



An Independent Licensee of the Blue Cross and Blue Shield Association

Florida Health Care Plans

Fraud, Waste and Abuse Compliance Training

INTRODUCTION

The United States spends more than \$2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates conservatively that of that amount, at least 3 percent, or more than \$60 billion, each year is lost to fraud.

Fraud, waste, and abuse increases the cost of health care and may harm patients, either by providing unneeded care or by withholding needed care. Reducing fraud, waste, and abuse would save money for Medicare, Medicaid and private payers, and ultimately improve the efficiency of the health care system.

Florida Health Care Plans (FHCP) contracts with the Centers for Medicare & Medicaid Services (CMS) to offer health and prescription drug coverage to eligible Medicare enrollees. As a Medicare Advantage (MA) Organization and Part D Plan (PDP) sponsor, FHCP is committed to following all applicable laws, regulations and guidance that govern MA and PDP programs.

As an entity that contracts with FHCP to provide health, prescription and/or other services to our Medicare Advantage and/or Part D beneficiaries, your organization must meet new CMS education and training requirements related to fraud, waste and abuse (FWA). Organizations such as yours are categorized by CMS as either a First tier, Downstream or Related Entity.

LEARNING OBJECTIVES

At the conclusion of this presentation, you will gain a better understanding of:

- Ways to identify, detect and prevent fraud, waste and abuse.
- Relevant laws and examples of potential fraud, waste and abuse.
- New fraud, waste and abuse education and training regulations applicable to Medicare Advantage and/or Part D Plans Sponsors and their health care delivery partners.
- Training requirements needed to comply with the new federal government regulations.
- Documentation and Certification requirements related to fraud, waste and abuse training.
- How to report and prevent potential fraud, waste and abuse.
- Resources that are available related to fraud, waste and abuse.

OVERVIEW OF FRAUD, WASTE & ABUSE

What is Fraud, Waste & Abuse?

- Fraud:** An intentional act of deception, misrepresentation, or concealment in order to gain something of value.
- Waste:** Over-utilization of services (not caused by negligent actions) or the misuse of resources.
- Abuse:** Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices. Refers to incidents that although not fraudulent, may directly or indirectly cause financial loss.

Who are the Fraud, Waste & Abuse Stakeholders?

- Beneficiaries/Patients
- Doctors
- Diagnostic Centers
- DME Providers
- Hospitals
- MA Organizations and Part D Sponsors
- Pharmacies
- Pharmacy Benefit Managers
- Skilled Nursing Facilities
- Any Other Entity that Provides Health Care

Examples of potential Fraud, Waste & Abuse:

Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully, and intentionally or with reckless disregard.

- Billing an insurer for non-covered services (e.g., cosmetic);
- Billing for items or services not rendered;
- Billing for work already reimbursed by another insurer;
- Overcharging for services or supplies;
- Completing an unjustified Certificate of Medical Necessity (CMN) form;
- Double billing resulting in duplicate payment;
- Misrepresenting medical diagnoses or procedures to maximize payments;
- Inappropriate use of place of service codes;
- Knowing misuse of provider identification numbers resulting in improper billing;
- Providing false employer group and/or group membership information;
- Providing medically unnecessary services;
- Routinely waiving deductibles/coinsurances;
- Submitting bills exceeding the limiting charge;
- Unbundling (billing for each component of the service instead of billing or using an inclusive code);
- Upcoding the level of service provided;
- Billing group health insurer for a known work-related injury.



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EXAMPLES OF FRAUD, WASTE & ABUSE LAWS

Laws and regulations related to MA and Part D Fraud, Waste and Abuse

FALSE CLAIMS ACT

Enacted soon after the American Civil War and since amended, the Federal False Claims (FCA) Act prohibits anyone from knowingly submitting a false claim to the government. The Act does not require proof of intent to defraud, only a reckless disregard of the truth or falsity of the information. The Act applies to all first tier, downstream, and related entities of a sponsor of a Medicare Advantage and Part D Plan.

Under the Federal False Claims Act, a person, provider, or entity is liable for up to triple damages and penalties between \$5,500 and \$11,000 for each false claim it knowingly submits or causes to be submitted to a Federal program.

