



Medicare Parts C & D Fraud, Waste, and Abuse Training and General Compliance Training



*Developed by the Centers
for Medicare & Medicaid
Services*

Updated May 2016

Important Notice

This training module consists of two parts: (1) Medicare Parts C & D Fraud, Waste, and Abuse (FWA) Training and (2) 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. This module *may* be used to satisfy both requirements.

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Part 1: Medicare Parts C and D Fraud, Waste, and Abuse Training

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FWA Training Exception - Notice

There is one exception to the FWA training and education requirement. Regulations effective June 7, 2010 implemented a “deeming” exception which exempts FDRs who are enrolled in Medicare Parts A or B from annual FWA training and education. Therefore, if an entity or an individual is enrolled in Medicare Parts A or B, the FWA training and education requirement has already been satisfied. If you are unsure if this “deeming” exception applies to you please contact your sponsor for more information.

Why Do I Need Training?

Every year *billions* of dollars are improperly spent because of Fraud, Waste, and Abuse (FWA). It affects everyone.

Including **YOU**.

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

YOU are part of the solution.

Course Objectives

When you complete this course, you should be able to correctly:

- Recognize Fraud, Waste, and Abuse (FWA) in the Medicare Program;
- Identify the major laws and regulations pertaining to FWA;
- Recognize potential consequences and penalties associated with violations;
- Identify methods of preventing FWA;
- Identify how to report FWA; and
- Recognize how to correct FWA

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)

Understanding FWA?

To detect FWA, you need to know the law.

The following screens provide high-level information the about following laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud;
- Anti-Kickback Statute;
- Stark Statute (Physician Self-Referral Law);
- Exclusion; and
- Health Insurance Portability and Accountability Act (HIPAA).

Fraud

Fraud is 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.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud and health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines up to \$250,000.

What Does That Mean?

In other words, fraud is intentionally submitting false information to the Government or a Government contractor in order to get money or a benefit.

Waste and Abuse

Waste includes 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.

Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments that the patient failed to keep;
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive higher payments.

Examples of FWA (continued)

Examples of actions that may constitute Medicare **waste** include:

- Conducting excessive office visits or writing excessive prescriptions:
- Prescribing more medications than necessary for the treatment of a specific condition; and
- Ordering excessive laboratory tests.

Examples of FWA (continued)

Examples of actions that may constitute Medicare **abuse** include:

- Billing for unnecessary medical services:
- Billing for a brand name drug when generics are dispensed;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as upcoding or unbundling codes.

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.

Laws You Need to Know About

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 False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA;
- Carries out other acts to obtain property from the Government by misrepresentation;
- Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay the Government;
- Makes or uses a false record or statement in support of a false claim;
- Presents a false claim for payment or approval.

Example:

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from Centers for Medicare & Medicaid Services (CMS);
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported;
- Failed to report the unsupported diagnosis codes to Medicare; and
- Agreed to pay \$22.6 million to settle FCA allegations.

Civil False Claims Act Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty. The Civil Monetary Penalty (CMP) may range from \$5,500 to \$11,000 for each false claim.

Civil FCA (continued)

Whistleblowers

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.

Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent but no more than 30 percent of the money collected.

Health Care Fraud Statute

The Health care Fraud Statute states that “Whoever knowingly and willfully executes, or attempts to execute, a scheme to defraud any health care benefit program shall be fined, imprisoned, or both.

Conviction under the statute does not require proof that the violator had knowledge of the law or specific intent to violate the law.

Example:

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and for drugs not dispensed;
- Pleaded guilty to health care fraud; and
- Received a 15 month prison term and was ordered to pay more than \$166,000 in restitution to the plan.

The owners of 2 Florida Durable Medical Equipment (DME) companies

- Submitted false claims of approximately \$4 million to Medicare for products that were not authorized and not provided;
- Were convicted of making false claims, conspiracy, health care fraud, and wire fraud;
- Were sentenced to 54 months in prison; and
- Were ordered to pay more than \$1.9 million in restitution.

Criminal Fraud

Persons who knowingly make false claims may be subject to:

- Criminal fines up to \$250,000;
- Imprisonment for up to 20 years; or
- Both.

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

Anti-Kickback Statute

The 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).

Example:

A radiologist who owned and served as a medical director of a diagnostic testing center in New Jersey:

- Obtained nearly \$2 million in payments from Medicare and Medicaid for MRIs, CAT scans, ultrasounds, and other resulting tests;
- Paid doctors for referring patients;
- Pleaded guilty to violating the Anti-Kickback Statute; and
- Was sentenced to 46 months in prison.

The radiologist was among 17 people, including 15 physicians, who have been convicted in connection with this scheme.

