2010 Fraud, Waste, and Abuse Training Materials
UnitedHealthcare Medicare Plans

Medicare Advantage
- AARP® MedicareComplete®
- Erickson Advantage®
- Evercare®
- Sierra Spectrum®
- Sierra Village HealthSM
- SecureHorizons®
- Senior Dimensions®
- UnitedHealthcare®

Part D
- AARP® MedicareRx
- UnitedHealth Rx
- UnitedHealthcare® MedicareRx
Overview

• The Centers for Medicare & Medicaid Services (CMS) require Medicare Advantage Organizations and Part D Plan Sponsors to provide annual fraud, waste, and abuse training to their employees.

• In December 2007, CMS published a final rule that requires these organizations to apply certain training and communication requirements to all entities they collaborate with to provide benefits or services in the Part C or Part D programs.
Purpose of these training materials

• This presentation has been prepared to meet the CMS requirement for Medicare Advantage Organizations and Part D Sponsors to provide training materials to their first tier, downstream, and related entities.

• In April 2010, CMS revised the training requirements to clarify that first tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the fee-for-service Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider are deemed to have met the training and education requirements for fraud, waste, and abuse.
Purpose of these training materials

- If you or your organization qualifies for this deemed status, please retain records or evidence in your files. You may be asked to provide for audit purposes.

- If you or your organization do not qualify for this deemed status, training is required by 12/31/2010 and annually thereafter. Please maintain records of all training – this is to include dates, method of training, materials used for training, identification of trained employees via sign-in sheets or other method, etc. We, CMS, or agents of CMS may request such records to verify that training occurred.

For your reference, a sample training log has been provided at the end of this training.
Purpose of these training materials

• If you or your organization has already completed a fraud, waste, and abuse training program – whether your own program or training through another health plan sponsor – AND that training meets CMS requirements, we will accept documentation of that training in lieu of the administration of this training material.

  – Training is considered to meet CMS requirements if it includes the following items:
    • Information on the various laws and regulations related to fraud, waste, and abuse.
    • Examples of or information on how to detect fraud, waste, and abuse.
    • Information on how and where to report suspected fraud, waste, and abuse.
    • Protections for employees who report suspected non-compliance or fraud, waste, and abuse.

• If you or your organization has contracted with other entities to provide health and/or administrative services on behalf of your patients covered by UnitedHealthcare, you must provide this training material to your subcontractor for training and ensure records of training are maintained by the subcontractor and any other entity they may have contracted with to perform the service.

• All contracted entities should have policies and procedures to address fraud, waste, and abuse – including effective training, reporting mechanisms, and methods to respond to detected offenses.
Purpose of these training materials

• Contracted Entity Definitions:
  – **First Tier:** Any party that enters into a written agreement with a plan sponsor to provide administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.
    • Examples include, but are not limited to, pharmacy benefit manager (PBM), contracted hospitals or providers.

  – **Downstream:** Any party that enters into a written agreement below the level of the arrangement between a sponsor and a first tier entity for the provision administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.
    • Examples include, but are not limited to, pharmacies, claims processing firms, billing agencies.

  – **Related:** Any entity that is related to the sponsor by common ownership or control and, 1) performs some of the sponsor’s management of functions under contract of delegation; 2) furnishes services to Medicare enrollees under an oral or written agreement; or 3) leases real property or sells materials to the sponsor at a cost of more than $2500 during a contract period.
Course Outline

• The Role of CMS
• The Seven Elements of a Compliance Program
• Fraud, Waste, and Abuse Defined
• Pertinent Laws and Regulations
• Examples of Fraud, Waste, and Abuse
• Reporting Obligation and Mechanisms
• Additional Resources
The Role of CMS

• The Centers for Medicare & Medicaid Services (CMS) is a government entity within the U.S. Department of Health and Human Services.

• CMS is responsible for oversight of the Medicare Program – including health plans such as Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), and Prescription Drug Plan (PDP).

• The main office for CMS is located in Baltimore, MD. CMS has 10 Regional Offices – in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, San Francisco, and Seattle.
The 7 Elements of a Compliance Program

• Federal law requires Medicare Advantage and Part D plan sponsors to implement and maintain a Compliance Program that incorporates measures to detect, prevent, and correct fraud, waste, and abuse.

• The Office of the Inspector General (OIG) has identified seven core elements of a Compliance Program.

  1. **Written Standards of Conduct** – policies, procedures and other operating guidelines.

  2. **High Level Oversight** – designate a leader responsible for implementing and monitoring the Compliance Program.

  3. **Effective Compliance Training** – development and implementation of regular and effective training, such as this one.
The 7 Elements of a Compliance Program

• The Seven Core Elements of a Compliance Program, cont.:

4. Effective Lines of Communication – ongoing communication and awareness about compliance expectations, including a system to receive, record and respond to compliance questions or reports of potential non-compliance.

5. Disciplinary Mechanisms – policies to consistently enforce standards, including enforcement of non-retaliation standards.

6. Monitoring and Auditing – systematic checks for compliance with requirements through monitoring and auditing activities.

7. Procedures for Responding to Detected Offenses – take the reasonable steps necessary to promptly respond to and prevent further non-compliance or misconduct – including corrective action as needed.

Additional information on CMS requirements, recommendations for compliance programs and addressing fraud, waste, and abuse is available within Chapter 9 of the CMS Prescription Drug Benefit Manual. See ‘Additional Resources’ at the end of this presentation for a link.
Fraud, Waste, and Abuse Defined

• **Fraud**
  – is a false statement - made or submitted by an individual or entity - who knows that the statement is false, and knows that the false statement could result in some otherwise unauthorized benefit to the individual or entity. These false statements could be verbal or written.

• **Waste & Abuse**
  – in the context of health care claims are generally broader concepts than fraud. They include over-use of services or other provider, contractor, or member practices that are inconsistent with sound business, financial or medical practices, and that cause unnecessary costs to the healthcare system.
Pertinent Laws and Regulations

• False Claims Act
  • The federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the federal False Claims Act.
    – A “claim” is broadly defined to include any submissions that results, or could result, in payment.
    – Under the False Claims Act, ‘knowing’ or ‘known’ means that a person:
      • Has actual knowledge;
      • Acts in deliberate ignorance of truth or falsity; or,
      • Acts in reckless disregard of truth or falsity.
      • Proof of specific intent to defraud is not required to fall within the definition of knowledge.
    – Claims “submitted to the government” includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.
• False Claims Act, cont.
  – Liability can also be created by the improper retention of an overpayment.
    • The Patient Protection and Affordable Care Act of 2010 (PPACA) or Health Care Reform Law expanded a provision of the False Claims Act referred to as a reverse false claim.
    • Overpayments or any funds received or retained under Medicare or Medicaid that a person or organization is not entitled to must be reported and returned within 60 days of identification.

– Whistleblower and Whistleblower Protections:
  • The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.
  • Individuals who file such suits are known as ‘whistleblowers’. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.
Pertinent Laws and Regulations

• False Claims Act, cont.
  – Examples include:
    • A physician who submits a bill to Medicare for medical services not provided.
    • A government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements.
    • An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor.
• **Anti-Kickback Statute**
  
  – The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs.
  
  – The Anti-Kickback law is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.
  
  – The Patient Protection and Affordable Care Act of 2010 (PPACA) or Health Care Reform Law has added a provision to the Anti-Kickback Statute where ‘knowingly and willfully’ does not mean the individual had the intent to specifically violate the statute. In addition, violations of the Anti-Kickback statute can now be considered a false and fraudulent claim under the False Claims Act.
Pertinent Laws and Regulations

• **Anti-Kickback Statute, cont.**
  
  – Examples include:
    
    • A frequent flier campaign in which a physician may be given a credit toward airline frequent flier mileage for each questionnaire completed for a new patient placed on a drug company's product.
    
    • Free laboratory testing offered to health care providers, their families and their employees to induce referrals.
    
    – In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.
Pertinent Laws and Regulations

• Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  • HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to the prevention of health care fraud and abuse.
    – HIPAA Privacy
      • The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.
    – HIPAA Security
      • The Security Rule outlines specific protections and safeguards for electronic PHI.

• If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.
Pertinent Laws and Regulations

• **Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

  • HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to the prevention of health care fraud and abuse.

  – Sample HIPAA Fraud, Waste, and Abuse Provisions

    • The creation of the Fraud Abuse and Control Program for coordination of state and federal health care fraud investigation and enforcement activities.

