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VÍVELO VERDE

Fraud, Waste and Abuse Training

Compliance Department

Fraud, Waste and Abuse : A Serious Problem that Needs Your Attention

Although no precise measure of health care fraud exists, those intent on abusing Federal and private health care programs can cost taxpayers billions of dollars while putting beneficiaries' health and welfare at risk.

To combat fraud, waste and abuse you need to know how to protect MCS and our business partners from engaging in abusive practices and/or civil or criminal law violations.

Fighting FWA is everybody's responsibility!

Objectives

- Define fraud, waste and abuse;
- Learn about the applicable laws and regulations (local and Federal) that apply in cases of FWA;
- Learn about the applicable penalties and consequences;
- Learn about schemes and cases related to FWA;
- Learn about the agencies (local and Federal) involved in FWA matters.
- Identify methods to PREVENT, DETECT, REPORT and CORRECT FWA;
- Understand the responsibility of MCS' employees, affiliates, contractors and FDRs with MCS' FWA Program.

What is Fraud, Waste and Abuse?

Definitions

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.

Knowing soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs. Making prohibited referrals for certain designated health services.

Making prohibited referrals for certain designated health services. In other words, fraud is intentionally submitting false information to the Government contractor to get money or benefit.

Definitions (cont.)

Abuse

- Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program.
- Abuse involves payments for items and/or services when there is no legal entitlement to that payment and the provider has **NOT** knowingly and/or intentionally misrepresented facts to obtain payment.

Waste

- Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.
- Waste in general is not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Chapter 21, Section 20 of the CMS Medicare Managed Care Manual and Chapter 9 of the Prescription Drugs Benefit Manual.

Differences Between Fraud, Waste and Abuse

Although we cannot differentiate categorically between fraud, waste and abuse, there are certain characteristics in each of these modalities.

- The main characteristic is the **intention** and the **knowledge**. For **fraud** to be present there must be an **intention** to obtain a payment and the **knowledge** that the actions are wrong.
- In the other hand, although **waste** and **abuse** may involve obtain an improper payment or creating an unnecessary costs to the Medicare Program but do not require the same **intention** and **knowledge**.

Some Examples

FRAUD

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient scheduled but who could not attend;
- Billing for non-existent prescriptions; and
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

ABUSE

- Unknowingly billing for unnecessary medical services;
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

WASTE

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

Applicable Laws

False Claims Act or FCA

Anti-Kickback Statute

Stark Statute (Physician Self-Referral Law)

Criminal Health Care Fraud Statute

Beneficiary Inducement Law

False Claims Act

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;
- Conceals or knowingly and improperly avoids or decreases an obligation to pay the Government;
- Makes or uses a false record or statement supporting a false claim for payment approval.

CASE 1

- A Medicare Part C sponsor in Florida hired an external company to review medical records to find additional diagnosis codes that could be submitted to increase risk capitation payments from the Centers for Medicare &Medicaid Services (CMS). They were informed by the external company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported.
- The sponsor failed to report the unsupported diagnosis codes to Medicare; and agreed to pay $22.6 million to settle FCA allegations.

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) increased in August 1, 2016 to amounts between $10,781.40 and $21,562.80

31 United States Code (U.S.C.), Sections 3729-3733.

False Claims Act (cont.)

- The False Claims Act has a *qui tam* provision that allows individuals who are not related or affiliated to the Government (commonly known as whistleblowers) to file lawsuits on behalf of the Federal Government.
- Any person who files lawsuits under the False Claims Act may receive part of the recovered damages (between **15%** and **30%**).
- This provision also protects the individual from being dismissed, degraded, suspended, threatened, bullied and discriminated against in terms of his/her working conditions.

Some important terms related to the False Claims Act:

Whistleblower

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 not more than 30 percent of the money collected.

31 United States Code (U.S.C.), Sections 3729-3733.

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 (including the Medicare Program).

CASE 1

- From 2012 through 2015, a physician operating a pain management practice in Rhode Island; conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl.
- He received $188,000 in speaker fee kickbacks from the drug manufacturer;
- He admitted the kickback scheme cost Medicare and other payers more than $750,000.
  The physician must pay more than $750,000 restitution and is awaiting sentencing.

PENALTIES

- Violations are punishable by:
  - A fines of up to $25,000;
  - Imprisonment up to 5 years.

42 U.S.C., Section 1320a-7b(b). *Social Security Act*, Section 1128B(b).

Physician Self-Referral Law or Stark Law

- The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:
  - An ownership/investment interest; or
  - A compensation arrangement (exceptions apply).

