

# Fraud, Waste, and Abuse Training

Providence Health Plans  
2010-2011

# Why Do I Have to Participate in Fraud, Waste and Abuse Training?

# The CMS Mandate

- The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Prescription Drug health plans to ensure that their employees complete Fraud, Waste, and Abuse training on an annual basis and no later than December 31<sup>st</sup> of each year.
- Providence Health Plans is providing this presentation to fulfill the training requirement.

# The Cost of Healthcare Fraud

- The U.S. spent \$2.47 trillion on health care in 2009
- Estimates suggest that 3% - 10% of health care dollars are lost to fraud<sup>1</sup>
- Prescription drugs constitute approximately 10% of all health care spending<sup>2</sup>
  - <sup>1</sup>[http://www.fbi.gov/publications/financial/fcs\\_report2007/financial\\_crime\\_2007.htm#health](http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health)
  - <sup>2</sup>[http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=56280](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=56280)

# Risk to Individuals

- Unnecessary procedures may cause injury or death
- Falsely billed procedures create an erroneous record of the patient's medical history
- Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions
- Prescription narcotics on the black market contribute to drug abuse and addiction

# How does CMS combat Fraud

1. Close coordination with contractors, providers, and law enforcement agencies
2. Developing Medicare Program compliance requirements that protect stakeholders
3. Applying fair and firm enforcement policies
4. Early detection through Medical Review and data analysis
5. Effective education of health insurers, physicians, providers, suppliers, and beneficiaries
  - Among other things, the fifth strategy led to the development of *this* FWA training requirement.

# Learning Objectives

- Describe the Medicare Advantage- Prescription Drug Fraud, Waste, and Abuse (FWA) training requirements
- Recognize examples of health care FWA
- Describe steps taken to prevent and combat FWA
- Describe how you can prevent health care FWA
- Report suspected health care FWA

# Key Terms and Definitions

- Part C Medicare Advantage Plans (MA)
  - Provides all of a person's Part A and Part B coverage
  - MA plans are offered by private entities and many include Part D prescription drug coverage
- Part D Plans
  - Optional drug coverage available to everyone with Medicare
  - Part D plans are either stand-alone prescription drug plans (PDPs) or Medicare Advantage plans offering prescription drug coverage (MA-PD)

# Key Terms and Definitions, Cont.

- Medicare Advantage Organizations
  - A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements
- Part D Sponsors
  - Refers to a PDP Sponsor, MA organization offering a MA-PD plan, a PACE\* organization offering a PACE plan including qualified prescription drug coverage, and a Cost Plan offering qualified prescription drug coverage. This includes employer- and union sponsored plans
- \* PACE is the Program of All-Inclusive Care for the Elderly.

# Key Terms and Definitions, Cont.

- Oregon Health Plan (OHP) –
  - OHP is a state Medicaid program of health care for people with low incomes. This health care includes services for medical care, dental care, mental health and substance abuse treatment.
    - Eligibility is different for children, pregnant women, and adults. Services available also vary depending on these same factors.
- Providence Oregon Option-
  - Providence's name for our Medicaid coverage option.
- Providence Health Assurance-
  - The name under which Providence Health Plans offers its Providence Oregon Option.

# What is Fraud, Waste and Abuse?

# Fraud

- ***Health Care Fraud:***
  - Intentionally, or knowingly and willfully attempting to execute a scheme to falsely obtain money from any health care benefit program
- ***Medicare and Medicaid Fraud:***
  - Purposely billing Medicare or Medicaid for services that were never provided or received

# Abuse

- ***Abuse:***
  - Improper behaviors or billing practices that create unnecessary costs
- Fraud is distinguished from abuse in that, in the case of fraudulent acts, there is clear evidence that the acts were committed knowingly, willfully, and intentionally or with reckless disregard.