Similarly, the False Claims Act imposes liability on any person, provider, or entity who submits a claim to the federal government that he or she knows (or should know) is false and knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided.

The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

Definition of False Claims Act continued:

The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital or provider that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

The FCA defines “knowing” to include not only the traditional definition but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a *qui tam*, or whistleblower, provision that allows a private individual to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries.

ANTI-KICKBACK STATUTE and CIVIL FALSE CLAIMS ACT ENFORCEMENT AUTHORITIES:

In 1972, Congress passed the anti-kickback statute which makes it illegal for providers, including doctors, to knowingly and willfully provide or attempt to provide, offer, solicit, or accept any monetary or non-monetary remuneration/payment for improperly obtaining or rewarding favorable treatment. It also prohibits the acceptance of bribes or other forms of remuneration/payments in return for generating Medicare, Medicaid or other federal health care program business. Likewise, a physician cannot offer anything of value to induce federal health care program business.

The Anti-Kickback Statute also covers and prohibits a wide variety of payments and incentives to induce referrals or the purchase of services or supplies, such as payments to a Medicare provider by a supplier to induce the purchase of Part B products from that supplier or payments or other incentives to a provider or contractor, such as a pharmacy to induce Medicare beneficiaries to enroll in a particular Medicare Advantage or Part D plan.

Since its creation, the Anti-Kickback Statute has been revised to allow more than 20 exceptions or “safe harbors” such as for investments in group practices. Still, there is room for trouble and the statute imposes stiff penalties for violations which are considered felonies.

Examples of Safe Harbors include:

- Investments in large publicly held health care companies;
- Investments in small health care joint ventures;
- Space rental;
- Equipment rental;
- Price reductions offered to health plans by providers;
- Investments in ambulatory surgical centers (ASCs);
- Specialty referral arrangements between providers and Cooperative hospital services organizations

PHYSICIAN SELF-REFERRAL PROHIBITION (STARK LAW):

The Physician Self-Referral Prohibition or Stark II Law:

The purpose of the Stark Law is to prohibit physician self-referrals. Basically, the law applies to any physician who provides health care services to Medicare, Medicaid, or other federal health program recipients/beneficiaries and says that the physician cannot refer the patient for certain designated health services to any entity with which the physician has a financial interest. That is, unless one of Stark's exceptions apply.

What is Stark III?

Stark III is actually Phase III of the physician self-referral prohibition, Phase III changes became effective December 4, 2007. This regulation provides further clarifications and modifications to Stark II, Phase II, especially regarding physicians in group practice and the relationships between physicians and hospitals.

Are Stark and the Anti-Kickback Legislation the same?

These two laws are separate but also integrated into each other. The laws refer to one another, making compliance with one contingent on complying with the other. The complications of complying with both laws are one reason to always seek legal counsel if there is any question of compliance. One big difference between the laws is that to be found guilty of an Anti-Kickback violation, prosecutors must prove criminal intent. By contrast, no proof of criminal intent is necessary to be found guilty of a Stark violation. However, both laws carry stiff penalties for violations including large monetary penalties,

exclusion from federal health care programs and in the case of an Anti-Kickback violation, imprisonment up to five years.

The Centers for Medicare and Medicaid Services provided a partial listing of Phase III changes in the final rule published in the [Federal Register of September 5, 2007](#).

In March and April 2008, *Family Practice Management* provided a two-part series titled "[Stark III: Refinement Not Revolution](#)," which provides more information on the changes of interest to family physicians.

Exceptions to Stark are many and each has its own qualifying provisions in the law.

General exceptions to both ownership and compensation arrangement prohibitions:

- Physicians' services
- In-office ancillary services
- Prepaid plans
- Services paid under ASC, DME, or hospice rates
- Academic Medical Centers
- Implants in an ASC
- Dialysis-related outpatient drugs
- Preventive services and immunizations

Other permissible exceptions are determined and specified in regulations to not pose a risk of program or patient abuse by the Secretary. General exception related only to ownership or investment prohibition for ownership in publicly traded securities and mutual funds.

