COMPLIANCE AND FRAUD, WASTE, AND ABUSE (FWA) AWARENESS TRAINING

FOR FIRST TIER AND DOWNSTREAM ENTITIES, SUB-CONTRACTORS, DELEGATES, AND BUSINESS PARTNERS

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Training Objectives

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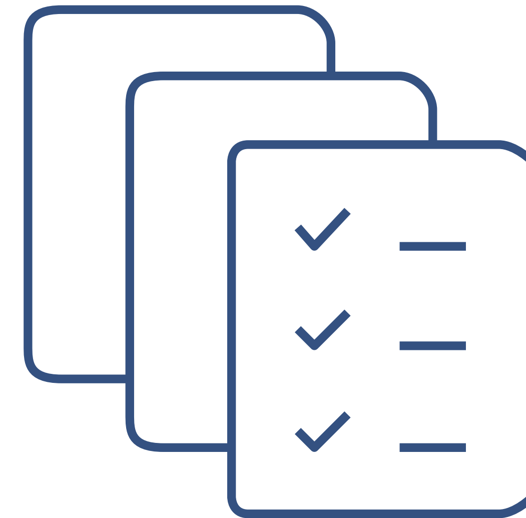
Training Objectives

After completing this training, you should:

- Understand how Medica’s compliance program operates
- Understand what fraud, waste, and abuse is and why it’s important
- Recognize how to report compliance concerns and/or fraud, waste, and abuse
- Have awareness of important laws



Use of ‘Medica’ throughout this training refers to both Medica and Dean Health Plan

General Overview

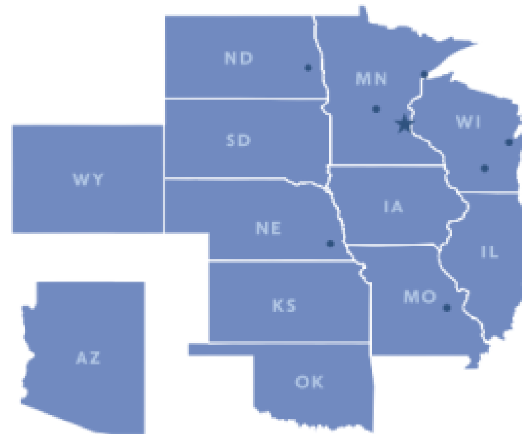
General Overview

Getting to know Medica

AT A GLANCE

- Minnetonka, MN
- Not-for-profit since 1975
- 2,000+ employees
- $37M in grants from Medica Foundation distributed

- **Mission:** To be the trusted health plan of choice for customers, members, partners, and our employees
- **2021:** Medica reached an agreement with SSM Health that brings Dean Health Plan and its 500,000 members and nearly 1,000 employees into the Medica family.



Serving members across 12 states

- Nearly 1.5 million members
  - Medicare & Medicaid
  - Individual & Family
  - Employer-Based

General Overview

Compliance is everyone’s responsibility!

- ✓ This training helps you detect, correct and prevent non-compliance, Fraud, Waste and Abuse
- ✓ You are part of the solution
- ✓ Medica Compliance Department works with all employees and business partners throughout the organization, including our vendors to ensure compliance and FWA awareness is available to everyone

General Overview

CMS requires plan sponsors to offer Compliance and FWA training to all First Tier and Downstream Entities, Sub-Contractors, Delegates and Business Partners

Providers, vendors, and staff involved with the administration or delivery of services of Medicare Advantage, Cost, and Prescription Drug Plans are required to have an effective training for employees, managers and directors, as well as their First Tier and Downstream Entities, Sub-Contractors, Delegates and Business Partners

This also applies to anyone Medica has entered into a contract with, to provide services on behalf of Medica for health plan enrollees

Training must occur within 90 days of contracting with Medica and annually thereafter

Likewise, our partners must train new employees within 90 days of hire and annually thereafter

General Overview

Your organization must maintain training records. Records must include:

- Materials used for training
- Dates training was provided
- Method(s) training was provided
- Training logs identifying trained employees

Medica, CMS, agents of CMS, and other authorized regulators may request such records to verify that training has occurred

Additional resource for FWA Training: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining

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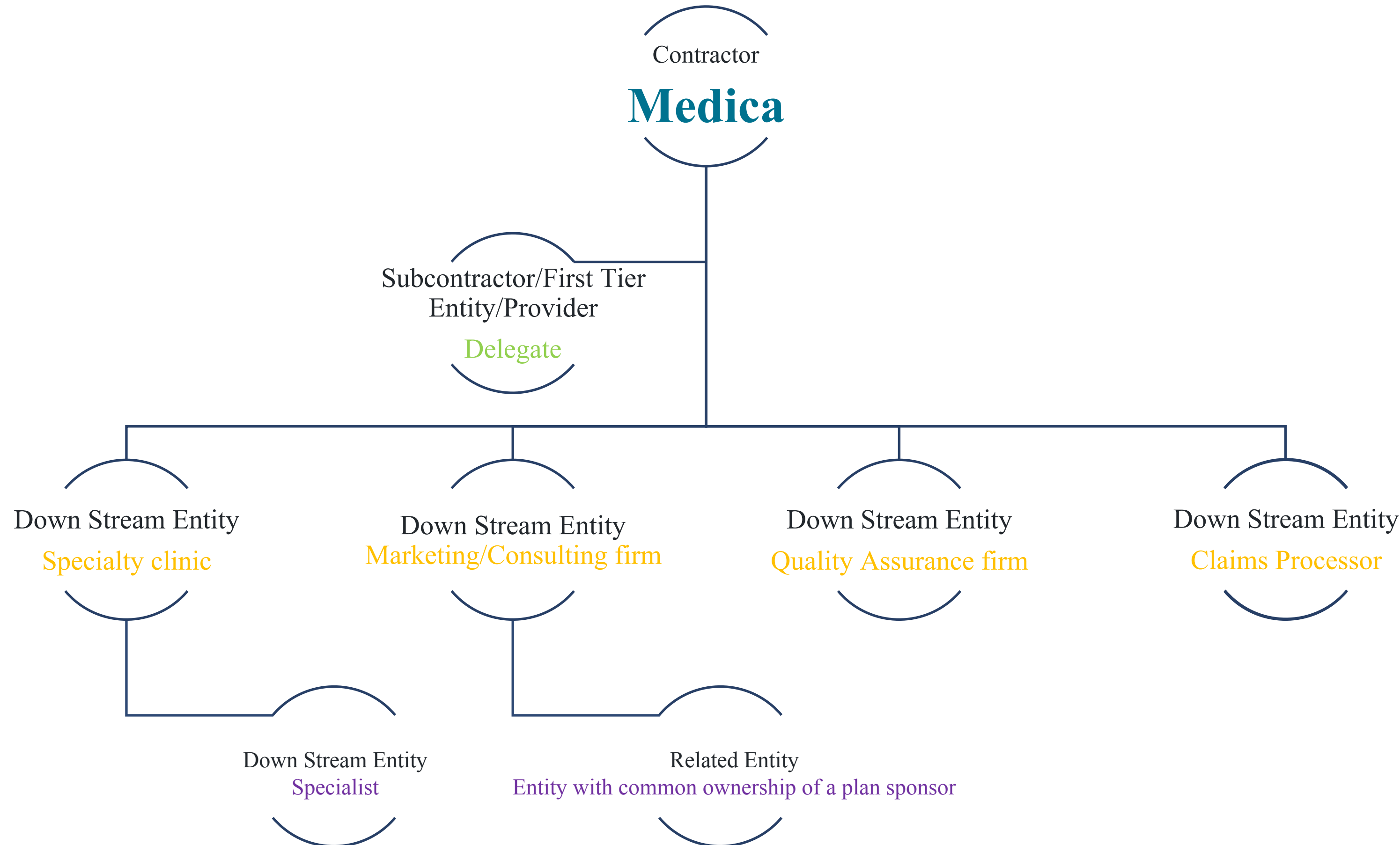
General Overview

Where Do I Fit In?



Medica contracts with vendors and providers to provide services such as administrative functions and health or prescription drug services

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General Overview

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, or abuse.

Open communication between employees, vendors, delegates and Medica's Compliance Department is essential to both our compliance program and to the maintenance of our ethical and compliant culture.

Medica's CEO, John Naylor, puts it this way: "*Medica believes it is important to help employees differentiate between the right behavior and the not-so-right behavior. If you see something that doesn't appear to be right, we want you to feel comfortable taking action*".

It is your responsibility to report the concern without hesitation; it is our responsibility to make certain there is no intimidation, retribution or retaliation against those who want to make a good faith report of any potential concern.

General Overview

What Are My Responsibilities?

- ❑ **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D 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 both our Standards of Conduct for business partners and your organization's Standards/Code of Conduct that articulates yours and your organization's commitment to standards of conduct and ethical rules of behavior.

Compliance Program

Overview

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Compliance Program Overview

Medica's compliance program fosters a culture that:

- Prevents, detects and corrects non-compliance
- Promotes our standards of conduct
- Establishes clear lines of communication for reporting non-compliance

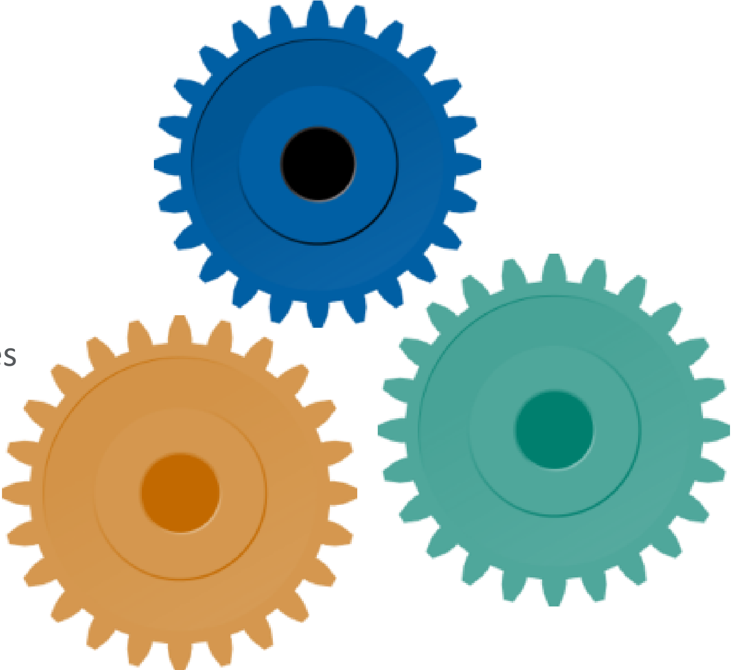
An effective compliance program is essential to prevent, detect and correct non-compliance and FWA

Compliance Program Overview

The Seven Elements of an effective Compliance Program are derived from Office of Inspector General (OIG) guidance and the Federal Sentencing Guidelines

Prevent

1) Written Standards of Conduct and Policies & Procedures
2) Oversight through Compliance Officer and Committee
3) Training & Education
4) Effective Lines of Communication



Correct

6) Prompt Correction of Identified Issues
7) Consistent Disciplinary Standards

Detect

5) Auditing and Monitoring Plans
(assess outcomes to look for risks)

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Compliance Program Overview

Seven Elements:

- Written standards and procedures, training and education, active auditing and monitoring, disciplinary action, mandatory reporting of non-compliance and active response and resolution to identified compliance matters are all fundamental to Medica’s compliance program. Communicating expectations for ethical behavior and how Medica does business is also fundamental to our program

The Standards of Conduct for Business Partners provide you with important principles and help establish expectations for how first tier and downstream entities, sub-contractors, delegates and business partners must conduct themselves to confirm and protect the integrity of Medica.

Fraud, Waste, and Abuse

Overview

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Fraud, Waste, and Abuse (FWA) Overview

What is fraud, waste, and abuse?

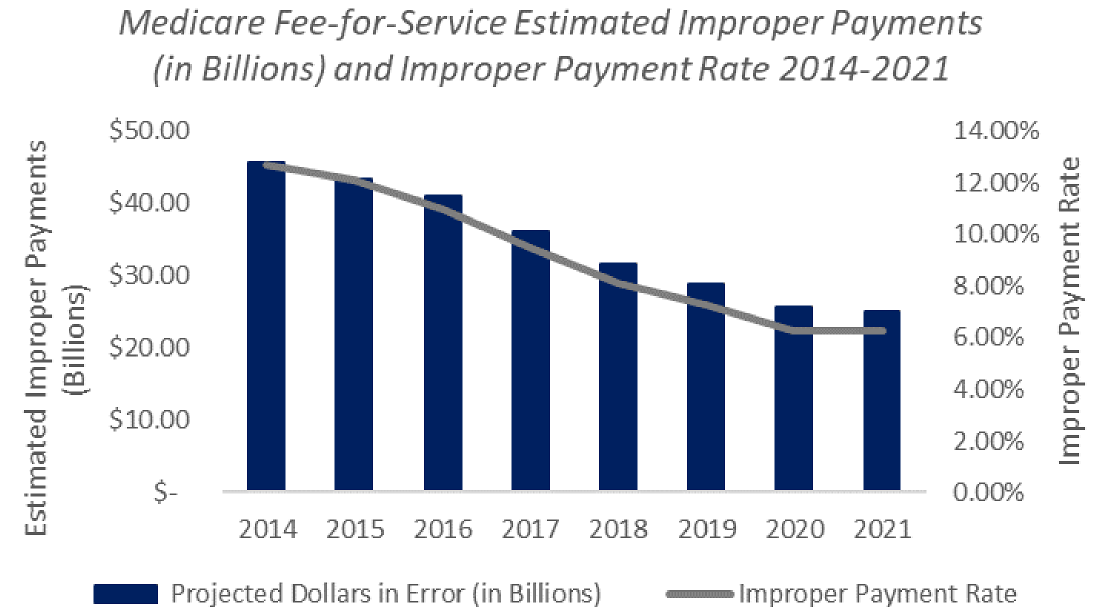
An intentional act of deception, misrepresentation or concealment in order to gain something of value

Rendering services or billing for services that are non-compliant with regulations, statutes, contracts or acceptable practices that does not include an intentional act

Unintentional over-utilization of services and/or the misuse of resources

Why is FWA Important

- Potential for patient harm
- Increased costs
- Estimates place FWA impacting 3%-10% of all healthcare claims



Source: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-medicare-fee-service-estimated-improper-payments-decline-over

Fraud, Waste, and Abuse Overview

Indicators of Potential Fraud, Waste, and Abuse

- Providing services or prescriptions not medically necessary.
- Knowingly billing for services not furnished or supplies not provided.
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.
- Conducting excessive office visits or writing excessive prescriptions.
- Billing for brand name drugs when generics are dispensed.
- Misusing codes on a claim, such as upcoding or unbundling codes.
- Excessively charging for services or supplies.

Reporting Non-Compliance or FWA Concerns

- Everyone is required to report suspected instances of non-compliance, fraud, waste, or abuse. Medica and your employer's Standards/Code of Conduct and Ethics should clearly state this obligation. Medica nor your employer **may not retaliate against you for making a good faith effort in reporting**
- You can report a compliance concern in a variety of ways:
  - Contact Medica's Compliance Officer- Milly Koranteng (Mildred.Koranteng@medica.com)
  - Medica Compliance Department (compliancedetectionandcorrection@medica.com)
  - Integrity/Fraud Reporting Line (can remain **anonymous** and available 24/7): 1-866-595 -8495
  - FWA Online Reporting Form found on medica.com
  - Medica's Special Investigations Unit: siu_mail@medica.com
  - Integrity Line QR Code

Any first tier, downstream entity, sub-contractor, delegate and business partner who knows of, but fails to report, suspected misconduct or non-compliance may be subject to termination of contract.

Laws You Should Know

Laws You Need to Know About

Civil False Claims Act (FCA) 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;
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus $11,000 per false claim filed. Additionally, under the criminal FCA, individuals or entities may face various criminal penalties.

Laws You Need to Know About

Criminal Health Care Fraud Statute prohibits:

- Knowingly and willingly executing, attempting to execute, a scheme or artifice to defraud any health care benefit program;

- Obtaining, 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

Knowingly making a false claim may result in criminal fines up to $250,000 or imprisonment up to 20 years. Violations resulting in death may result in longer imprisonment.

Laws You Need to Know About

- **Laws with Similar Purpose**

Anti-Kickback Statute (AKS)

- Prohibits offering, giving, soliciting or receiving ***remuneration*** in exchange for ***referrals or business generation***
- Claims submitted as a result of tainted referrals can be pursued under FCA
- Applies to **any** federal healthcare program
- Applies to **any** referral source
- Criminal and civil enforcement

Stark Law

- Prohibits referrals by ***physicians to get designated health services from a provider with whom*** the physician or physicians immediate family member has a **financial relationship**
- Prohibits billing by entity for improper referrals
- Applies to Medicare (& Medicaid)
- Civil enforcement; significant penalties

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Laws You Need to Know About

Potential Penalties for violating AKS and Stark Laws:

Criminal (AKS):

- ✓ Fine up to-$25,000
- ✓ Imprisonment up to 5 years; or
- ✓ Both

Civil (AKS & Stark):

- ✓ Up to $25,000 per violation or for each service;
- ✓ Up to 3-times the amount of improper remuneration or amount claimed; and/or
- ✓ Civil Monetary Penalties and exclusion from participation in federal health care program
- ✓ False Claims Act Liability

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Laws You Need to Know About

Civil Monetary Penalties Law:

- Authorizes the Office of Inspector General (OIG) to seek Civil Monetary Penalties (CMPs) and sometimes exclusions for a variety of health care fraud violations. Violation that may result in CMPs, include but are not limited to:
  - Arranging for an excluded individual’s or entity’s services or items
  - Filing a claim you know or should know is for an item or service that wasn’t provided as claimed or is false or fraudulent
  - Providing false or misleading information expected to influence a discharge decision
  - Making false statements or misrepresentations on applications or contracts to participate in federal health care programs

Penalties and assessments vary. Penalties can be approximately $10,000-$50,000 and damages may be tripled.

Laws You Need to Know About

Exclusion Statute:

- Requires the OIG to exclude individuals and entities convicted of the following offenses, from participation in federal health care programs:
  - Medicare or Medicaid fraud
  - Patient abuse or neglect
  - Felony convictions or other health care-related fraud, theft, or financial misconduct
  - Felony convictions for unlawful manufacture, distribution, prescribing, or dispensing controlled substances

The OIG maintains the List of Excluded Individuals and Entities (LEIE) website. The U.S. General Services Administration (GSA) administers the Excluded Parties List System, which enables agencies to take debarment actions.