CASE 1

- 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.

PENALTIES

- Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around **$24,250** can be imposed for each services provided. There may also be around **$161,000** fine for entering into a unlawful arrangement or scheme.

42 U.S.C., Section 1395nn.

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 … or imprisoned not more than 10 years, 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.

CASE 1

- A Pennsylvania Pharmacist submitted claims to a Medicare Part D sponsor for non-existent prescriptions and for drugs not dispensed. He pleaded guilty to health care fraud and received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the sponsor.

CASE 2

- The owners of two Florida Durable Medical Equipment (DME) companies submitted false claims of approximately $4 million to Medicare for products that were not authorized and not provided. They were convicted of making false claims, conspiracy, health care fraud, and wire fraud and were sentenced to 54 months in prison and ordered to pay more than $1.9 million in restitution.

18 U.S.C., Section 1347.

Beneficiary Inducement Law

Makes it illegal to offer exchange or compensation to which the person knows or should know that could influence a beneficiary when selecting a provider, practitioner, or supplier in particular. This includes:

- Offering payment or gifts to influence members to receive a consultation or treatment;
- Eliminating copayments and deductibles to induce beneficiaries to receive services from a provider.

- Gifts given to beneficiaries cannot exceed **$15 individually** or **$75 annually** per beneficiary. Under no circumstances can cash or gift cards be given to beneficiaries.

18 U.S.C., Section 1347.

Additional Federal Regulations

Criminal Fraud

Anyone who knowingly submits a false claim is subject to:

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

18 U.S.C., Section 1347

HIPAA

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 with access to protected health care information, you must comply with HIPAA.

HIPAA webpage

Exclusions

OIG - Office of the Inspector General of the US Department of Health and Human Services

GSA - US General Services Administration

42 U.S.C., Section 1320a-7

Exclusions

OIG

Office of the Inspector General of the US Department of Health and Human Services

- Any individual or entity shall be excluded from participation in Federal Programs Health Services Delivery (Medicare and / or Medicaid).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). You can access the LEIE at https://exclusions.oig.hhs.gov on the Internet

GSA

US General Services Administration

- Similarly, the United States General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS at https://www.sam.gov on the Internet.

42 U.S.C., Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901.

Exclusion Type

Mandatory Exclusions

- Medicare fraud;
- Patient abuse or negligence;
- Other serious crimes related to the health system:
- Fraud, theft or other financial misconduct;
- Unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Permisive Exclusions

- Misdemeanor convictions relating to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances;
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity;
- Provision of unnecessary or substandard services;
- Submission of false or fraudulent claims to a Federal health care program;
- Engaging in unlawful kickback arrangements;
- Defaulting on health education loan or scholarship obligations;
- Controlling a sanctioned entity as an owner, officer, or managing employee.

What Should I do with Exclusions?

Every Medicare Advantage Organization (Health Plan), providers and delegated entities must review the exclusion status of all its employees, contractors or associates prior to hiring or contracting and monthly thereafter.

These reviews must be performed against the following exclusion lists:

Applicable Local Regulations

Law #230 of the Commissioner of Insurance of PR	Law #10 of the Commissioner of Insurance of PR	Contract with the Puerto Rico Health Insurance Administration
• Requires all insurance companies to adopt an action plan to detect, prevent and fight fraud in the insurance business.	• Grants civil immunity to those individuals whom, in good faith, report fraud within the insurance business to the Office of the Commissioner of Insurance of PR and/or any other law enforcement agency.	• Requires all health insurance companies to implement a fraud, waste and abuse plan for Medicaid and dual-eligible beneficiaries (Platino).

Law Enforcement Agencies and Other Entities Allied to CMS

CMS Works along the following agencies to prevent, identify and stop FWA:

- **HHS-OIG** -> Office of the Inspector General of the US Department of Health and Human Services
- **FBI** -> Federal Bureau of Investigations
- **DOI** -> Department of Justice
- **MFOCU** -> Medicaid Fraud Control Units

CMS has contract with the following agencies to prevent, identify and stop FWA:

- Program Safeguards Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs)
- NBI MEDIC -> National Benefit Integrity Medicare Drug Integrity Contractor
- Recovery Audit Contractors (RACs)
- Comprehensive Error Rate Testing (CERT) Program
- Auditors

Local Agencies Support the Fight Against FWA

What is your role in the fight against FWA?

Where do I fit?