Exceptions related to other compensation arrangements:

- Rental of office space or equipment
- Bona fide employment relationships
- Personal service arrangements
- Remuneration unrelated to the provision of designated health services
- Physician recruitment and retention
- Payments by a physician for items or services
- Group practice arrangements with a hospital (continuous since 1989 only)



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FIRST TIER, DOWNSTREAM & RELATED ENTITIES

How they differ:

- **First Tier Entity:** A party that enters into a written agreement with a MA Organization or Part D Plan Sponsor to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs. Examples include Individual Practice Associations (IPA's), Medical Groups, Pharmacy Benefits Manager (PBM), contracted hospitals, clinics, and allied providers.
- **Downstream Entity:** A party that enters into a written arrangement, with persons or entities involved in the MA or part D benefit, below the level of the arrangement between a MA Organization or Part D 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 MA Organization or Part D Plan Sponsor by common ownership or control and performs some of the MA Organization or Part D 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 MA Organization or Part D Plan Sponsor at a cost of more that \$2,500 during a contract.

Obligations of the first tier, downstream, and related entities:

As a first tier entity of FHCP all contracted providers are required to develop and implement programs appropriate to the size of the entity that will reduce the likelihood of behavior inconsistent with the regulations that govern today's health care landscape. Below is a guide containing information intended to assist all FHCP contracted health care providers with developing effective programs.

The burden placed upon providers by health care laws, rules, and regulations, new technologies, and other external forces is tremendous. To reduce the likelihood of inappropriate behavior, it is in the best interest of all health care organizations to have in place mechanisms that educate staff about applicable standards, identify inappropriate behavior, and prevent reoccurrence of improper conduct. Effective Compliance Plans shall:

- Formulate effective internal controls to assure compliance with Federal and State laws, rules, regulations and internal policies and procedures;
- Improve collaboration, communication, and cooperation between health care providers and payors, as well as within the organization itself;
- Improve communication with and satisfaction of patients;
- Establish the ability to more quickly and accurately react to operational concerns and the capability to effectively target resources to address those concerns;
- Demonstrate to employees and the community at large of the organization's strong commitment to honest and responsible corporate conduct;

- Increase likelihood of identification and prevention of unlawful and unethical conduct;
- Create a centralized source for distributing information on health care statutes, regulations and other program directives;
- Foster an environment that encourages employees to report potential problems;
- Establish procedures that allow the prompt, thorough investigation of possible misconduct by employees and independent contractors;
- Improve relationships with entities that oversee the organizations operations;
- Allow early detection and reporting, minimizing the loss due to inaccurate claims, thereby reducing the organization's exposure to civil damages and penalties, criminal sanctions, and administrative remedies such as program exclusion;
- Certify as to the accuracy, completeness and truthfulness of all data submitted to payers;
- Review that all individuals performing contracted activities are not excluded from participation in any government health care program; and
- Cooperate in compliance activities, including monitoring, audits, investigations and corrective actions.

First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.

What can you do?

Compliance Plan Guidance

The U. S. Department of Health and Human Services' Office of the Inspector General has developed Compliance Plan guidance for a number of different health care provider types. These guidelines can be accessed via the Internet at: <http://www.dhhs.gov/progorg/oig/modcomp>. In general each contains the following seven elements:

Policies and Standards

An organization must have established standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of inappropriate conduct.

Oversight Responsibility

Specific individual(s) within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures.

Training, Education & Communications

The organization must have taken steps to effectively communicate its standards and procedures to all employees and other agents, i.e., by requiring participation in training plans or by disseminating publications that explain in a practical manner what is required.

Effective Lines of Communication

The organization must maintain an effective line of communication between employees and the individual responsible for overseeing compliance with applicable standards and policies.

Enforcement & Discipline

The organization must have in place standards that ensure the plan is consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense. Adequate discipline of individuals responsible for an offense is a necessary component of enforcement; however, the form of discipline that will be appropriate will be case specific.

Auditing, Monitoring, and Reporting

The organization must take reasonable steps to achieve compliance with its standards. Such steps should take the form of monitoring and auditing systems reasonably designed to detect inappropriate conduct by its employees and other agents, and by having in place and publicizing a reporting system whereby employees and other agents could report inappropriate conduct by others within the organization without fear of retribution.