# Waste

- **Waste:** Health care spending that can be eliminated without reducing the quality of care
  - Quality Waste: Overuse, underuse, and ineffective use
  - Inefficiency Waste: Redundancy, delays, and unnecessary process complexity

# What are Some Examples of Fraud, Waste, and Abuse?

# Potential Risks – Health Plans

- Failure to provide medically necessary services
- Marketing schemes such as offering beneficiaries a cash payment as an inducement to enroll in Part D
- Selecting or denying beneficiaries based on their illness profile or other discriminating factors
- Inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness

# Potential Risks – Medical Billing



## Prescription Drug FWA

- Illegal remuneration schemes, such as selling prescriptions
- Prescription drug switching
- Script mills
- Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad, or e-prescribing log-in information
- Falsifying information in order to justify coverage

# Potential Risks - Members

- Beneficiary ID card sharing
- Misrepresentation of status
- Doctor shopping
- Prescription forging and altering
- Resale of drugs on the black market
- Looping (i.e., arranging for a continuation of services under another beneficiary's ID)
- Identity theft

# Who is at risk for Fraud, Waste, and Abuse?

- Stakeholders include:
  - Health Plans
  - Pharmacies
  - Providers
  - Pharmacy Benefit Managers
  - Beneficiaries
- Schemes:
  - Vary in degree of severity
  - Are not necessarily unique to a single stakeholder
  - May involve multiple types of fraud, waste, or abuse

# What are the Laws Relevant to Healthcare Fraud, Waste and Abuse?

# False Claims Act

- The ***False Claims Act*** prohibits any false or fraudulent claim for government money or property, whether or not the claim is presented to a government official, and whether or not the defendant specifically intended to defraud the government. Liability attaches to government funds dispersed through intermediaries including state agencies, and may apply to subcontractors as well as funds received from Medicare Advantage Plans and Medicaid HMOs.

***American Recovery and Reinvestment Act of 2009  
(ARRA)***

# Anti-Kickback Statute

- The ***Anti-Kickback Statute*** makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.
- **Remuneration** includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

# Oregon Statutes

- Oregon law (ORS 165.690 & .692) states:
- A person commits the crime of making a false claim for health care payment when the person:
  - Knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; or
  - Knowingly conceals from or fails to disclose to a health care payor the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled.

# Washington State Statute

- **Washington State Statute RCW 48.80.030 states**
- A person shall not make or present or cause to be made or presented to a health care payer a claim for a health care payment knowing the claim to be false.
- No person shall knowingly make a false statement or false representation of a material fact to a health care payer for use in determining rights to a health care payment. Each claim that violates this subsection shall constitute a separate violation.
- No person shall conceal the occurrence of any event affecting his or her initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service. A person shall not conceal or fail to disclose any information with intent to obtain a health care payment to which the person or any other person is not entitled, or to obtain a health care payment in an amount greater than that which the person or any other person is entitled.
- No provider shall willfully collect or attempt to collect an amount from an insured knowing that to be in violation of an agreement or contract with a health care payor to which the provider is a party.

# Healthcare Reform Impact

## Fraud, Waste, and Abuse Efforts

- As of September 23, 2010, the federal health reform act has prohibited group health plans from rescinding a plan or coverage with respect to an enrollee unless the "covered individual" has committed fraud. In order to prove fraud, we'll need to show that these 9 things are true:
  - A **representation** (statement of fact) was made by the enrollee
  - The representation was **false**
  - The representation was **material** (matters to what the hearer [PHP] was about to do)
  - The speaker (enrollee) **knew it to be false** (or was reckless as to its truth)
  - The speaker was **intending that PHP rely** on the representation
  - PHP was **ignorant of the falsity**
  - PHP **relied on** the representation
  - PHP had the **right to rely** on the representation
  - PHP was **injured**

# How is Fraud, Waste and Abuse Combated and Prevented?

# Combating Fraud is a Collaborative Effort



- Department of Justice (DOJ), including the Federal Bureau of Investigation (FBI)
- Office of Inspector General (OIG) of the Department of Health and Human Services (HHS)
- Quality Improvement Organizations (QIOs)



## Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Monday, August 30, 2010

**South Florida Doctor, Clinic Owner and Five Nurses Plead Guilty in Home Health Care Fraud Scheme**

**Doctor Admits to Referring 858 Medicare Beneficiaries for Unnecessary Home Health Care Services**

WASHINGTON – A medical doctor, a clinic owner and four nurses, all South Florida residents, pleaded guilty today before U.S. District Judge Adalberto Jordan in U.S. District Court in Miami for their participation in a fraudulent Medicare home health care scheme, the Departments of Justice and Health and Human Services (HHS) announced. Another nurse pleaded guilty on Aug. 25, 2010, to charges for her role in the scheme.

