



CMS Fraud, Waste, and Abuse Training and General Compliance Training



*Developed by the Centers
for Medicare & Medicaid
Services*

Issued: February, 2013

Important Notice

This training module consists of two parts: (1) CMS Fraud, Waste, and Abuse (FWA) Training and (2) CMS General Compliance Training. All persons who provide health or administrative services to federally-funded enrollees must satisfy general compliance and FWA training requirements. This module *may* be used to satisfy both requirements.



Part 1: CMS Fraud, Waste, and Abuse (FWA) Training



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Why Do I Need Training?

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including **YOU**.

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

YOU are part of the solution.

Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse (FWA)
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

Requirements

The Social Security Act and CMS regulations and guidance govern federally-funded healthcare programs.

- CareOregon, as a federally-funded healthcare sponsor, has an effective compliance program which includes measures to prevent, detect and correct non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- CareOregon has effective FWA 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)6666

Where Do I Fit In?

As a person who provides health or administrative services to a federally-funded enrollee you are either:

- Part C or D Sponsor Employee
- First Tier Entity
 - Examples: Pharmacy Benefit Manager (PBM), a Claims Processing Company, contracted Sales Agent
- Downstream Entity
 - Example: Pharmacy
- Related Entity
 - Example: Entity that has a common ownership or control of a Part C/D Sponsor

What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow CareOregon's Code of Conduct that articulates your and the organization's commitment to standards of conduct and ethical rules of behavior.

An Effective Compliance Program

- Is essential to prevent, detect, and correct non-compliance as well as fraud, waste and abuse.
- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Prevention

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.

Policies and Procedures

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with CareOregon's policies and procedures.

Detection

Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse
you need to know the **Law**

Criminal FRAUD

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.

18 United States Code §1347

What Does That Mean?

Intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Waste and Abuse

Waste: overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to any federally-funded healthcare 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 any federally-funded healthcare 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.

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.

Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to CareOregon's Compliance Department and we will investigate and make the proper determination.

Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in federally-funded healthcare programs.

Key Indicators: Potential Beneficiary Issues

- Does the prescription look altered or possibly forged?
- 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?
- Does the beneficiary's medical history support the services being requested?

Key Indicators: Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?

Key Indicators: Potential Provider Issues

- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

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?

Key Indicators: Potential Pharmacy Issues

- 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 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?

How Do I Report Fraud, Waste, or Abuse?

Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and Abuse. CareOregon's Code of Conduct clearly state this obligation. CareOregon may not retaliate against you for making a good faith effort in reporting.

Reporting Fraud, Waste, and Abuse

Every federally-funded healthcare program is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review CareOregon's Prevention, Detection, and Reporting of Fraud, Waste, and Abuse Policy and Procedure for the ways to report fraud, waste, and abuse.

When in doubt, call the CareOregon Compliance Department.

Correction

Correction

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures CareOregon is 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 Katherine Ellis, CareOregon'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.

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 Fraud

Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between \$5,000 and \$10,000 for each claim.

Criminal Fraud Penalties

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

18 United States Code §1347

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).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

Fine of up to \$25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute (Physician Self-Referral Law)

Prohibits a physician from making a referral 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 with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark are not payable. Up to a **\$15,000** fine for each service provided. Up to a **\$100,000** fine for entering into an arrangement or scheme.

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 Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

HIPAA

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

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

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences

Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs

Quiz and Self-Assessment



Scenario #1

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 process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

Scenario #1

- 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 #1 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.

CareOregon may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

Scenario #2

You are in charge of payment of claims submitted from providers. You notice a certain provider 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 providers and realize that these claims far exceed any other provider that you reviewed.

What do you do?

Scenario #2

- A. Call the provider 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 # 2 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 3

True or False?

The Centers for Medicare & Medicaid Services (CMS) is the part of the Federal government that oversees federally-funded healthcare program.

Scenario 3 Answer

True.

CMS is an entity within the U.S. Department of Health and Human Services that is responsible for oversight of any federally-funded healthcare program, including the Medicare Program.

Scenario 4

True or False?

If I identify or am made aware of potential misconduct or a suspected fraud, waste, or abuse issue, I should keep this information to myself and mind my own business.

Scenario 4 Answer

False.

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.

Reporting Potential FWA

If you, or anyone, identifies potential FWA, contact Katherine Ellis, CareOregon's Compliance Officer at (503) 416-5921.

CareOregon's detailed Fraud, Waste, and Abuse Policies and Procedures are in DMS. Go to CO Documents, Policies and Procedures [080 Fraud, Waste, and Abuse – Prevention, Detection and Reporting](#).

Calling the toll free hotline at 888-331-6524 or filing a report at www.ethicspoint.com are two easy ways to report potential FWA and to do so anonymously, if you wish.

Below are examples of information that will assist CareOregon with an investigation:

- Contact information (e.g. Name of individual making the allegation, address, telephone number).
- Type of item or service involved in the allegation.
- Place of alleged offense.
- Nature of the allegation(s).
- Timeframe of the allegation(s).
- Who is involved in the alleged offense.
- Has a police report been filed, what is the police report number and the city, county, and state the report was filed in and the name of the responding police officer.

As situations warrant, CareOregon may make referrals to appropriate law enforcement.

Summary

- CareOregon management and Board of Directors support the compliance program.
- Compliance violations and FWA must be reported to the Compliance Officer or reported via EthicsPoint.
- Employees are aware of pertinent laws and regulations regarding FWA.
- Employees are required to disclose to Human Resources any debarment or exclusion from federal healthcare programs.

Who is the Compliance Officer?

Who: Katherine Ellis
Where: 8th Floor
Phone: (503) 416-5921
E-mail: Ellisk@careoregon.org



CONGRATULATIONS!

You have completed the Centers for Medicare & Medicaid Services Fraud, Waste and Abuse Training

NOTICE

This concludes the CMS Fraud, Waste and Abuse training. Please continue to the next slides to take CMS Compliance Training.



Part 2: CMS Compliance Training



*Developed by the
Centers for Medicare &
Medicaid Services*

IMPORTANT NOTICE

This training module will assist federally-funded 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.

Why Do / Need Training?

Compliance is EVERYONE'S responsibility!

As an individual who provides health or administrative services for federally-funded healthcare program enrollees, every action you take potentially affects the enrollees and any federally-funded healthcare programs.

Training Objectives



To understand CareOregon's commitment to ethical business behavior

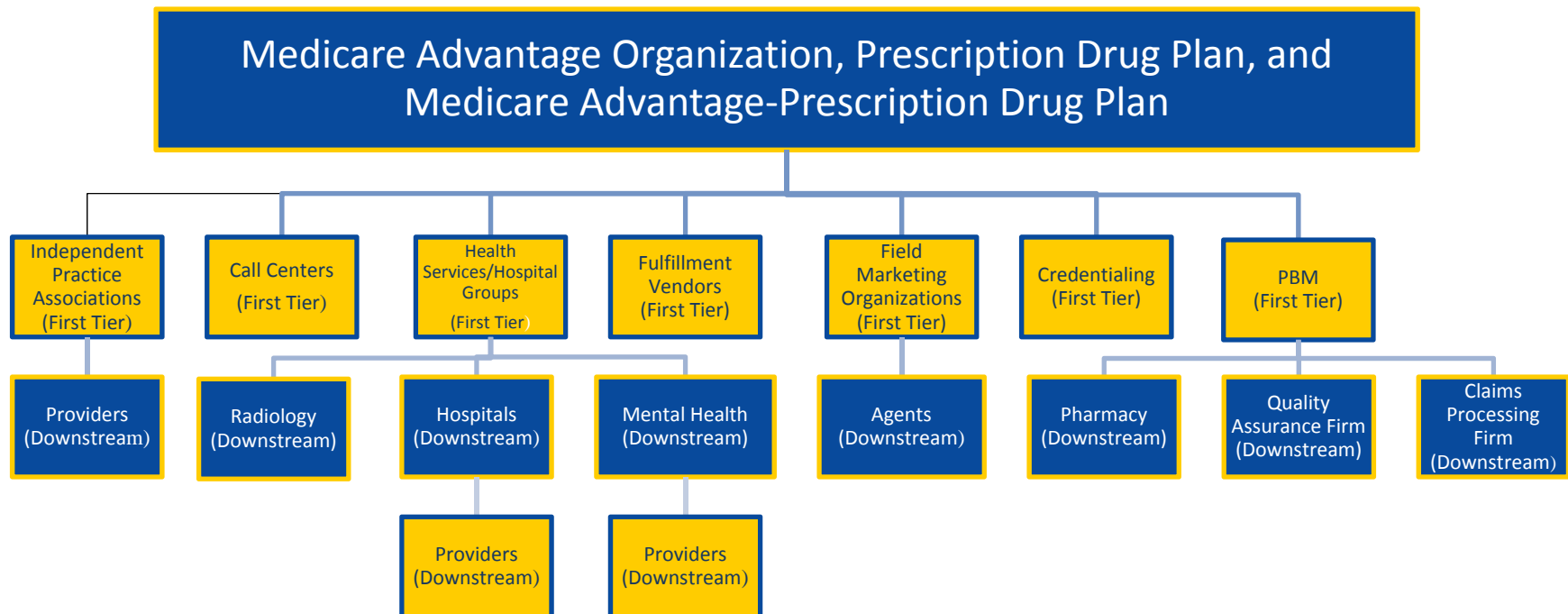


To understand how a compliance program operates



To gain awareness of how compliance violations should be reported

Where Do I Fit in the Federally-Funded Healthcare Program?



Background

- CMS requires any federally-funded healthcare program Sponsors (“Sponsors”) to implement an effective compliance program.
- An effective compliance program should:



Compliance

A culture of compliance
within an organization:

Prevents
noncompliance

Detects
noncompliance

Corrects
noncompliance

Compliance Program Requirements

At a minimum, a compliance program must include the 7 core requirements:

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

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual (“IOM”), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

Compliance Training

- CMS expects that all Sponsors will apply their training requirements and “effective lines of communication” to the entities with which they partner.
- 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 the letter and spirit of the law

As a part of the federally-funded healthcare program, it is important that you 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?

Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which CareOregon operates.

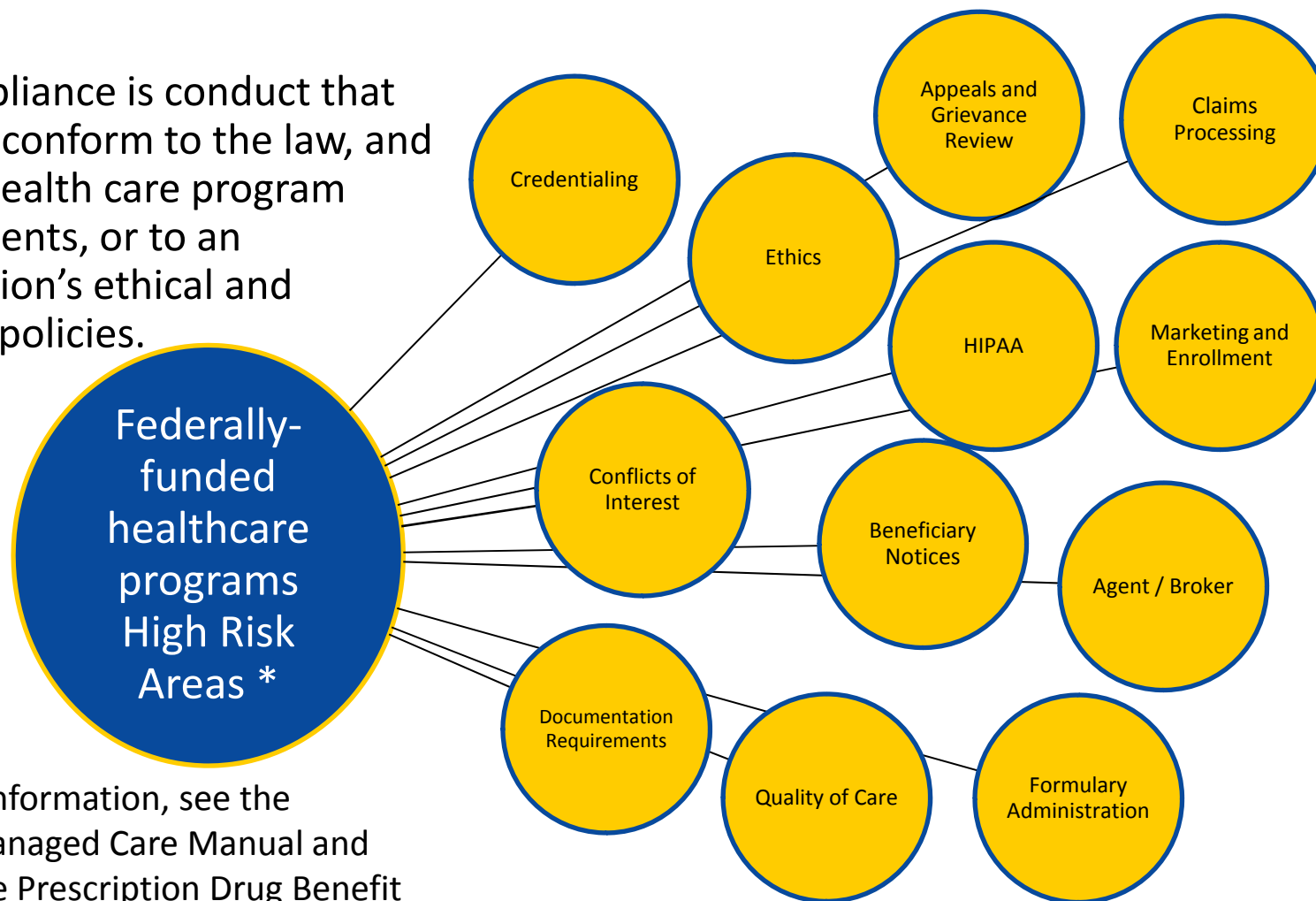
How Do I Know What is Expected of Me (cont.)?

Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

CareOregon's policy for Prevention, Detection, and Reporting of Fraud, Waste, and Abuse (FWA) tells you how to report potential or actual compliance or FWA issues.

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>

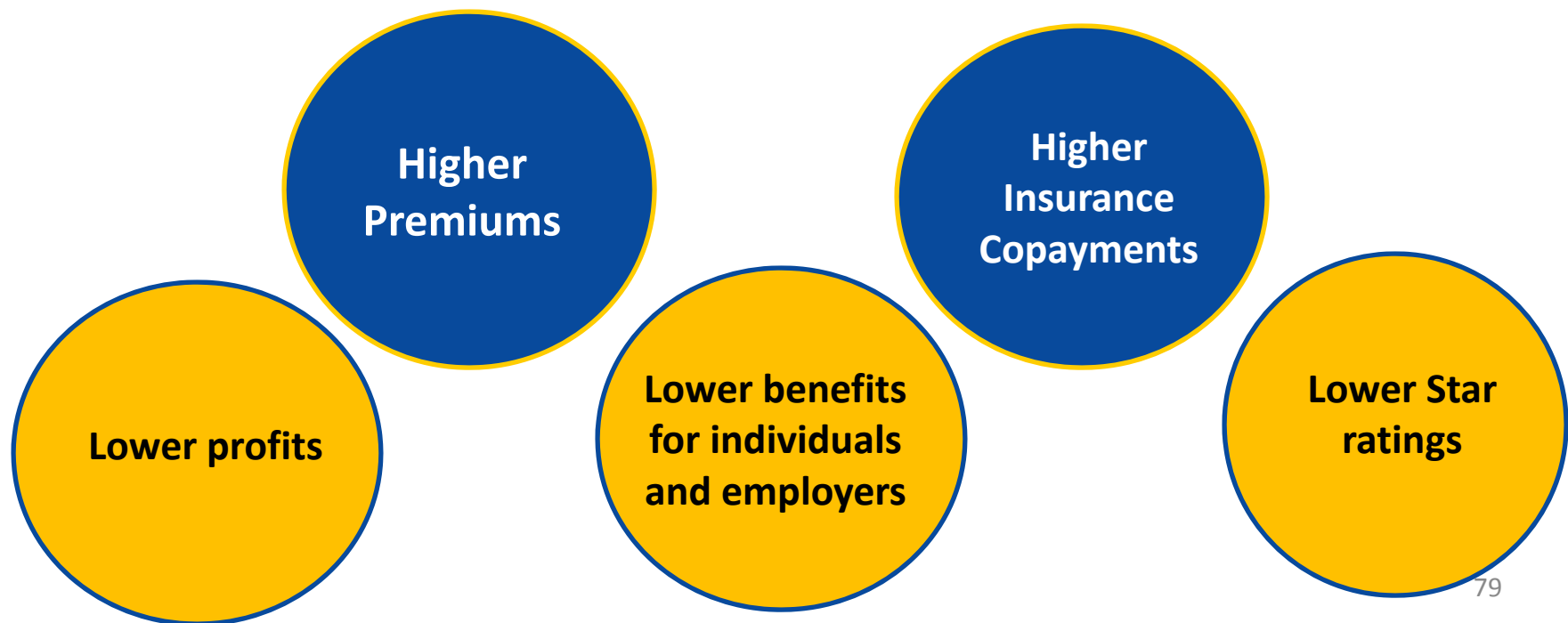
Noncompliance Harms Enrollees



Noncompliance Costs Money

Non Compliance affects EVERYBODY!

Without programs to prevent, detect, and correct noncompliance you risk:



I'm Afraid to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

CareOregon offers reporting methods that are:



How Can I Report Potential Noncompliance?

Employees of any federally-funded healthcare program Sponsor

- Call the 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 CareOregon's compliance hotline
- Call 1-800-Medicare

What Happens Next?

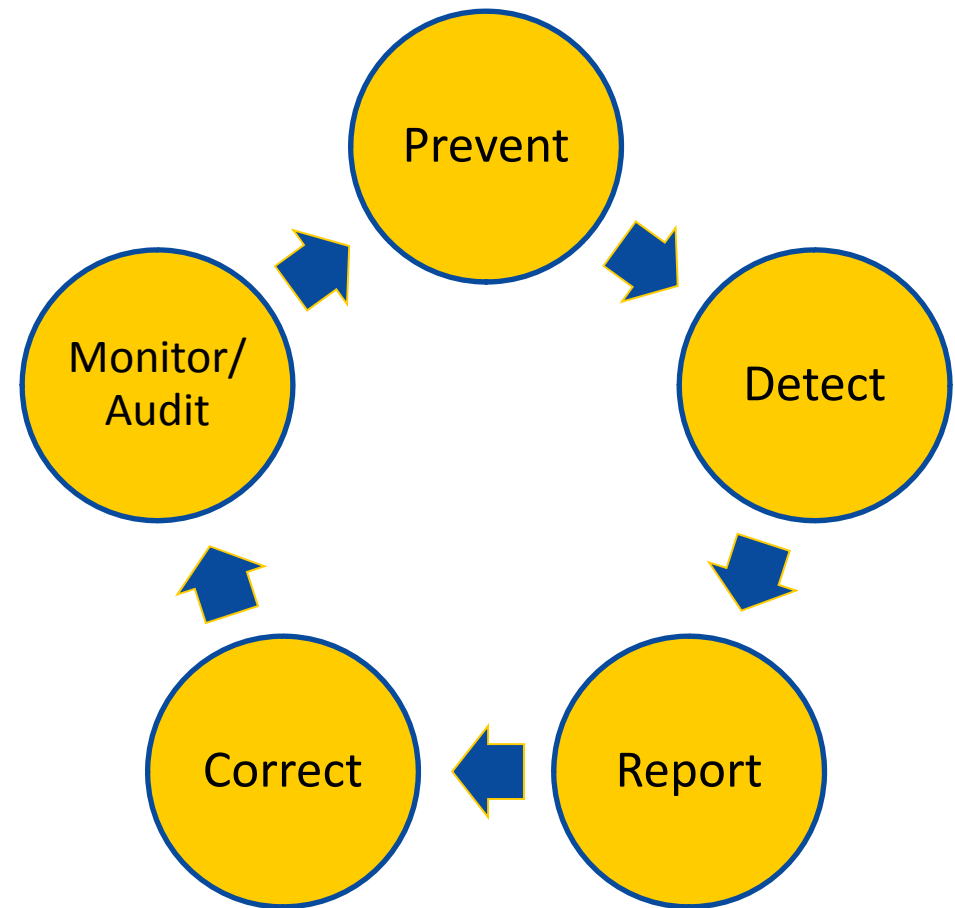


Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
- 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



Know the Consequences of Noncompliance

CareOregon has disciplinary standards in place for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:



Compliance is EVERYONE'S Responsibility!!

PREVENT

- Operate within CareOregon'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!

Scenario 1

Who is responsible for compliance within CareOregon:

- A. Compliance Director
- B. CEO
- C. Board of Directors
- D. Everyone

Scenario 1 Answer

The correct answer is D – Everyone within CareOregon is responsible for compliance.

Scenario 2

A good compliance program helps CareOregon increase its:

- A. Cost of healthcare
- B. Quality of patient care
- C. Ability to identify and correct misconduct early
- D. Both b and c
- E. All of the above

Scenario 2 Answer

The correct answer is D – both b and c.

An effective compliance program helps improve the quality of patient care and makes it easier to identify and correct misconduct earlier.

Scenario 3

Which of the following is not an essential element of an effective compliance program?

- A. Written Standards of Conduct
- B. High Level Oversight
- C. Effective Lines of Communication
- D. Conference Calls

Scenario 3 Answer

2. D – Conference Calls.

Conference calls are not an essential element of an effective compliance program. CMS has identified these elements as part of an effective compliance program:

1. Written Standards of Conduct
2. High Level Oversight
3. Effective Training and Education
4. Effective Lines of Communication
5. Enforcement and Disciplinary Guidelines
6. Auditing and Monitoring
7. Response to Identified Issues

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>



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