- Any person providing health or administrative services to a Medicare Part C and Part D enrollee, either from the clinical or administrative perspective, plays an important role in the fight against fraud, waste and abuse. This applies to the following:

Plan Sponsor	First-tier Entities	Downstream Entities	Related Entities
•Employees; •Board of Directors; •High Management	•Pharmacy Benefit Management (PBM); •Mail Processing Companies; •Hospital; •Health care facility, •Provider group; •Doctor office; •Clinical laboratory •Customer service provider; •Claims processing and adjudication company; •Company that handles enrollment, disenrollment, and membership functions; •Contracted sales agent	•Pharmacies; •Doctor office •Firms providing agent/broker services; •Marketing firms; •Call centers	•Entity with common ownership or control of a Sponsor; •Health promotion provider.

What are your responsibilities?

1. **Comply** with all statutory and regulatory requirements of Medicare (Parts C and D) and any other healthcare program requirements.

2. **Report** any concern, suspicion or knowledge of potential violations to the MCS Compliance Department.

3. **Follow** the MCS Code of Conduct, which describes the standards of conduct and ethical behavior that is expected from you.

How to prevent FWA?

How can you prevent FWA?

- Look and report any suspicious activity;
- ACT in an ethical manner all the time;
- Make sure you always provide accurate information (including the billing processes);
- Keep updated with policies and procedures, standards of conduct, laws, regulations and CMS guidance;
- Comply with all regulatory trainings related to FWA and Compliance, also review all related information that is provided.

Policies, Procedures and Code of Conduct

Stay familiar with MCS' policies and procedures!

In MCS we have policies and procedures related to fraud, waste and abuse. They provide guidance to help you detect, prevent, report and correct FWA incidents. This is also expected from our delegated entities (FDRs).

In addition, MCS has a Code of Conduct that provide details about:

Remember: Compliance is everyone's responsibility!

How can I access the policies, procedures and Code of Conduct?

All our policies and procedures, the Compliance Program and the Code of Conduct are accessible to all MCS employees through the Compliance 360 tool.

To have access to all this information you only have to:

The policies and procedures related to FWA, as well as the Code of Conduct and the Compliance Program are available to FDRs through the MCS Compliance Department.

Remember: Compliance is everyone's responsibility!

MCS Methods to Prevent FWA

MCS has the following mechanisms to prevent FWA and guarantee compliance with CMS:

- Written standards (Compliance Program, Code of Conduct, policies and procedures);
- Automatic pre-payment system edits;
- Payment suspension and hold codes, if applicable;
- Fraud, Waste and Abuse Committee, and other work groups;
- Educational FWA initiatives for beneficiaries, providers, employees, contractors and delegated entities;
- Provider credentialing process according to CMS guidelines;
- Routine FWA monitoring and identification systems;
- Among others.

How to detect FWA?

How does MCS detects FWA situations?

The MCS Special Investigations Unit identifies cases of potential fraud, waste and/or abuse through the following mechanisms. Also, FDRs are required to have mechanisms in place to detect FWA.

- Internal sources (ACTRight, *mystery shopping*, internal audits, monitoring of operational areas, etc.)
- External sources (Medicare and Medicaid Fraud Workgroups, alerts from Federal and local agencies, media, referrals etc.)
- Internal and external databases (STARSSentinel, utilization reports provided by FDRs, CMS *Risk Assessments,* etc.)
- Internal procedures (CA-COMP-060 – Procedure for the verification of individuals and entities against the OIG and GSA lists, etc.)
- Among other mechanisms.