Anti-Kickback Statute Damages and Penalties

Violations are punishable by:

- A fine of up to \$25,000;
- Imprisonment for up to 5 years; or
- Both

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making a referrals 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
- A compensation arrangement (exceptions apply).

Example:

A physician paid the Government \$203,000 to settle allegations that he violated the physician self-referral prohibition in the Stark Statute for routinely referring Medicare patients to an oxygen supply company he owned.

Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark Statute are not payable. A penalty of up to a **\$15,000** may be imposed for each service provided. There may also be up to a **\$100,000** fine for entering into an unlawful arrangement or scheme.

Civil Monetary Penalties Law

The Office of Inspector General (OIG) may impose Civil penalties for a number of reasons, including:

- Arranging for services or items from an excluded individual or entity;
- Providing services or items while excluded;
- Failing to grant OIG timely access to records;
- Knowing of an overpayment and failing to report and return it;
- Making false claims; and
- Paying to influence referrals.

Example:

A California pharmacy and its owner agreed to pay over \$1.3 million to settle allegations they submitted claims to Medicare Part D for brand name prescription drugs that the pharmacy could not have dispensed based on inventory records.

Civil Monetary Damages and Penalties

The penalties range from \$10,000 to \$50,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item; or
- Of remuneration offered, paid, solicited or received.

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 OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).

The United States General Services Administration (GSA) administers the Excluded parties List System (EPLS), which contains debarment action taken by various Federal agencies, including the OIG.

Example:

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the Food and Drug Administration concerning oversized morphine sulfate tablets. The executive of the pharmaceutical firm was excluded based on the company's guilty plea. At the time the executive was excluded, he had not been convicted himself, but there was evidence he was involved in misconduct leading to the company's conviction.

HIPAA

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

HIPAA created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards help prevent unauthorized access to protected health care information. As an individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Damages and Penalties:

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

Example:

A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

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.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties;
- Civil prosecution;
- Criminal conviction/fines;
- Exclusion from participation in all Federal health care programs;
- Imprisonment; or
- Loss of provider license

Where Do I Fit in?

As a person who provides health or administrative services to a Medicare Part C or D enrollee, you are either an employee of a:

- Sponsor;
- First-tier entity (Examples: Pharmacy Benefit manager (PBM), hospital or health care facility, provider group, doctor office, clinical laboratory, customer service provider, claims processing and adjudication company, a company that handles enrollment, and membership functions, and contracted sales agent.
- Downstream entity (Examples: pharmacies, doctor office, firms providing agent/broker services, marketing firms, and call centers);
or
- Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers).

Where Do I Fit in? (continued)

I am an employee of a Part C Plan Sponsor or an employee of a Part C Sponsors first-tier or downstream entity

The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship shows examples of functions that relate to the Sponsors Medicare Part C contracts. First Tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first tier entity is an independent practice, then a provider could be a downstream entity. If the first tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

Where Do I Fit in? (continued)

I am an employee of a Part D Plan Sponsor or an employee of a Part D Sponsors first-tier or downstream entity

The Part D Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship shows examples of functions that relate to the Sponsors Medicare Part D contracts. First Tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first tier include call centers, PBMs, and field marketing organizations. If the first tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first tier entity is a field marketing organization, then agents could be a downstream entity.

What are my responsibilities?

You are a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare non-compliance.

- **FIRST**, you must comply with all applicable, statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- **SECOND**, you have a duty to the Medicare Program to report any compliance concerns, and suspected or actual violations 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 You Prevent FWA?

- Look for suspicious activity;
- Conduct yourself in an ethical manner;
- Ensure accurate and timely data/billing;
- Ensure you coordinate with other payers;
- Keep up to date with FWA policies and procedures, standards of conduct, laws, regulations, and the Centers for Medicare & Medicaid Services (CMS) guidance; and
- Verify all information provided to you.

Policies and Procedures

Stay Informed about Policies and Procedures

Familiarize yourself with your entity's policies and procedures.

Every Sponsor, First Tier, Downstream, and Related Entity (FDR) must have policies and procedures in place to address FWA. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Standards of Conduct should describe the Sponsor's expectations that:

- All employees conduct themselves in an ethical manner;
- Appropriate mechanisms are in place for anyone to report non-compliance and potential FWA; and
- Reported issues will be addressed and corrected.

Standards of Conduct communicate to employees and FDRs that compliance is everyone's responsibility, from top of the organization to the bottom.

Reporting Fraud, Waste, and Abuse

Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

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. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain and FWA Hotline.

Reporting Fraud, Waste, and Abuse (continued)

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each sponsor must accept anonymous reports and cannot retaliate against you for reporting. Review your organizations materials for the ways to report FWA.