Response and Corrective Action

The organization must have in place a mechanism by which the organization will respond to detected offenses and prevent further similar offenses - including any necessary modifications to its plan to prevent and detect violations of law.

FHCP requires that all of its providers conduct themselves and their practices in an ethical and lawful manner. We strongly encourage all of our contracted providers to develop programs appropriate for their settings that reduce the likelihood of inappropriate conduct.



**Florida
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TRAINING AND DOCUMENTATION REQUIREMENTS

EDUCATION REQUIREMENTS

According to federal regulations, FHCP is ultimately responsible for oversight and monitoring of education and training of first tier, downstream and related entities.

How can you as one of these entities comply with the FWA education and training requirements?

Three Options

1. Provide your own training in accordance with CFR 422.504(b)(4)(vi)(c).
2. Take training from another MA and/or Part D Plan Sponsor, or other organization.
3. Complete training provided by FHCP.

Your organization must maintain internal training logs, and submit the required attestation.

Documentation Requirements

Your organization is required to complete the attestation which must be signed by an authorized representative. Upon request, your organization may be required to submit copies of training logs demonstrating that your employees received fraud, waste and abuse training.

If your organization has contracted with other entities to provide health and/or administrative services on behalf of FHCP Medicare Advantage and/or Part D beneficiaries you will need to obtain attestations from those entities that they have completed FWA training. In additions, those entities will also need to provide your organization with copies of their training logs.

ATTESTATION OF TRAINING COMPLETION

As a first, downstream or related entity, _____ (Name of Organization) attests that it has conducted appropriate education and training to identify, 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 12/5/07. *If you have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program you are deemed to have met the training and educational requirements for fraud, waste, and abuse.*

Please select the method of education and training that your organization chose to comply with the final rule requirement:

- Conducted our own education and training per CFR 422.503(b)(4)(vi)(c) or 423.504(b)(4)(vi)(c);
- Took training and education provided by Florida Health Care Plans; or
- Took training and education provided by another Medicare Advantage and Part D sponsor or another source

Signature attest that your organization has completed appropriate education and training to identify, correct and prevent potential fraud, waste and abuse, and your organization will furnish upon request to FHCP training logs to validate that training was completed.

Print Name

Organization Name

Title

Tax ID

Signature

Street Address

Date

City, State, Zip Code

Please return this completed attestation to: FHCP Compliance Department, 1340 Ridgewood Avenue, Holly Hill, FL 32117

REPORTING FRAUD, WASTE AND ABUSE

Reporting Potential Fraud, Waste & Abuse

Everyone has the right and responsibility to report possible fraud, waste, or abuse. Reports of suspected FWA should contain sufficient information to investigate the concerns raised. No adverse action or retribution of any kind will be taken against an individual because he or she, in good faith, reports a suspected FWA.

To report suspected fraud, waste and abuse to FHCP please call/contact any of the following:

FHCP's Ethics & Concerns Help Line @ (386) 615-4080 or

FHCP's Member Services Department @ 1-877-615-4022

The Centers for Medicare & Medicaid Services (CMS)

- By Phone: 1 – 800 – MEDICARE (1-800-633-4227)
- By TTY: 1 -877 -486-2048

The Office of Inspector General (OIG)

- By Phone: 1 – 800 – HHS-TIPS (1 – 800 – 447 – 8477)
- By TTY: 1 – 800 -377-4950
- By E-mail: HHSTips@oig.hhs.gov

Callers are encouraged to provide information on how they can be contacted for additional information, but they may remain anonymous if they choose. Retaliation is prohibited when you report a concern in good faith.

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 are prohibited by law from retaliating against whistleblowers.

Federal False Claims Act Protection

Employees are also protected from retaliation under United States Code [31 USC 3730\(h\)](#) for False Claims Act complaints.

(h) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

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/hotline/>

Centers for Medicare and Medicaid Services (CMS)

- [Overview State Program Integrity Support & Assistance](#)

CMS Information about the Physician Self Referral Law:

- www.cms.hhs.gov/PhysicianSelfReferral

CMS' Prescription Drug Benefit Manual

- http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FW_A.pdf

Medicare Learning Network (MLN) Fraud & Abuse Job Aid

- http://www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf