Medicare Advantage and Medicaid

General Compliance, and Fraud, Waste and Abuse Training

General Compliance Training

- Why this training?
- What will I learn?
- Fraud, Waste, and Abuse terms
- Compliance and Fraud, Waste, and Abuse Laws
- Highmark's and HVHC's expectations of Contractors, their employees and Subcontractors
- Examples of Fraud, Waste, and Abuse
- Where to ask questions or report potential Fraud, Waste and Abuse violations

Why This Training?

CMS amended its Medicare Advantage (MA) regulations to clarify the obligations of MA organizations and contractors, such as HVHC, Visionworks and Davis Vision, to include general compliance and fraud, waste and abuse training in their education plans for their providers and contractors and providers'/contractors' employees, managers, directors and subcontractors

Why This Training?

All providers, contractors, their employees and subcontractors must receive specialized training in issues posing compliance risks upon initial hire, at time of contracting and annually thereafter as a condition of employment.

Terms You Should Know

- Theft by deception – The use of deception for unlawful gain or unjust advantage.
- Fraud – Knowingly and willfully, 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, representation, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.
- Waste – the overutilization of services, or other practices that, directly or indirectly result in unnecessary costs to the Medicare program. (Misuse of Resources)

Terms You Should Know

- Abuse – includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. (Knowledge and /or Intent is not required)
- Conspiracy – An agreement between two or more persons to perform together an illegal wrongful or subversive act.
- Compliance Program – A program to ensure that HVHC, its employees and contractors comply with all applicable laws and contractual requirements, including those regulating the Medicare Advantage programs and those prohibiting waste, fraud and abuse.

Expectations

HVHC's expectations of our contractors:

- Conduct business activities and interactions with our members ethically and with integrity.
- Conduct business activities in full compliance with applicable statutory, regulatory and Medicare Program requirements.
- Maintain records that are accurate, complete and appropriately reflect treatment or interactions with members.
- Retain these records for ten years.
- Call the Highmark Integrity Office (HVHC's parent company) when you have compliance questions or concerns about potential fraud and abuse.
- Cooperate with HVHC's gifting policy.

Compliance with the Law

- The activities of HVHC, its companies and each of its providers, contractors and their employees, managers and directors must be carried out in accordance with applicable laws and related HVHC policies and procedures.
- Federal and state laws may include matters such as; submission of data, record keeping, access to records, and privacy of protected health information.
- Special provisions apply to government programs such as Medicare Advantage and Medicaid.
- Violations of laws may subject you to individual civil or criminal liability, as well as disciplinary action.

Conflicts of Interest

Conflict of interest with HVHC, its parent, Highmark and its members should be avoided.

- Conflicts of interest may arise when outside personal interests, employment, or affiliations influence or appear to influence business or medical practice decisions.
- The self-referral law (Stark) prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies. It also prohibits an entity from presenting or causing to be presented under a Medicare Advantage plan a claim for a designated health service furnished as a result of a prohibited referral.

Gifts, Gratuities and Entertainment

- Providers, Contractors and their employees may not offer any gift or entertainment that might be perceived to be primarily intended to gain favor or to compromise a business or health care decision under a Federal health care program.
  - For example, providing gifts to HVHC employees in a position to influence decisions about your participation is prohibited.
  - Offering gifts to Medicare beneficiaries may also violate the prohibition on beneficiary inducements.
- Accepting gifts from pharmaceutical companies, device manufacturers or other entities that are not incidental to a business relationship, or might be perceived to be primarily intended to gain favor or to compromise a medical or business decision must be avoided.

Compliance with Relevant Laws

Medicare Advantage organizations and Medicaid sponsors are paid in part using federal Medicare funds. Therefore, Medicare Advantage plans and contractors that furnish services are subject to laws applicable to individuals and entities receiving federal funds, including but not limited to, the Age Discrimination Act, the American with Disabilities Act, the Patient Protection and Affordable Care Act, HITECH, OIG/GSA Exclusion, applicable provisions of criminal law, the False Claims Act, Fraud Enforcement and Recovery Act (FERA) of 2009, Anti-Kickback Statute, and False Statements Statute.

HIPAA/HITECH

- The HIPAA Privacy Rule regulates the use and disclosure of Protected Health Information (PHI).
- If a covered entity discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose.
- Encryption requirements are necessary for certain electronic transactions.

Fraud, Waste, and Abuse Laws

The False Claims Act

- Prohibits knowingly presenting (or causing to be presented) to the Federal government a false or fraudulent claim for payment or approval.
- Prohibits knowingly making, 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 Government.
- Applies to claims made to Medicare Advantage Organizations and Medicaid MCOs.
- Has been interpreted to mean that it is a potential violation of federal law if a provider, contractor , or subcontractor makes little or no effort to validate the truth and accuracy of his or her statements, representations, or claims or otherwise acts in a reckless manner as to the truth.

Fraud, Waste, and Abuse Laws

Fraud Enforcement and Recovery Act (FERA) of 2009

- Amended the False Claims Act
- Eliminates need to show that the claimant intended to defraud; the only issue is whether statements were material to the payment of government funds.
- Eliminates the requirement to demonstrate a clear link between the alleged fraud and the government's payment—no need to prove that the defendant intended that the government pay or approve the false claim.

Fraud, Waste, and Abuse Laws

Anti-Kickback Statute

- Prohibits knowingly and willfully paying, offering, soliciting or receiving remuneration (anything of value)
  - to induce a referral of a patient for items or services for which payment may be made, in whole or in part, under a Federal health care program; or
  - in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program.
- There are certain exceptions specified in so-called "safe harbors" specified by law.

Fraud, Waste, and Abuse Laws

False Statements

- It is a violation of law (civil or criminal) to make a false statement to the government. It prohibits lying to or concealing information from a federal official.
- Anyone can be charged with making a false statement, who knowingly and willfully:
  - Falsifies, conceals, or covers up a material fact by any trick, scheme, or device.
  - Makes any materially false, fictitious, or fraudulent statement or representation.
  - Makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry.

Fraud, Waste, and Abuse Laws

Prohibition on beneficiary remuneration/ inducement

- Prohibits offering or providing anything of value to beneficiaries to influence them to receive services from particular providers.

Payment Prohibitions-OIG/GSA Exclusions

- Part C & D Plan Sponsors shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the DHHS OIG or GSA
- Under its contracts with the federal government, Highmark is prohibited by law from contracting or doing business with any person or entity that is currently debarred, suspended, excluded, proposed for debarment or declared ineligible to perform work under any government contract or subcontract.
- Sponsors and FDRs it contracts with must review the OIG List of Excluded Individuals and Entities and the GSA Excluded Parties List System prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member or FDR, and **monthly** thereafter, to ensure none of these persons or entities are excluded or become excluded from participation in federal programs.

Examples of Fraud, Waste and Abuse

Professional Provider/Contractor

- Making false statements.
- Misreporting/upgrading procedure codes to receive a higher payment.
- Submitting to Highmark encounter, diagnostic or other data that the Provider/Contractor knows is incorrect.
- Altering a records inappropriately.
- Accepting remuneration (payment) in exchange for services.
- Prescribing drugs inappropriately.
- Performing or ordering inappropriate or unnecessary procedures/tests.

Examples of Fraud, Waste and Abuse

Facility

- Failing to supply patient with his/her prescribed take-home drugs.
- Billing for drugs never received by the patient.
- Reselling drugs not used by patients.
- Billing for labs, procedures or services the patient did not receive.
- Drug diversion.

Examples of Fraud, Waste and Abuse

Pharmacy

- Submitting false claim for payment.
- Altering prescriptions to receive higher payment.
- Dispensing expired drugs.
- Collecting higher co-pays than allowed or charging more than the negotiated price.
- Routinely waiving co-pays.
- Manipulating the amount of out-of-pocket payments a beneficiary has made.
- Accepting illegal payments to convince beneficiaries or physicians to switch drugs.

Examples of Fraud, Waste and Abuse

Beneficiary

- Permitting another person to use their Medicare ID number/card.
- Falsifying Coordination of Benefits information to collect duplicate payments from multiple insurance plans.
- Participating in schemes that involve conspiracy between a provider/supplier and beneficiary.