When in doubt, call your Compliance Department or FWA Hotline.

Reporting FWA Outside Your Organization

If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General, the Department of Justice, or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

Details to include When Reporting FWA

- Contact information for the source of the information, suspects, and witnesses;
- Details of the alleged FWA;
- Identification of the specific Medicare rules allegedly violated; and
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

Where to Report FWA

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.gov
- Online: <https://forms.oig.hhs.gov/hotlineoperations>

For Medicare Parts C and D:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRX (1-877-772-3379)

For all other Federal health care programs:

- CMS Hotline at 1-800-MEDICARE (1-800-633-4227 or TTY 1-877-486-2048)

HHS and U.S. Department of Justice (DOJ): <https://www.stopmedicarefraud.gov>

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. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future non-compliance;
- Tailor the corrective action to address the particular FWA problem, or deficiency identified. Include timeframes for specific actions;
- Document corrective actions addressing non-compliance or FWA committed by a Sponsor's employee or FDR's employee and include consequences for failure to satisfactorily complete the corrective action; and
- Once started, continuously monitor corrective actions to ensure they are effective.

Corrective Action Examples

Corrective actions may include:

- Adopting new repayment edits or document review requirements;
- Conducting mandated training;
- Providing educational materials;
- Revising policies and procedures;
- Sending warning letters;
- Taking disciplinary action, such as suspension of marketing, enrollment or payment; or
- Terminating the employee or provider.

Indicators of Potential Fraud, Waste, and Abuse

Now that you know your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing fraud, waste, or abuse.

The following slides present issues that may be potential FWA. Each slide provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in the delivery of Medicare Parts C and D benefits to enrollees.

Key Indicators:

Potential Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- 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?
- Is the person receiving the medical service the actual beneficiary (identity theft)?

Key Indicators:

Potential Provider Issues

- Does the provider write prescriptions for diverse drugs or primarily only for controlled substances?
- Does the provider bill the Sponsor for services provided?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider prescribing 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?

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 Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics and then making up the prices and sending to other smaller wholesalers or pharmacies?

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?

Scenario sec1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?

Scenario #1

- A. Fill the prescription for 160
- B. Fill the prescription for 60
- C. Call the prescriber to verify quantity
- D. Call the sponsor's compliance department
- E. Call law enforcement

Scenario #1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor's compliance hotline. The sponsor will provide next steps.

Scenario #2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor's process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

Scenario #2

- A. Do what is asked of your immediate supervisor
- B. Report the incident to the compliance department (via compliance hotline or other mechanism)
- C. Discuss concerns with immediate supervisor
- D. Contact law enforcement

Scenario #2 Answer

Answer: B

Report the incident to the compliance department (via compliance hotline or other mechanism)

The compliance department is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

Scenario #3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider (“Doe Diagnostics”) has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed.

What do you do?

Scenario #3

- A. Call Doe Diagnostics and request additional information for the claims
- B. Consult with your immediate supervisor for next steps
- C. Contact the compliance department
- D. Reject the claims
- E. Pay the claims

Scenario # 3 Answer

Answers B or C

Consult with your immediate supervisor for next steps

or

Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

Scenario #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

Scenario #4

- A. Call the local law enforcement
- B. Perform another review
- C. Contact your compliance department
- D. Discuss your concerns with your supervisor
- E. Follow your pharmacies procedures

Scenario #4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.

NOTICE

This concludes the Medicare Parts C & D Fraud, Waste and Abuse training. Please select the next slide to take the Medicare Parts C & D Compliance Training.

CPHL Compliance Contact Information

- Compliance Officer contact information
 - ❖ Lfaust@centersplan.com
 - ❖ (718) 215-7000 Ext. 3104
- Anonymous hot-line number (855-699-5046)
- Anonymous Online Reporting:
www.centersplan.ethicspoint.com
- Voicemail system Ext. 2204
- Email system (compliance@centersplan.com)
- External Regulatory contact information
OIG (Office Inspector General) Fraud Hotline number
(800)-HHS-TIPS



CONGRATULATIONS!

You have completed the Centers for Medicare & Medicaid Services Parts C & D Fraud, Waste and Abuse Training. Please enter your name and date and email this confirmation page to providerservices@centersplan.com

<TYPE YOUR NAME HERE>

<Insert Today's Date>

Part 2: Medicare Parts C & D Compliance Training



*Developed by the
Centers for Medicare &
Medicaid Services*

IMPORTANT NOTICE

This training module will 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.

While Sponsors may choose to use this module to satisfy compliance training requirements, completion of this training in and of itself does not ensure that a Sponsor has an “effective Compliance Program.” Sponsors are responsible for ensuring the establishment and implementation of an effective Compliance Program in accordance with CMS regulations and program guidelines.