# What is PHP doing?

- Data Mining
- Publishing internal/external reporting methods
- Educating internal and external customers
- Conducting claim reviews, pends, denials, edits, and audits
- Responding to potential fraud, waste, and abuse

# How This is Done in Special Investigations Unit (SIU)



- Allegation received
- Facts vetted, determination of merit
- Investigator gathers evidence – Medical Director engaged
- Evidence either proves or disproves (exculpatory evidence) the allegation.
- Decision documented and provider/member notified
- Recovery sought as appropriate

# Remediation

- PHP and the government have several possible outcomes to a FWA investigation, they may:
  - Educate the provider or entity
  - Report the provider or entity to other organizations
  - Use Administrative sanctions
  - Use Civil litigation and settlements
  - Use Criminal prosecution including;
    - Automatic debarment
    - Prison time

# What Can I Do?

# PH&S Fraud and Abuse Policy

- Providence's Fraud and Abuse Protection -
  - See policy ([PROV-ICP-711](#)), this requires that employees, agents and contractors who create and file claims for Providence services are to use true, complete and accurate information.
  - Providence will monitor claims for payment to detect errors and inaccuracies and to prevent false claims.
- Mistakes while you perform your duties is not considered fraud. The government and PHP are concerned about patterns of fraud and abuse. You should check that information used in your work is accurate and truthful.
  - If you do notice a mistake that might affect any claim for payment, please report the concern using the [4-Step Reporting Process](#) so the error can be corrected.

# Best Practices for Preventing Fraud, Waste, and Abuse

- Learn about and follow the compliance program
- Verify accuracy of claims and applications before applying benefits.
- Monitor claims for accuracy - ensure coding reflects services provided
- Monitor medical records – ensure documentation supports services rendered
- Follow policies and procedures within your department.

# Best Practices

- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem

# Whistleblower Protections

- ***Whistleblower:*** An employee, former employee, or member of an organization who reports misconduct to people or entities that have the power to take corrective action
- A provision in the False Claims Act allows individuals to:
  - Report fraud anonymously
  - Sue an organization on behalf of the government and collect a portion of any settlement that results
  - Employers cannot threaten or retaliate against whistleblowers

# PH&S Whistleblower Protections

- **Non-Retaliation Policy**
- Providence feels very strongly about its non-retaliation policy. Providence Health System in Oregon does not, under any circumstances, tolerate retaliation against an employee who reports an issue. If you experience retaliation by a supervisor or a coworker, please contact the Integrity Office as soon as possible.
- See Policy PROV-HR-419

# How Do I Report Suspected Fraud, Waste, or Abuse?

# To Report Suspected Fraud, Waste and Abuse to PHP



- For cases involving our members call us:
  - Contact Providence Health Plan’s Special Investigations Unit at (503) 574-8505 or the toll free number is 1-888-233-4101
- Or mail your letter to:
  - Special Investigations Unit
  - PO Box 3150
  - Portland, OR 97208-3150

# Confidential Methods for Reporting to Medicare/Medicaid



- Office of the Inspector General
  - By Phone: **1-800-HHS-TIPS (1-800-447-8477)**
  - By TTY: **1-800-377-4950**
  - By E-mail: **HHSTips@oig.hhs.gov**
- Centers for Medicare & Medicaid Services (CMS)
  - By Phone: **1-800-MEDICARE (1-800-633-4227)**
  - By TTY: **1-877-486-2048**

Callers are encouraged to provide information on how they can be contacted for additional information, but they may remain anonymous if they choose.

# Summary:

## What you should know now

- Understand Fraud, Waste, and Abuse definitions
- Understand how to report suspected Fraud, Waste and Abuse
- Understand relevant state and federal statutes, and regional policies
- Understand what Providence Health Plans and the Government are doing to combat Fraud, Waste, and Abuse