Consequences of Committing Fraud, Waste and Abuse

- Administrative Recoupment/Restitution
- Criminal and/or civil prosecution
- Fines/Penalties
- Imprisonment
- Suspension/Loss of Provider License
- Exclusion from the Medicare program

Identifying Possible Fraud, Waste and Abuse

You are a vital part of the effort to prevent, detect, investigate and report possible fraud, waste and abuse issues. To do that you need to be able to identify various potential misconduct that reflects evidence of fraud, waste or abuse and report information to HVHC.

Read the following situations to better understand how to identify potential fraud, waste or abuse.

Identifying Possible Fraud, Waste and Abuse

Professional Provider/Contractor situations:

- Patient records, claim forms, and electronic claim forms, show signs of alteration to obtain higher payments.
- "Double billing" – charging more than once for the same service, for example by an individual code then again as part of an automated or bundled set of services.
- Providing false information on reports of services provided.

Identifying Possible Fraud, Waste and Abuse

Facility Situations:

- Drug Diversion – Employees taking patients' pain medications for recreational use.
- Billing for supplies, medications, procedures or lab services not provided to the patient.
- Billing for a higher level of care than the patient was receiving.

Identifying Possible Fraud, Waste and Abuse

Pharmacy Situations:

- The pharmacist offers to waive a member's co-pay if he agrees to use this pharmacy for all his prescriptions.
- A pharmacy employee bills the insurance company for a narcotic using the information from the pharmacy database. The patient never received the medication.
- "Short Filling" – A pharmacy bills for more than the amount of medication dispensed.

Identifying Possible Fraud, Waste and Abuse

Beneficiary Situations:

- A member goes to a number of different doctors for prescriptions for the same controlled substance.
- A member gets a prescription from her physician allegedly for herself intending that her husband will take it.
- Letting someone use your Medicare Number or ID card to obtain supplies, medications, procedures or lab services.

Your Involvement

HVHC and its parent, Highmark, engages in activities such as auditing, monitoring and other oversight to identify compliance issues. However, we need your assistance:

- Providers and Contractors: Establish a fraud, waste and abuse prevention policy.
- Management: Educate employees of the importance of fraud and abuse prevention.
- All Individuals: Report any potential incidents of fraud waste or abuse to HVHC and/or Highmark.

Policies Regarding Inquiries and Reports

All inquiries are confidential, subject to limitations imposed by law. If an individual is unwilling to identify himself or herself despite this protection, they may make an anonymous report. If an individual does not identify himself or herself, we ask that he or she provide some method of future contact. This will allow the internal investigator to ask follow up questions. HVHC policy prohibits intimidation or retaliation against individuals who raise questions in good faith.

How to Obtain More Information About, or Report Potential Fraud, Waste, and Abuse

- Where can a provider or contractor go to ask questions about potential waste, fraud, and abuse?
- How should a provider, contractor or their employees report potential fraud, waste, or abuse?

Follow-up

- For any credible report of potential waste, fraud and/or abuse, Highmark will undertake a reasonable investigation and may refer the issue, as appropriate, to a MEDIC, CMS or law enforcement.
- The MEDIC (Medicare Drug Integrity Contractor) is an organization assigned by CMS to manage anti-fraud and abuse efforts in the Medicare Part C and D programs. The MEDIC will further investigate referrals, develop the investigations, and make referrals to appropriate law enforcement agencies or other outside entities when necessary

General Compliance

- Sponsors must in ensure that General Compliance Training is communicated to First Tier, Downstream & Related Entities.
- HVHC's Compliance Program ensures that HVHC's employees and contractors comply with all applicable laws and contractual requirements, including those regulating the Medicare Advantage, Medicaid and Part D programs, and those prohibiting fraud, waste and abuse.