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



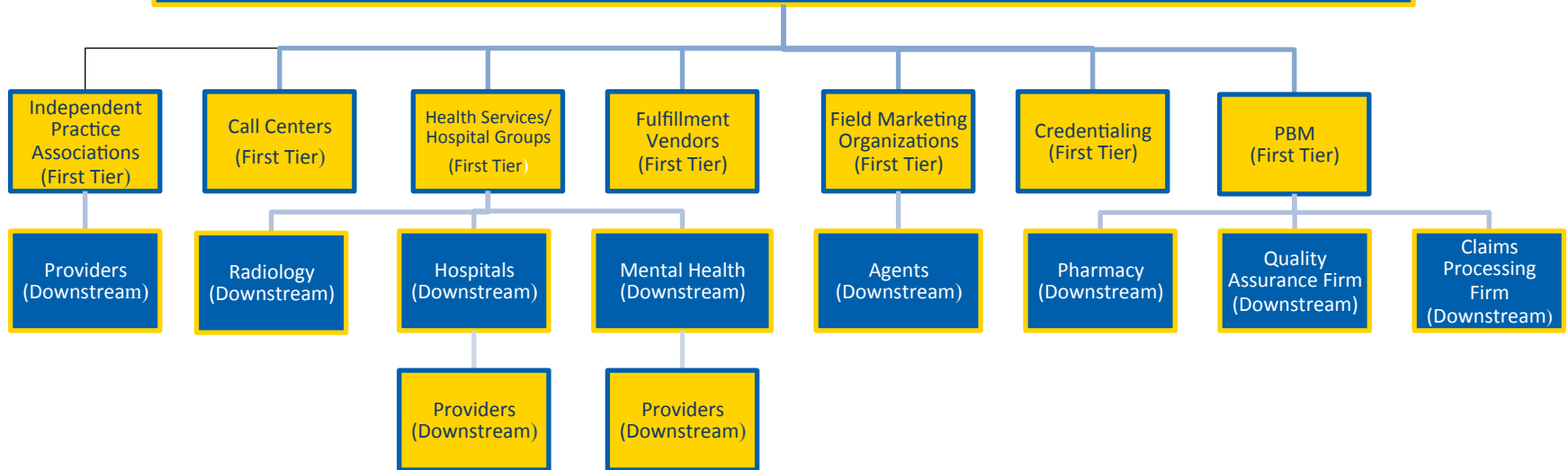
To understand how a compliance program operates



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

- The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage, Medicare Advantage-Prescription Drug, and Prescription Drug Plan Sponsors (“Sponsors”) to implement and maintain an effective compliance program.
- An effective compliance program should:



Compliance

What is an Effective Compliance Program?
An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

Prevents, detects and corrects non-compliance

Is fully implemented and is tailored to an organization's unique operations and circumstances

Has adequate resources

Promotes the organization's Standards of Conduct

Establishes clear lines of communication for reporting non-compliance

Compliance Program Requirements

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as Fraud, Waste, and Abuse (FWA). It must at a minimum, include the seven core compliance program requirements.

The Seven Core Compliance Program Requirements are:

1. **Written Policies, Procedures and Standards of Conduct**

These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct

2. **Compliance Officer, Compliance Committee and High Level Oversight**

The Sponsor must designate a compliance officer and a compliance committee that will be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

3. **Effective Training and Education**

This covers the elements of the compliance plan as well as prevention, detection, and reporting of FWA. This training and education should be tailored to the different responsibilities and job functions of employees.

Compliance Program Requirements

The Seven Core Compliance Program Requirements (continued)

4. **Effective Lines of Communication**

Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith reporting of compliance issues and First-Tier, Downstream, or Related Entity (FDR) levels.

5. **Well Publicized Disciplinary Standards**

Sponsor must enforce standards through well-publicized disciplinary guidelines.

6. **Effective System for Routine Monitoring and Identification of Compliance Risks**

Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

NOTE: Sponsor's must ensure that FDRs performing delegated administrative or health service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

7. **Procedures and System for Prompt Response to Compliance Issues**

The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

Compliance Training

Compliance Training – Sponsors and their FDRs

CMS expects that all Sponsors will apply their training requirements and “effective lines of communication” to their FDRs. 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!

Act Fairly and Honestly

Comply with all applicable laws, regulations, and CMS requirements

As a part of the Medicare program
you must conduct yourself in an
ethical and legal manner.
It's about doing the right thing!

Adhere to high ethical standards in
all that you do

Report suspected violations

How Do I Know What is Expected of Me?