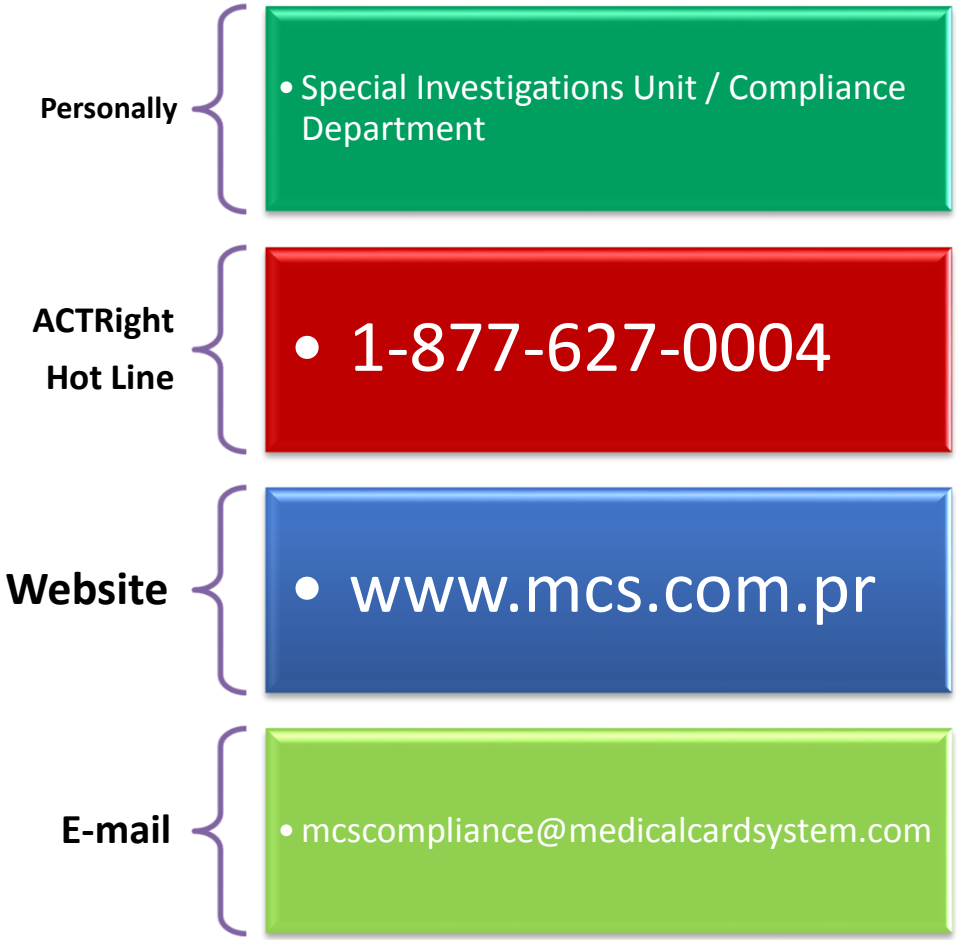
How to report FWA?

How can you report FWA internally?

- Any person who has suspicion or knowledge of FWA must report it. The MCS Code of Conduct emphasizes on the importance of reporting and guarantees that no retaliation will be taken against those individuals who report in good faith.

- Once reported, the Compliance Department, through the Special Investigations Unit, will conduct an investigation to take the necessary actions, including the referral to applicable agencies.

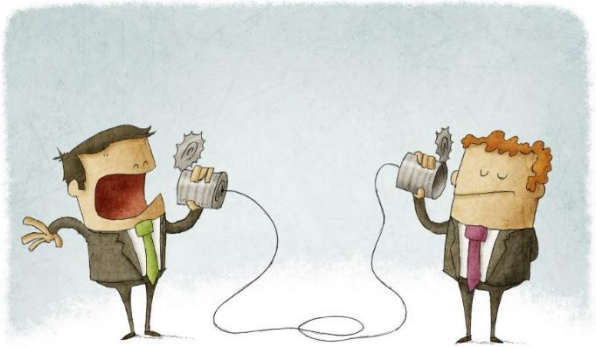
- These mechanisms are accessible for employees, contractors, delegated entities, providers and beneficiaries.



How can you report FWA internally? (cont.)

In addition to the reporting mechanisms indicated previously, you may report situations through:

- Your Supervisor, Manager, Director or Vice-President
- Chief Compliance Officer: Maité Morales, Esq.
- Special Investigations Unit AVP: Mrs. Elizabeth Roussel
- MCS Compliance Department
- MCS Human Resources Department
- MCS Legal Department



What you should know about referrals

All referrals are handled with strict confidentiality.

As per MCS' policy, NO retaliation will be taken against the employee who reports.

All referrals may be presented anonymously.

Reporting FWA Externally

- If necessary, MCS and FDRs should report potential fraud situations to Government authorities, including the Office of the Inspector General, the Department of Justice, the Office of the Commissioner of Insurance, the Puerto Rico Health Insurance Administration and CMS.
- Individuals or entities who may want to report voluntarily fraud situations that may have been self-identified, may do so directly to the OIG under the Self-Disclosure Protocol (SDP). This protocol gives the provider the opportunity to avoid costs and disruptions associated with Government investigations.

- **The Special Investigations Unit includes the following when reporting FWA externally:**
  - Contact information of the person who is referring, the suspects and the witnesses;
  - Details of the allegation;
  - Details of the violation;
  - The Compliance history of the suspect (educations, trainings, communications, among others).