    • The expansion of the exclusion authority so that any health care fraud conviction, even if the fraud is not related to Medicare or Medicaid, results in mandatory exclusion from participation in the Medicare or Medicaid programs.

    • The creation of a new series of federal crimes, together referred to as ‘health care fraud’, which make it a federal crime to defraud health care benefit programs – any benefit program, not just Medicare or Medicaid.
Examples of Fraud, Waste, and Abuse

• Consumer Fraud, Waste, and Abuse:
  – **Doctor Shopping** – Consumer or other individual consults with a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

  – **Prescription diversion and inappropriate use** – Consumers obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a consumer’s medications by a caregiver or anyone else.

  – **Identity Theft or Medical Identity Theft** – A person uses another person’s Medicare card to obtain services or prescriptions – OR – another person’s information is used to bill for procedures that were never done or for supplies that were never received.
Examples of Fraud, Waste, and Abuse

• **Pharmacy Fraud, Waste, and Abuse:**
  - **Prescription Drug Switching** – The Pharmacy or PBM receives a payment to switch a consumer from one drug to another or influence the prescriber to switch the patient to a different drug.
  - **Prescription Drug Shorting or Splitting** – A pharmacy or PBM mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the patient or make arrangements to provide the balance, but bills for the fully-prescribed amount. The pharmacy splits original prescription to receive additional dispensing fees.
  - **Inappropriate billing practices such as:**
    • Billing for brand when generics are dispensed
    • Billing for non-covered prescriptions as covered items
    • Billing for prescriptions that are never picked up
Examples of Fraud, Waste, and Abuse

• **Prescriber Fraud, Waste and Abuse:**
  
  – *Script mills* – Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.

  – **Illegal remuneration schemes** – Prescriber is offered, or paid, or solicits, or receives unlawful remuneration (payment or items of value) to induce or reward the prescriber to write prescriptions for drugs or products.

  – **Prescription drug switching** – Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.
Examples of Fraud, Waste, and Abuse

• Sales Agent Fraud, Waste and Abuse
  — Marketing Schemes —
  • Enrollment of a consumer in a Medicare Plan without the consumer’s knowledge or consent.
  • Offering consumers a cash payment or other reward as encouragement to enroll in a Medicare, Medicaid, or a healthcare benefit Plan.
  • Selling or marketing insurance without a license.
  • Using consumer information supplied through a third party (another agent, friend, etc) to market Medicare plans.
  • Agents splitting commissions or agent referral fees.
  • Misrepresenting themselves as a representative of the government (Medicare / Social Security / Federal Government).
Reporting Obligation and Mechanisms

• If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it.

• Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

• Contracted network providers can call the main phone number associated with the secure website(s) where they transact administrative activities for their patients:

  – OxfordHealth.com – (800) 666-1353
  – PacifiCare.com – (888) 866-8297
  – UnitedHealthcareOnline.com – (877) 842-3210
  – Health Plan of Nevada (healthplanofnevada.com) and Sierra Health and Life Insurance Company (sierrahealthandlife.com) – (702) 242-7088
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• Contracted network providers can call the main phone number associated with the secure website(s) where they transact administrative activities for their patients:

  – AmeriChoice.com –
  – APIPA AZ – (800) 445-1638
  – New Jersey – (888) 362-3368
  – New York – (866) 362-3368
  – Tennessee – (800) 690-1606
  – Wisconsin – (877) 651-6677

  – Great Lakes Health Plan (glhp.com) – (800) 903-5253

  – Unison (unisonhealthplan.com) –
  – Ohio – (877) 886-4766
  – Pennsylvania – (412) 858-4000
  – Delaware – (302) 729-4200
  – Washington D.C. – (877) 856-6444
  – South Carolina – (803) 798-6210
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• Contracted vendors or delegates can call the UnitedHealthcare Medicare Solutions Vendor Fraud Hotline – (877) 401-9430
Additional Resources

• CMS’ Prescription Drug Benefit Manual – Chapter 9

• Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504)

• Office of the Inspector General
  – http://www.oig.hhs.gov/fraud.asp

• Medicare Learning Network (MLN) Fraud & Abuse Job Aid
# Sample Training Log

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