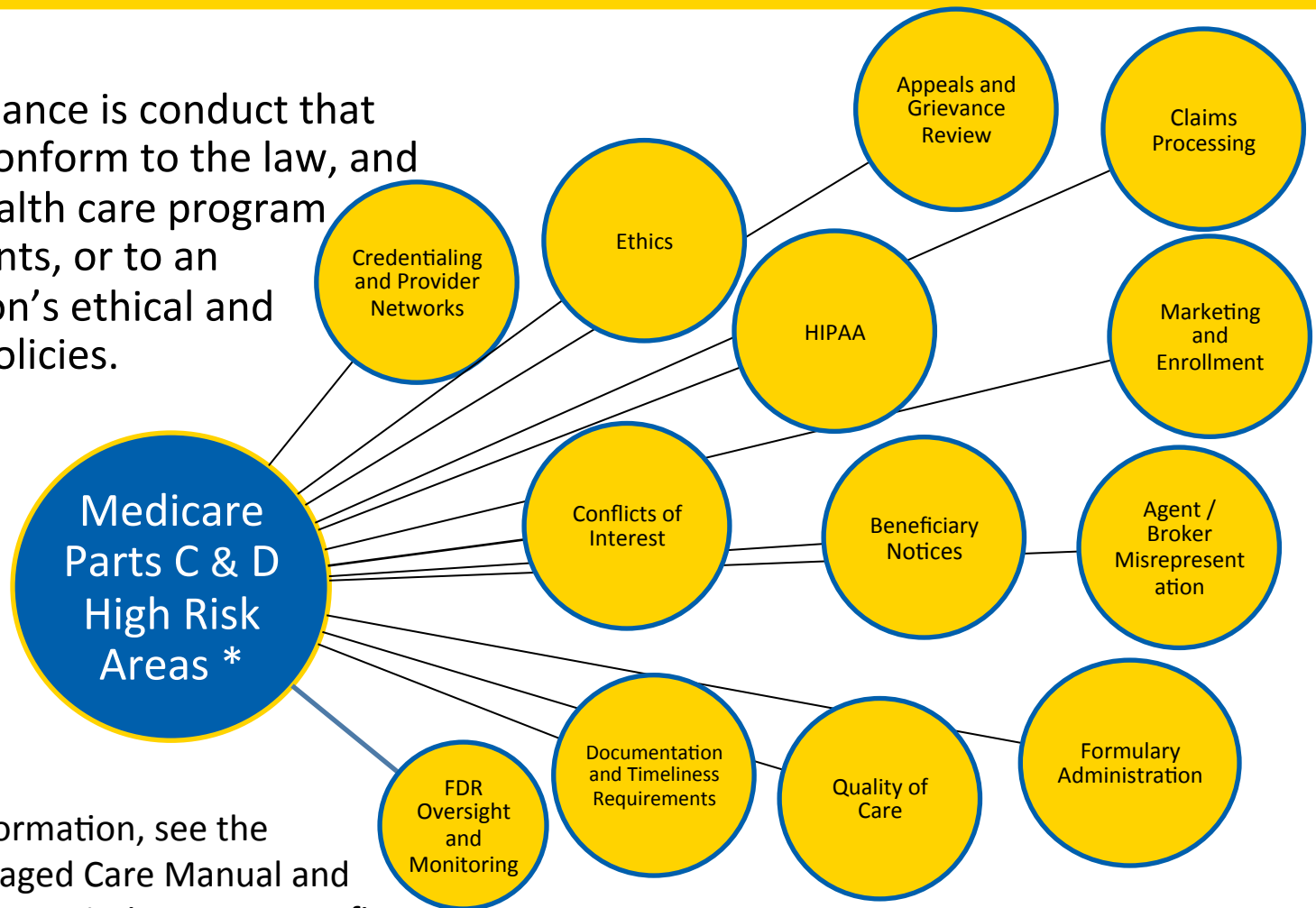
Beyond following the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation? Standards of Conduct (or Code of Conduct) state compliance expectations and the principals and values by which an organization operates. Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations. If you are not aware of your organizations standards of conduct, ask your management where they can be located.

Everyone has a responsibility to report violations of Standards of Conduct and suspected non-compliance.

An organization's Standards of Conduct and Policies and procedures should identify this obligation and tell you how to report suspected non-compliance.

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>

Know the Consequences of non-Compliance

Failure to follow Medicare program requirements and CMS guidance can lead to serious consequences including:

- Contract termination;
- Criminal penalties;
- Exclusion from participation in all Federal health care programs;
- Civil monetary penalties.

Additionally, your organization must have disciplinary standards for non-compliance behavior. Those who engage in non-compliant behavior may be subject to any of the following:

- Mandatory training or re-training;
- Disciplinary action; or
- Termination.