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Laws You Need to Know About

Health Insurance Portability and Accountability Act (HIPAA)

- Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), as modified by the Health Information Technology for Economic and Clinical Health Act (HITECH).
- Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
- Promotes the adoption of meaningful use of health information technology.
- Safeguards to prevent unauthorized access to protected health care information.
- As an individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Laws You Need to Know About

HIPAA

- The beneficiary information we are required to safeguard is referred to as *Protected Health Information*, or PHI.
- PHI is information that could be used to identify the beneficiary and has information about their health, health care they received, or payment for care.
- That includes beneficiary demographic data such as name, address, birth date, Social Security numbers, etc.
- If a beneficiary's name is used in a way that identifies them as a Medica member, it is PHI.

Knowledge Check

Knowledge Check

#1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery. What is your next step?

a) Fill the prescription for 160

b) Fill the prescription for 60

c) Call the prescriber to verify quantity

d) Call the Health Care Plan’s and/or your internal compliance department

e) Call law enforcement

Knowledge Check

#1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the Health Care Plan and/or your internal compliance hotline for next steps.

Knowledge Check

#2

Your job is to submit risk diagnoses to CMS for purposes of payment. As part of this job, you are to verify the data is accurate following a documented process. Your immediate supervisor tells you to ignore the process and to adjust/add risk diagnosis codes for certain individuals. What do you do?

a) Do what is asked of by 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

Knowledge Check

#2 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. The Health Care Plan and/or supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

Knowledge Check

#3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider (“Doe Diagnostics”) has requested a substantial payment for a large number of beneficiaries. Many of these claims are for the same procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed. What do you do?

a) Call Doe Diagnostics 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

Knowledge Check

#3 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.

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Knowledge Check

#4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy. What should you do?

a) Call the local law enforcement

b) Perform another review

c) Contact your compliance department

d) Discuss your concerns with your supervisor

e) Follow your pharmacies procedures

Knowledge Check

#4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.

Knowledge Check

#5

Which of the following are one of the seven elements of a Compliance Program? (select all that apply)

a) Written Standards of Conduct and Policies & Procedures

b) Oversight through Compliance Officer and Committee

c) Training & Education

d) Effective Lines of Communication

e) Auditing and Monitoring Plans

f) Prompt Correction of Identified Issues

g) Consistent Disciplinary Standards

Knowledge Check

#5 Answer

Answer A, B, C, D, E, F, G

All are one of the seven elements of a Compliance Program

Knowledge Check

#6

You are a key part of Medica's Compliance Program and adherence to the Compliance Program is essential to its effectiveness.

a) True

b) False

Knowledge Check

#6 Answer

Answer A (True)

Knowledge Check

#7

How can suspected instances of non-compliance, fraud, waste, or abuse be reported? (select all that apply)

a) Contact Medica’s Compliance Officer- Milly Koranteng (Mildred.Koranteng@medica.com)
b) Medica Compliance Department (compliancedetectionandcorrection@medica.com)
c) Integrity/Fraud Reporting Line (can remain **anonymous** and available 24/7): 1-866-595-8495
d) FWA Online Reporting Form found on medica.com
e) Medica’s Special Investigations Unit: siu_mail@medica.com
f) Integrity Line QR Code

Knowledge Check

#7 Answer

Answer A, B, C, D, E, F (all)

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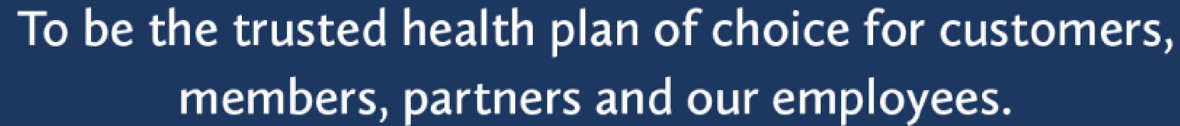
Congratulations!

You have completed the Compliance and Fraud, Waste, and Abuse Awareness Training

for business partners

MISSION



To be the trusted health plan of choice for customers, members, partners and our employees.

VISION

To be trusted in the community for our unwavering commitment to high-quality, affordable health care.

VALUES

Customer-Focused • Excellence • Stewardship • Diversity • Integrity

THANK YOU