Compliance
Fraud, Waste and Abuse

Overview

- The Center for Medicare & Medicaid Services (CMS) requires Medicare Advantage organizations (MAD) and Part A sponsors to provide annual compliance and fraud, waste and abuse training to first tier, downstream and related entities.

- As per 42 CFR Parts 422 and 423 of the Medicare Advantage Program and Prescription Drug Benefit Program the plan sponsor must:
  - Maintain appropriate oversight and develop a compliance plan that includes measures to detect, prevent and correct fraud, waste and abuse.
  - Establish fraud, waste and abuse training and effective lines of communication between the Medicare Advantage or Part D plan and its first tier, downstream and related entities.

What is a Compliance Plan?

- A compliance plan is a series of internal controls and measures to ensure the plan sponsor follows applicable laws and regulations that govern Federal programs like Medicare.
- Organizations contracting directly or indirectly with the Federal government are obliged to: Report fraud, waste and abuse
- Demonstrate their commitment to eliminating fraud, waste and abuse
- Implement internal policies and procedures to identify and combat health care fraud

WHAT ARE SPONSORS AND ENTITIES?

- **Plan Sponsor**: An entity that has a contract with CMS to offer a Medicare Advantage Plan, Medicare Prescription Drug Plans or 1876 Cost Plans.

- **First Tier Entity**: An entity that enters into a written arrangement, acceptable to CMS, with a Plan Sponsor to provide health care or administrative services for a Medicare eligible individual under the MA or Part D programs. Examples include: Pharmacy Benefits Manager (PBM) Provider Organization (IPA) Hospitals.

- **Downstream Entity**: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between the MAD and the first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

- **Related Entity**: Any entity that is related to the MAD by common ownership or control and (1) performs some of the MAD management under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAD at the cost of more than $2,500 during a contract period.

Non-Compliance

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and Timeliness requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

Definitions

FRAUD

- Fraud is the intentional misrepresentation of data for financial gain. Fraud occurs when an individual knows or should know that something is false and makes a knowing deception that could result in some unauthorized benefit to themselves or another person.

- Examples of fraud:

- Billing for services not furnished
- Billing for services of a higher rate than is actually justified
- Violations of the physician self-referral “Stark” prohibition

Definitions

ABUSE

- Abuse involves payment or services where there was no intent to deceive or misrepresent but the outcome of poor insufficient methods results in unnecessary costs to the Medicare program.

- Examples of abuse:
  - Providing medically unnecessary services
  - Billing Medicare based on a higher fee schedule than is used for patients not on Medicare

Definitions

WASTE

- Waste is the extravagant, careless or needless expenditure of healthcare benefits or services that results from deficient practices or decisions.

- Examples of waste:
  - Over-utilization of services
  - Misuse of resources

Fraud and Abuse Types

There are several common ways fraud and abuse can occur:

- False claims
- Kickbacks
- Identity theft
- Identity swapping
- Marketing schemes
- Duplicate billing

Examples of Potential Fraud

- Billing for services not rendered
- Unnecessary treatments (rent-a-patient schemes) Unbundling, upcoding
- Soliciting, altering or receiving a kickback, bribe or rebate
- Eligibility fraud (misrepresenting the date services were rendered or the individual who received the services)
- Misrepresentation of services (misrepresenting who rendered the service or billing of non-covered services as covered items)

FWA Laws - The False Claims Act

The False Claims Act makes it illegal to:

- Knowingly present, or cause to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval.
- 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.
- Conspiring to defraud the Government by getting a fraudulent claim allowed or paid.
- Has actual knowledge of the information Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

FWA Laws - The False Claims Act

The False Claims Act imposes two sorts of liability:

- The submitter of the false claim/statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the Government any damages and even if the claim is rejected.
- The submitter of the claim is liable for damages that the government sustains because of the submission of the false claim.
- Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment by the government are liable for three times the Government's damages plus civil penalties of $5,000 to $10,000 per false claim.

FWA - Anti-Kickback Statute

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully solicit, receive, offer or pay remuneration (including any kickback, bribe or rebate) in return for:

- Referrals for the furnishing or arranging of any items or service reimbursable by a Federal Health Care Program.
- Purchasing, leasing, ordering or arranging for any items or service reimbursable by a Federal Health Care Program.
- Remuneration is defined as the transfer of anything of value, directly for indirectly, overtly or covertly in cash or in kind.
- If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute.
- Criminal penalties for violating the anti-kickback statute may include fines, imprisonment, or both.

FWA Laws - Physician Self-Referral Law

The Physician Self-Referral Law (Stark Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

- Penalties for Stark Law violations include fines and exclusion from participation in all Federal Health Care Programs.

FWA Laws - Whistleblower (Qui Tam) Protection

- The whistleblower provision protects employees who assist the federal government in investigation and prosecution of violations of False Claims Act. The provision prevents retaliation against employees assisting in the investigation and prosecution. If any retaliation does occur, the employee has a right to obtain legal counsel to defend the actions.

- A whistleblower is someone such as an employee who reports suspected misconduct that would be considered an action against company policy or federal laws or regulations.

Reporting Suspected FWA

Compliance Is <u>Everyone's</u> Responsibility!

Prevent: Operate within your organization's ethical expectations to prevent non-compliance!

Detect & Report: Report detected potential non-compliance!

Correct: Correct non-compliance to protect beneficiaries and save money!

Reporting a Compliance Concern

How Do I Reach Compliance?

There are many ways to reach a team member.

- **Go to your Manager/Director**
- **Call the HOTLINE at 1-844-536-3273**
- **Visit the website at www.mycompliancereport.com**
  - **Company ID is MONH**
- **Call the System Compliance Officer at 304-598-1571**
- **Call the Privacy Officer at 304-285-2204**
- **Send an email to compliance@monhealthsys.org**

Mon Health

Compliance Contact Information

COMPLIANCE HOTLINE
844-536-3273

Compliance@monhealthsys.org
Privacy@monhealthsys.org

JANEL MUDRY
304-376-6108

LAURAN GREGORY
304-285-2204

DIERDRA HUNTER
304-285-2254