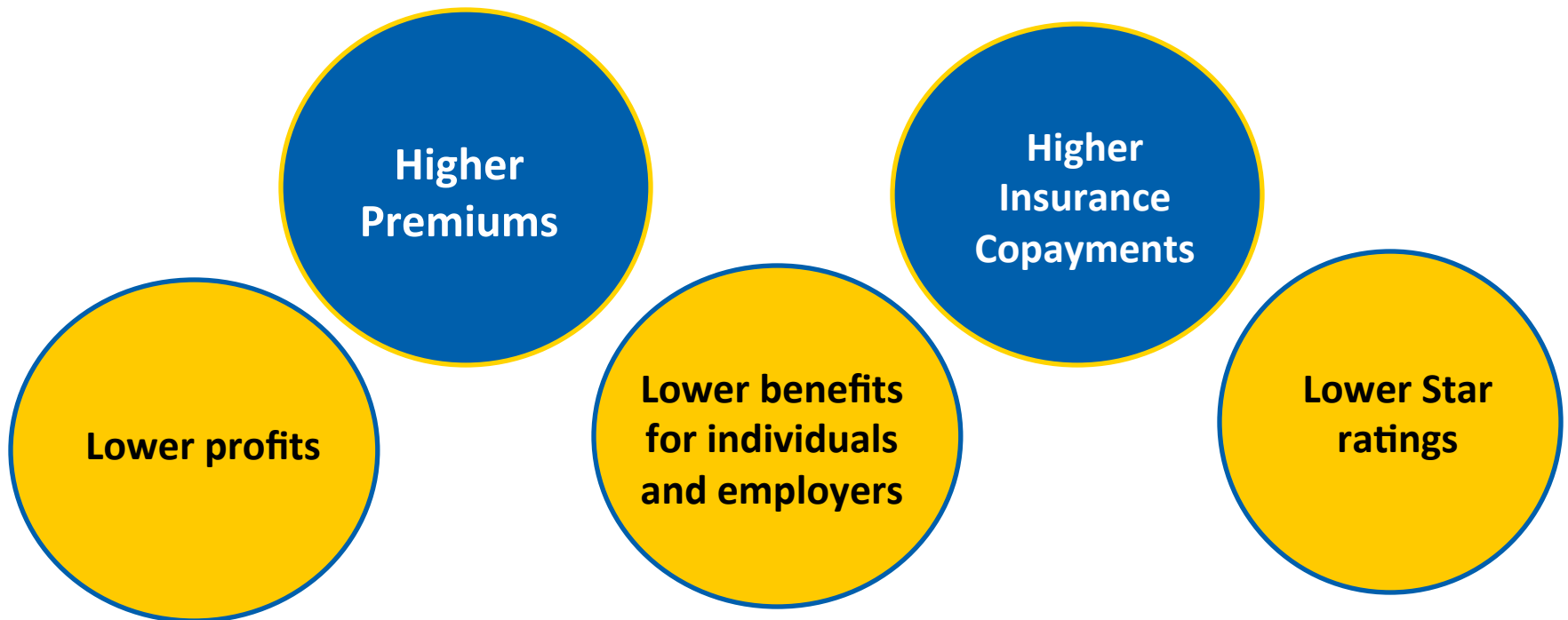
Noncompliance Harms Enrollees



Noncompliance Costs Money

Non Compliance affects EVERYBODY!

Without programs to prevent, detect, and correct non-compliance we also risk:



Don't Hesitate to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected non-compliance in good faith.

Each Sponsor must offer reporting methods that are:



How to Report Potential Non-compliance?

