Introduction

• The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage Organizations (MAO) to have policies and procedures to identify and address Fraud, Waste and Abuse (FWA) in the delivery of health care services through the Medicare Advantage benefit.

• CMS also requires the MAO to have a procedure in place to facilitate FWA training and education for vendors and providers.
Affinity’s Responsibilities

- Affinity Health Plan must ensure that all delegated and external entities implement a fraud, waste, and abuse training for all personnel who deal directly with our Medicare members or who view Protected Health Information (PHI) in any capacity.
- We are required to establish training requirements and communication to our first tier, downstream and related entities of which we have a contractual relationship.
- We take our responsibility to all our stakeholders – CMS, the State of NY, pharmacies, Pharmacy Benefit Managers, our Members, and participating Providers – very seriously because of our fiduciary responsibility to assure that all program funds are spent and distributed wisely and legitimately.

Providers and Other Entities Responsibilities

- Organizations contracting directly or indirectly with the federal government are obligated to:
  - complete training as defined in [42 CFR 422.503](#) (“Medicare Advantage Programs”) and [42 CFR 423.504](#) (Voluntary Medicare Prescription Drug Benefit”) by 12/31/2009
  - retain records that you completed the training for Affinity on Fraud, Waste, and Abuse for Medicare Advantage and/or Part D beneficiaries
  - report fraud, waste and abuse issues
  - demonstrate their commitment to eliminating fraud, waste and abuse and
  - implement internal policies and procedures to identify and combat health care fraud
  - deliver the training annually in the following years
Learning Objectives

• What you should know at the end of this training:
  – What is fraud, waste and abuse (FWA) and how to identify it
  – How to report issues about FWA to Affinity
  – Your obligation to protect for employees or other individuals who report suspected fraud, waste and abuse
  – An understanding of how other laws and regulations such as the False Claims Act, Anti-Kickback Statute and HIPAA

Affinity’s Fraud and Abuse Prevention Program

• In order to assure these objectives are met on a continuous basis, Affinity has developed and implemented a Fraud and Abuse Prevention Program to prevent, identify, investigate, report on and prosecute fraud, waste, and abuse in the managed care environment.
Affinity’s Compliance Program

• Affinity also implemented comprehensive compliance program which significantly reduces the risk of fraud, abuse and waste in the health care setting, while providing quality of services and care to patients.

• The Compliance Program includes:
  – Written policies, procedures, standards of conduct and a plan to identify and respond to fraud, waste and abuse issues.
  – Designation of a compliance officer and compliance committee.
  – Effective training and education to all staff and new employees
  – Effective lines of communication.
  – Enforcement of standards through disciplinary guidelines.
  – Internal monitoring and auditing procedures.
  – Procedures to ensure prompt response and corrective action for detected offenses

Fraud

• Fraud is an intentional deception or misrepresentation that an individual or entity makes, knowing that the misrepresentation could result in some unauthorized benefit to the individual, the entity, or to some other party. Fraudulent activities are often criminal, although the specific nature or degrees of the criminal acts vary. Remember, that potential fraud should be referred to as “alleged.”
Elements of Fraud

• There are five elements of fraud which must be present to satisfy the definition of fraud:
  – **Material Statement** – The individual makes a statement (orally or in writing) that is a statement of fact and another party relies on that statement.
  – **Knowledge of its falsity** - The statement is false and the individual who is making the statement knows it is false.
  – **Intent to defraud** - The individual who is making the false statement does so with the specific intent to defraud.
  – **Justifiable reliance by the intended victim** – The party to whom the false statement is made relies on the information and acts upon it.
  – **Resulting damage** – The party has some monetary or other loss which results from the fraudulent statement.

Examples of Fraud Provider

• Provider Fraud can be found in some day-to-day operations within any medical practice. Some forms of fraud may include:
  – Billing for items or services not rendered or not provided as claims.
  – Submitting claims for equipment or supplies and services that are not reasonable and necessary.
  – Double billing resulting in duplicate payments.
  – Unbundling.
  – Failure to properly code using coding modifiers or up-coding the level of service provided, inappropriate use of place of service codes.
  – Altering medical records.
Beneficiary Fraud

- Examples of fraud committed by beneficiaries of a federal program may include:
  - Identify theft
  - Resale of drugs on black market
  - Falsely reporting loss or theft of drugs to receive replacements
  - Doctor shopping

Pharmacy Benefit Manager (PBM) Fraud

- Fraud committed by a PBM may include:
  - Unlawful remuneration in order to steer a beneficiary toward a certain plan or drug, or for formulary placement. Includes unlawful remuneration from vendors beyond switching fees.
  - Not offering a beneficiary the negotiated price of a Part D drug.
Plan Sponsors and MAO Fraud

• Plan Sponsors and MAOs may commit fraud by:
  – Making payments for excluded drugs.
  – Conducting marketing schemes.
  – Offering beneficiaries a cash payment as an inducement to enroll.
  – Unsolicited door-to-door marketing.
  – Enrollment of beneficiaries without their consent.
  – Stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS.
  – Requiring beneficiaries to pay up front premiums.