Reporting FWA Externally

Office of the Inspector General (OIG)

- Telephone: 1-800-HHS-TIPS
- Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.gov
- Online: https://forms.oig.hhs.gov/hotlineoperations

NBI MEDIC (Medicare Parts C & D)

- Telephone: 1-877-7SafeRx

CMS (other Federal Healthcare Programs)

- Telephone: 1-800-MEDICARE

HHS and the Department of Justice

- Online: https://www.stopmedicarefraud.gov

How to correct FWA?

How do we correct FWA?

Once we have detected a fraud, waste or abuse incident, we must correct it promptly. Correcting the problem helps prevent the additional loss of money and assures the compliance with CMS requirements. With this purpose, the SIU develops investigations that allow us to identify the reach of the incident and delineate an action plan that includes:

- Design of corrective actions that address the incident as per identified in the investigation;
- Adaptation of corrective actions to address specifically the FWA incident that was identified, including due dates for the implementation of such actions;
- Documentation of corrective actions taken;
- Monitoring the implementation of the corrective actions to guarantee that no recurrence exists.

How do we correct FWA? (cont.)

In MCS we take the adequate measures to guarantee the prevention and attention of incidents of fraud, waste and abuse with promptness. Corrective actions are developed to help avoid the recurrence of such incidents. Those corrective actions may include:

- Definition of new pre-payment edits or documentation of new systematic requirements;
- Regulatory and specialized trainings;
- Modifications of policies and procedures;
- Warning and/or educational letters about correct billing practices;
- Disciplinary actions (suspensions, terminations, re-trainings, among others);
- Contract terminations;
- Financial recoveries;
- Referral to regulatory and/or law enforcement agencies; among others.

Your Responsibilities….

All our employees, delegated entities, providers and contractors are responsible for preventing and correcting fraud, waste and abuse by:

- Providing only medically necessary and high quality services;
- Documenting transactions and services appropriately;
- Billing, coding and processing services and claims correctly;
- Verifying the exclusions list as required by CMS;
- Complying with all policies and procedures of MCS;
- Establishing systems for a prompt response and initiation of investigations of potential fraud, waste, abuse and/or non-compliance situations.

Potential FWA Indicators

Some Indicators

Now that you know your role in the prevention, reporting and correction of FWA, the following indicators will provide you guidance, based on your duties, in identifying potential FWA incidents.

Indicators Related to Beneficiaries

- Does the prescription, medical record or laboratory test results look forged or altered?
- Does the beneficiary's medical record supports the requested services?
- Does the beneficiary have multiple prescriptions from different prescribers for the same medication?
- Is the beneficiary the person who is receiving the service? (Identity Theft)
- Is the prescription appropriate for the beneficiary according to the beneficiary's history?

Indicators Related to Providers

- Are the prescriptions appropriate for the beneficiary's conditions (medically necessary)?
- Is the provider billing for services that were not rendered?
- Is the physician prescribing a high volume of controlled substances or other drugs for diverse drugs?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a high quantity than medically necessary?
- Are the diagnoses provided by the physician documented on the patient's medical record?
- Does the provider's prescription have their active and valid National Provider Identifier on it?

Indicators Related to Pharmacies

- Are the drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Is the pharmacy dispensing expired, adulterated, diluted, illegal or fake medications?
- Are generic drugs provided when the prescription required dispensing brand drugs?
- Is the pharmacy or PBMs billing for prescriptions that were not dispensed or that the patient never picked up?
- Are proper provisions made if the entire prescriptions is not filled (no additional dispensing fees for split prescriptions)?
- Are there prescriptions that seem to be altered (quantity, DAW, etc.)?

Indicators Related to Wholesalers

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, marking up the prices, and sending to other smaller wholesalers or pharmacies?

Indicators Related to Manufacturers

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer knowingly provide samples to entities that bill Federal health care programs for them?

Indicators Related to Sponsors (Advantage Plans)

- Does the Sponsor encourage or support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe the cost of benefits is one price, when the actual cost is higher?
- Does the Sponsor offer beneficiaries cash inducements to join the plan?
- Does the Sponsor use unlicensed agents?

Fraud, Waste and Abuse : Puerto Rico is not exempt

During the last year, various cases of fraud were prosecuted in Puerto Rico and MCS provided strong collaboration to the agencies to stop fraudulent schemes in Puerto Rico.

We encourage you to continue supporting MCS to prevent, detect and report Fraud, Waste and Abuse

Questions or Doubts?

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