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

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

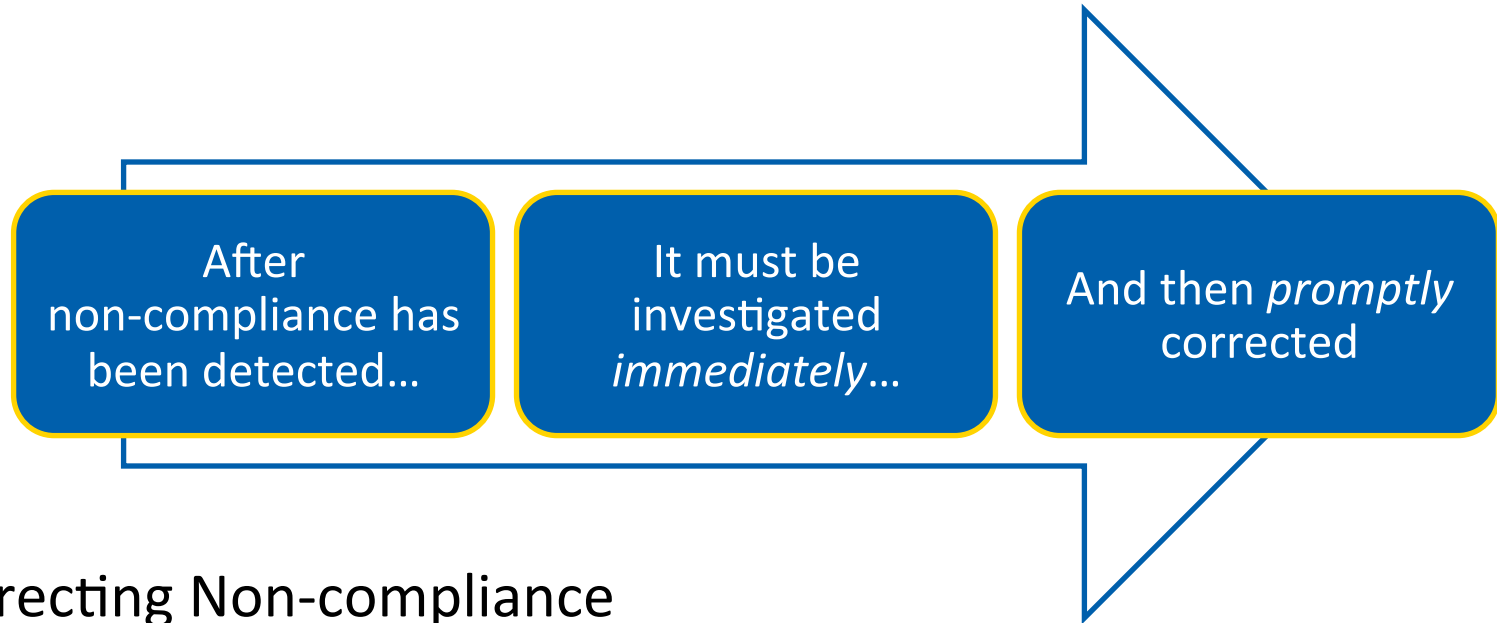
FDR Employees

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

Beneficiaries

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

What Happens After Non-Compliance is Detected?

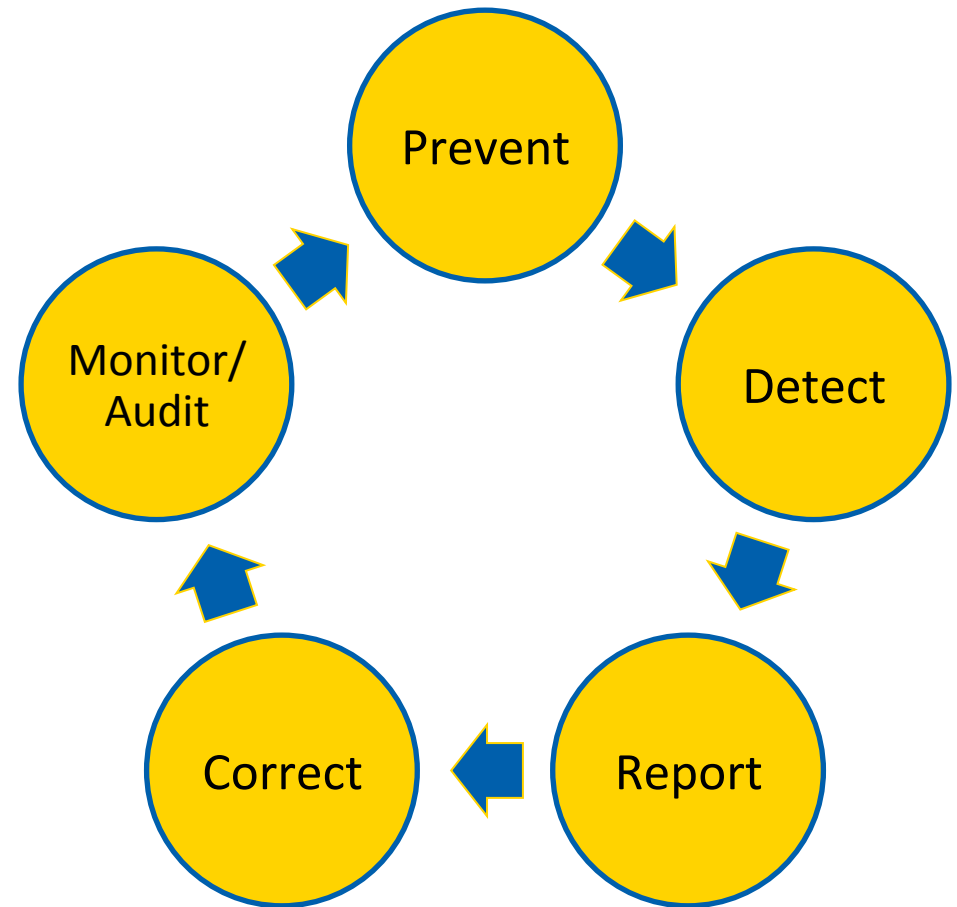


Correcting Non-compliance

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

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

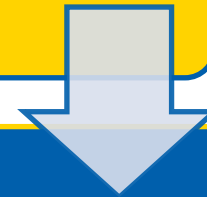
- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures



Compliance is EVERYONE'S Responsibility!!