Waste

• Waste is defined as over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
Abuse

- Abuse differs from fraud in that it describes incidents or practices of providers, beneficiaries (patients) vendors, or employees that are inconsistent with accepted sound clinical, business or fiscal practices (including but not limited to excessive or unnecessary care, improper business practices, poor clinical documentation, inaccurate coding, and repeated billing mistakes) that are not knowingly or intentionally misrepresented facts to obtain additional payments or other benefits to the individual, the entity, or to some other party.

Examples of Abuse

- **Provider**
  - Billing for a non-covered service.
  - Misusing codes on the claim.
  - Inappropriately allocating costs on a cost report.

- **Beneficiary**
  - “prescription drug shopping” for such as oxycontin during multiple office visits to various providers. This is done without the knowledge of each individual provider.
What is the Impact of Healthcare Fraud and Abuse?

• In 2007, 2.26 trillion dollars were spent on health care goods and services. The National Health Care Anti-Fraud Association (NHCAA) estimates 3% or 68 billion dollars will be lost of fraud! This may be a conservative estimate… many other agencies estimate as much as 10% or 226 billion dollars are being lost to fraud each year!

Who are Committing Fraudulent and Abusive Activities?

• According to the Health Insurance Association of America, the sources of the suspected fraud and abuse cases are from:
  – 72% - Medical Professional
  – 8% - Health Care Facilities
  – 10% - Consumer
  – 10% - Other
Who are the Victims?

- Because we are all taxpayers, we are all victims of fraud, waste and abuse! How? When you get your paycheck, remember a portion of your Federal and State Income Taxes goes to pay for the services provided through the Medicaid and Medicare programs.

- How else do people or organizations get hurt? Our beneficiaries are at risk by potentially receiving unnecessary services or treatments.

False Claims Act

- A person is in violation of the False Claims Act if they have:
  - Purposefully supplied false information on an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
  - Known about, but did not disclose, any event affecting the right to receive a benefit;
  - Knowingly submitting a claim for a physician service that was not rendered by a physician or
  - Supplied items or services and asked for, offered, or received a kickback, bribe or rebate.

- Under the 42 U.S.C section 1320a-7b(a), if an individual participates in an activity above, they will be found guilty of a felony and upon conviction shall be fined a maximum of $50,000 per violation or imprisoned for up to five years per violation or both.
**Anti-Kickback Statute**

- The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits offering, soliciting, paying, or receiving remuneration for referrals for services that are paid in whole or in part by the Medicare Program.
  - Remuneration is defined as the transfer of anything of value, directly or indirectly, overtly or covertly in cash or in kind. When this happens, both parties are held in criminal liability of the impermissible “kickback” transaction.
- An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the Office of the Inspector General (OIG).
- Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on their facts.

**Whistle Blower Provision**

- Under the Whistle Blower or qui tam provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. Government and may share a percentage of the recovery realized from a successful action.
Physician Self-Referral “Stark” Prohibition

- The physician self-referral prohibition commonly known as the “stark law”, prohibits physicians from referring Medicare patients for certain designated health services (DHS) to an entity where the physician or member of the physician’s immediate family has a financial relationship.
- In 2003, Congress amended section 1877 by establishing an 18-month moratorium (in effect from 12/08/03 – 06/07/05) on physician referrals to certain specialty hospitals in which the referring physician has an ownership or investment interest. Under the moratorium, specialty hospitals cannot fill or submit claims to anyone for DHS furnished as a result of a referral that is prohibited under the moratorium.
- On June 7, 2005, CMS instituted a temporary suspension on the processing of specialty hospital applications for participation in the Medicare program.

Health Insurance Portability and Accountability Act (HIPAA)

- The Administrative Simplification provisions of the HIPAA of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers.
- It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system will improve the use of electronic data interchange.
Legal Actions

- A provider, supplier or health care organization that has been convicted of fraud may receive a significant fine, prison sentence or be temporarily or permanently excluded from the Medicare program or other Federal health care programs, and in some states, lose their license. Failure to comply with fraud and abuse laws may result in:
  - Investigations referred to the OIG
  - Civil Monetary Penalties that can result in up to $10,000 per violation and exclusion from the Medicare program
  - Denial or revocation of a Medicare Provider Number
  - Suspension of payments

How can you report Fraud, Waste, and Abuse Concerns?

- Affinity has added a Fraud, Waste, and Abuse Hotline at 1-888-651-6229 for all individuals
  - It is a confidential reporting tool, available 24 hours a day, 7 days a week for providers, Members, and vendors to report any concern related to any type of wrongdoing.
  - Inquiries are investigated by the Compliance Department to assure the prompt attention to and resolution of the matter.
  - The Compliance Director and Special Investigators are actively working on the cases identified through the Program.
Additional Contacts

You may also contact:

• Caron Cullen, Medicare Compliance Officer at ccullen@affinityplan.org or (718) 794-5731

• Keith Payet, Compliance Director, at kpayet@affinityplan.org or (718) 794-5738