Elements of an Effective Compliance Program

1. Written Policies, Procedures and Standards of Conduct
2. Compliance Officer, Compliance Committee and High Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards
6. Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
7. Procedures and System for Prompt Response to Compliance Issues

Written Policies, Procedures and Standards of Conduct

- Policies and procedures are developed to address the Medicare C&D programs' statutory, regulatory and program requirements
- HVHC uses the Highmark *Vendor Code of Business Conduct* reflects HVHC and Highmark's commitment to comply with all applicable statutory, regulatory and program requirements.
- It is HVHC and Highmark's expectation that all vendors adopt this same commitment to compliance with these requirements.

Compliance Officer, Compliance Committee and High Level Oversight

- Compliance Officer
  - Highmark's Medicare C & D Compliance Officer is accountable to Senior Management/Governing Body and is responsible for implementation and maintenance of the Medicare C & D Compliance Program and works with HVHC's Compliance Department to ensure compliance.
- Compliance Committee
  - Senior Management of Highmark has established a Medicare C & D Compliance Committee that advises the Medicare C & D Compliance Officer and assists in implementation of the Medicare C & D Compliance Program.

Effective Training and Education

- Sponsor's employees (including temporary workers and volunteers), governing body members, as well as FDRs' employees who have involvement in the administration or delivery of Parts C & D benefits must, at a minimum, receive FWA training within 90 days of initial hiring (or contracting in the case of FDRs), and annually thereafter.
- Sponsors must ensure that general compliance information is communicated to their FDRs.

Effective Lines of Communication

- Effective lines of communication among the Compliance Office, Compliance Committee, Employees, Governing Body, and FDRs
- Communication and Reporting Mechanisms
- Enrollee Communications and Education

Effective lines of communication among the Compliance Office, Compliance Committee, Employees, Governing Body, and FDRs

- The Compliance Officer must have an effective way to communicate information to others regarding laws, regulations and guidance for sponsors and FDRs
- The dissemination of information from the Compliance Officer must be made with in a reasonable time and to all appropriate parties

Communication and Reporting Mechanisms

- Suspected compliance concerns should be reported for investigation.
- Reported concerns are confidential and may be anonymous if desired.
- HVHC and Highmark maintain a policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns

Enrollee Communications and Education

- Enrollees must be educated about indentifying and reporting potential FWA
- Education methods include direct mailings to enrollees including but not limited to: letters, pamphlets, enrollment packages the Explanation of Benefits and can be published on the sponsor websites.

Well-Publicized Disciplinary Standards

- Sponsors must have well-publicized disciplinary standards which encourage good faith participation in the compliance program by all affected individuals
- Standards must include policies that:
  - Articulate expectations for reporting compliance issues and assist in their resolution;
  - Indentify noncompliance or unethical behavior; and
  - Provide for timely, consistent, and effective enforcement of standards when noncompliance or unethical behavior is determined.

Effective System for Routine Monitoring, Auditing and Identification of Compliance Risk

- CMS requires sponsors to establish and implement an effective system for routine monitoring and identification of compliance risk
- System should include internal monitoring and audits and, as appropriate, external audits, to evaluate the sponsor's, including FDRs', compliance with CMS requirements and the overall effectiveness of the compliance program.

Contact Information

For information and inquiries or to report potential misconduct contact HVHC's Compliance Department at 210-245-2403 or The Highmark Integrity Office via mail, fax or by email to: integrity@highmark.com

- Confidential U.S. Post Office Box:
  Highmark Inc.
  Integrity Office
  P. O. Box 150
  Enola, PA 17025

- Confidential Fax
  Camp Hill Fax: (717) 302-3650
  Pittsburgh Fax: (412) 544-2475

Communication and Reporting Mechanisms (cont)

- Compliance concerns can also be reported confidentially and anonymously (if desired) by phoning:
- Michael Jensen, HVHC Compliance Director: (210) 245-2403
- Anne Crawford, Highmark Medicare C & D Compliance Officer: (412) 544-2815
- Integrity Office (800) 985-1056
- Fraud Hotline: (800)-438-2478

Thank you

You can print and complete the certificate on the following page as evidence you have completed this training.

Medicare Advantage and Part D General Compliance Training

Presented to

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For completion of the Medicare Advantage and Part D General Compliance course offered by Highmark, Inc.

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

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Date