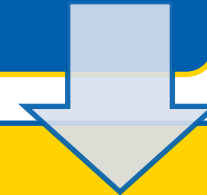
PREVENT

- 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!

Conflict of Interest

- A conflict of interest may exist where there is a private or personal interest that may influence your decisions or performance as a CPHL employee
- These might be related to outside employment, relationships with vendors, favoring friends or family, or financial gain
- Conflicts of interest may (or may appear to) influence objective professional judgment
- Disclose any potential conflicts of interest to the Compliance Department and HR.

Scenario 1

You have discovered an unattended email address or fax machine in your office which receives beneficiary appeals requests.

You suspect that no one is processing the appeals. What should you do?

Scenario 1

- A) Contact Law Enforcement
- B) Nothing
- C) Contact your Compliance Department
- D) Wait to confirm someone is processing the appeals before taking further action
- E) Contact your supervisor

Scenario 1

The correct answer is: C – Contact your Compliance Department.

Suspected or actual noncompliance should be reported immediately upon discovery. It is best to report anything that is suspected rather than wait and let the situation play out.

Your Sponsor's compliance department will have properly trained individuals who can investigate the situation and then, as needed, take steps to correct the situation according to the Sponsor's Standards of Conduct and Policies and Procedures.

Scenario 2

A sales agent, employed by the Sponsor's first-tier or downstream entity, has submitted an application for processing and has requested two things:

- i) the enrollment date be back-dated by one month
- ii) all monthly premiums for the beneficiary be waived

What should you do?

Scenario 2

- A) Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department
- B) Make the requested changes because the sales agent is responsible for determining the beneficiary's start date and monthly premiums
- C) Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions). You will not file a report because you don't want the sales agent to retaliate against you
- D) Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.
- E) Contact law enforcement and CMS to report the sales agent's behavior.

Scenario 2

The correct answer is: D - Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

The enrollment application should be processed in compliance with CMS regulations and guidance. If you are unclear about the appropriate procedure, then you can ask your supervisor or the compliance department for additional, job-specific training.

Your supervisor and the compliance department should be made aware of the sales agent's request so that proper retraining and any necessary disciplinary action can be taken to ensure that this behavior does not continue. *No one*, including the sales agent, your supervisor, or the Compliance Department, can retaliate against you for a report of noncompliance made in good faith.

Scenario 3

You work for an MA-PD Sponsor. Last month, while reviewing a monthly report from CMS, you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan.

You spoke to your supervisor, Tom, who said not to worry about it. This month, you have identified the same enrollees on the report again.

What do you do?

Scenario 3

- A) Decide not to worry about it as your supervisor, Tom, had instructed. You notified him last month and now it's his responsibility.
- B) Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.
- C) Wait until next month to see if the same enrollees are on the report again, figuring it may take a few months for CMS to reconcile its records. If they are, then you will say something to Tom again.
- D) Contact law enforcement and CMS to report the discrepancy.
- E) Ask Tom about the discrepancies again.

Scenario 3

The correct answer is: B - Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

There can be no retaliation for reports of noncompliance made in good faith. To help promote reporting, Sponsors should have easy-to-use, confidential reporting mechanisms available to its employees 24 hours a day, 7 days a week.

It is best to report any suspected noncompliance to the Compliance Department promptly to ensure that the Sponsor remains in compliance with CMS requirements. Do the right thing! Compliance is everyone's responsibility.

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>

CPHL Compliance Contact Information

- Compliance Officer contact information
 - ❖ Lfaust@centersplan.com
 - ❖ (718) 215-7000 Ext. 3104
- Anonymous hot-line number (855-699-5046)
- Anonymous Online Reporting:
www.centersplan.ethicspoint.com
- Voicemail system Ext. 2204
- Email system (compliance@centersplan.com)
- External Regulatory contact information
OIG (Office Inspector General) Fraud Hotline number
(800)-HHS-TIPS



CONGRATULATIONS!

You have completed the Centers for Medicare & Medicaid Services Parts C & D Compliance Training.

Please enter your name and date and email this confirmation page to providerservices@centersplan.com

<TYPE YOUR NAME HERE>

<Insert Today's Date>