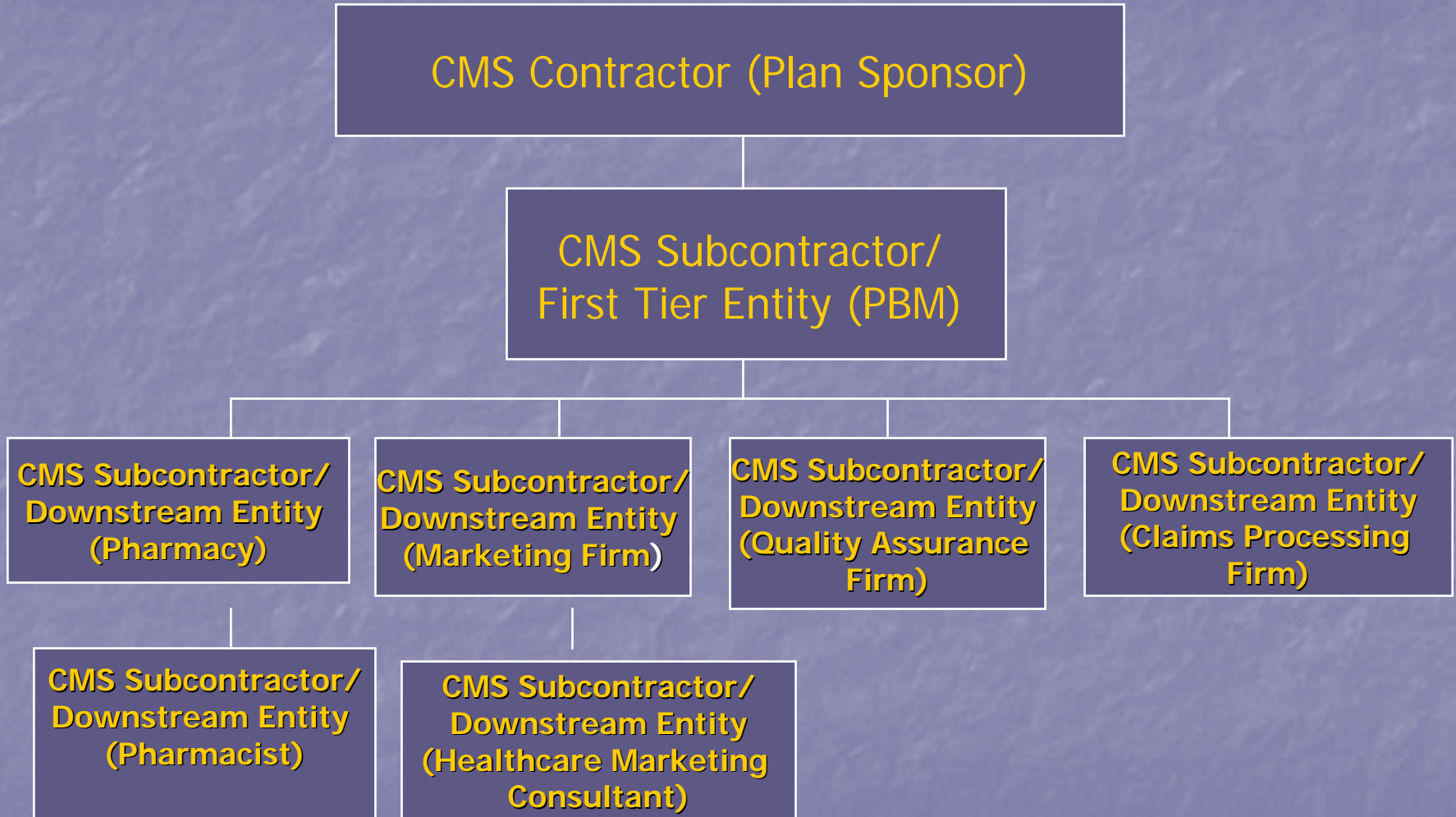
- **Downstream Entity:**

A party that enters into a written arrangement acceptable to CMS, with persons 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: pharmacies, marketing firms or claims processing firms

- **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 estate 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: CMS Prescription Drug Benefit Manual, Chapter 9 Part D Program to Control Fraud, Waste and Abuse Rev. 2, 4/25/06

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
 - Consists of training, education and effective lines of communication
 - Applies such training, education and communication requirements to all entities which provide benefits or services under MA, MAPD or PDP programs
 - Produces 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 7 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 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

Compliance Plan

Effective Compliance Plan Core Elements

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 that address dealing with individuals or entities that are excluded from participating in Medicare programs

Compliance Plan

Effective Compliance Plan Core Element 6: Effective Monitoring and 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 inquiries, 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

Compliance Plan

Effective Compliance Plan Core Element 7: Policies and Procedures

- Procedures for responding to detected offenses and corrective action
- Policies to respond to and initiate corrective action to prevent similar offenses, including a timely reasonable inquiry

Why Focus on Fraud Waste and Abuse?

- Scams alone cost the health care industry millions of dollars annually
- Fraud, Waste and Abuse programs save Medicare dollars which benefits taxpayers, government, health plans and beneficiaries
- Detecting, correcting, and preventing fraud, waste and abuse requires collaboration between:
 - Pharmacies
 - Providers of services such as physicians, nurses and pharmacies
 - State and federal agencies
 - Beneficiaries

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 for patients that are not theirs. The scripts are usually written, 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 for controlled substances or other medications

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)

Fraud, Waste and Abuse Wholesaler Examples

- **Counterfeit, Impure Drugs Through Black Market**
Black Market includes fake, diluted, expired, illegally imported drugs, etc.
- **Diverters**
Individuals who illegally gain control of discounted medicines, apply a mark-up and then move these products to small wholesalers
- **Inappropriate Documentation of Pricing Information**
Submitting false or inaccurate pricing or rebate information

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 prescriber 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

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 for CMS

Payment for Excluded Drugs

- Receiving payment for drugs not covered by the plan Sponsor's formulary

Fraud, Waste and Abuse Pharmacy Benefits Manager (PBM) Pharmacy 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 prescription as covered items

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 a physician's immediate family member has a financial relationship – unless an exception applies

Fraud, Waste and Abuse Reporting

Everyone Has the Right and Responsibility to Report Possible Fraud, Waste and Abuse - Report issues to :

- Your organization's compliance officer
- The compliance officer or compliance hotline of the applicable Plan Sponsor with whom you participate

Fraud, Waste and Abuse Reporting

Contact Information

- Compliance hotline numbers are available on each Plan Sponsor's website and/or 1-800-Medicare
- Contact Network Platinum Medicare Advantage Plans at www.nppdrugplans.com (a Fraud Waste and Abuse issues reporting link can be found in the Provider section) or contact the Network Health Insurance Corporation Medicare Compliance Administrator at 920-720-1225
- Remember: you may report anonymously and retaliation is prohibited when you report a concern in good faith

Fraud, Waste and Abuse Resources

- Federal government websites are sources of information regarding detection, correction and prevention of fraud
- Department of Health and Human Services Office of Inspector General: <http://oig.hhs.gov/fraud/asp>
- Centers for Medicare & Medicaid Services (CMS): <http://www.cms.hhs.gov/MDFraudAbuseGenInfo>
- CMS Information about the Physician Self-Referral Law: www.cms.hhs.gov/Physicianselfreferral

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