Medicare Compliance Oversight
Targeting Fraud, Waste, and Abuse

A training module for Medicare Advantage First-tier, Downstream and Related Entities (FDRs)
Commitment to Compliance

SelectHealth has a compliance oversight program which supports compliant behavior by its employees and any of its contracted business partners, including first-tier, downstream and related entities (FDRs), in Medicare and Medicaid programs. The aim is to minimize potential violations of the Centers for Medicare and Medicaid Services (CMS) rules and regulations.

As a Medicare Advantage Plan it’s important that we educate our FDR partners on general compliance requirements and on measures to prevent, detect, and correct fraud, waste, and abuse (FWA). We also want you to be aware of the communication channels for reporting compliance concerns or suspected FWA.

By completing this training you are being compliant with CMS requirements and helping SelectHealth be compliant with CMS regulatory requirements. Both SelectHealth and FDRs are required to maintain training and education records (including time, attendance, topic, certificate of completion if applicable, and test scores, if any) for a period of 10 years.
• **First Tier Entity** is any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or Part D plan sponsor to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

• **Downstream Entity** is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between the MAO or Part D sponsor and a first tier entity.

• **Related Entity** means any entity that is related to an MAO or Part D sponsor by common ownership or control and
  1. Performs some of the MAO or Part D plan sponsor’s management functions under contract or delegation;
  2. Furnishes services to Medicare enrollees under an oral or written agreement; or
  3. Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.
Examples of First-Tier and Downstream Relationships

SelectHealth
Medicare Advantage Prescription Drug Plan

- Credentialing (First Tier)
- Fulfillment Vendors (First Tier)
- Health Services/Hospital Groups (First Tier)
- Agents (First Tier)
- Pharmacies (First Tier)

- Hospitals (Downstream)
- Mental Health (Downstream)

- Providers (Downstream)
- Providers (Downstream)
The primary purposes of an effective compliance program is to:

• **Prevent, detect, and correct** program noncompliance and fraud, waste, and abuse.

The 7 elements of an effective compliance program are listed to the right.
Compliance Program Element 1

Policies, Procedures, and Standards of Conduct

As part of Intermountain Healthcare, SelectHealth adheres to the Intermountain Code of Ethics.

SelectHealth expects all of its employees to follow the Code of Ethics and also makes its Code of Ethics available to FDRs and their employees.

Policies and Procedures provide guidance on how to identify and report compliance issues through appropriate reporting channels (including a method for anonymous reporting).

Your organization may have its own Standards of Conduct and compliance policies and procedures.

Compliance is everyone’s responsibility. SelectHealth requires all of its contracted business partners to adhere to the laws and regulations that pertain to their role in the Medicare Advantage program.
Compliance Program Oversight

The SelectHealth Medicare Compliance Committee and the SelectHealth Board of Trustees oversee the Medicare Compliance Program by supporting and advising the Medicare Compliance Officer. They are provided regular reports of compliance activities, risk areas, and program status.

The Medicare Compliance Officer and the Medicare Compliance team implement the Medicare Compliance Program and can be contacted to report non-compliance and fraud, waste, and abuse.

Senior management, including the SelectHealth CEO, also participate in Compliance Program oversight.

Wade Thornock
Medicare Compliance Officer
Phone: 801-442-7212

Designation of Compliance Officer and Committee
Effective training and education helps you understand the rules and regulations and prepares you and your employees to respond appropriately when noncompliance or fraud, waste, or abuse is suspected.

Completing compliance education and fraud, waste, and abuse training is a CMS requirement. Training and education is required for new FDR employees within 90 days of hire and annually thereafter.
There are many people available to hear your concerns. It’s up to you to speak up.

**Failure to report** actual or suspected noncompliance or FWA may result in investigation of you and/or your organization and potentially disciplinary action.

Remember, any individual who reports a legitimate concern in good faith will be protected from retaliation and intimidation. Anonymous reporting and interpretation services are available through the Compliance Hotline.

**It’s important** that concerns relating to SelectHealth Advantage are reported to SelectHealth either directly or through your organization’s procedures for referring issues to Medicare Advantage plans sponsors.
**SelectHealth** policies enforce standards when an investigation reveals noncompliant or unethical behavior.

**Disciplinary standards** may include training or corrective actions up to and including termination of a contractual relationship depending on the severity of noncompliance.

**Our Code of Ethics** requires that when working with vendors, we do so free from conflict of interest. The same is expected of our FDRs supporting Medicare programs. Any concerns about conflict of interest should be reported to SelectHealth.

---

**A Conflict of Interest**

A situation in which an individual’s financial, professional, or other personal considerations may directly or indirectly affect, or have the appearance of affecting their professional judgment in performing the duties or responsibilities for which they are contracted. A situation that may appear to fit these criteria but has been duly disclosed, reviewed, and has had specific controls put in place to manage the potential conflict in accordance with applicable SelectHealth policy will not be deemed to constitute a “Conflict of Interest.” SelectHealth reserves the right to rescind its approval of any potential conflict or conflict management plan when later experience proves the situation to be problematic. A conflict may also exist at the institutional or organizational level and will be addressed in a similar manner described above.
SelectHealth performs regular risk assessments in order to identify necessary monitoring and auditing activities, including monitoring and auditing of functions delegated to FDRs, together these activities comprise the program audit plan.

Monitoring and auditing activities are structured to regularly review plan operations, including delegated functions, to confirm ongoing compliance with program rules and regulations and contractual agreements.

As a federally funded health benefit plan sponsor, SelectHealth also monitors required excluded individual and entity databases which list excluded providers and other entities with which SelectHealth is not allowed to do business. SelectHealth withholds reimbursement to providers and vendors who are excluded from participating in federally funded programs.
Response and Corrective Action

**Discovery:** Compliance issues may be discovered through several methods, including the Compliance Hotline, a member complaint, during routine monitoring and auditing activity, or by regulatory authorities.

**Investigation:** If misconduct is discovered or suspected, a prompt investigation is initiated by the SelectHealth Compliance Team and/or the SelectHealth SIU.

**Corrective Action:** Corrective action plans are designed to address the underlying problem and aim to prevent future noncompliance. At times, the corrective action could include disclosing the issue to the applicable regulator(s)/federal contractor(s).
Introduction to Fraud, Waste and Abuse

Our compliance program reduces the risk of fraud, waste, and abuse...

But only if you are an active part of the process. Remember, fraud, waste, and abuse can occur anywhere along the healthcare continuum—from the application for plan enrollment to the payment for covered services.

- Every year millions of dollars are improperly spent because of fraud, waste and abuse in the health care environment.

- It affects our industry, it affects our organization, it affects providers, it affects members, it affects YOU!

Be an active part of the process. As a trusted partner with both SelectHealth and Medicare beneficiaries enrolled in the SelectHealth Advantage plan, you are in a unique position to identify areas of concern and report them.

Training helps prevent, detect, and correct fraud, waste and abuse. Everyone is part of the solution.
It is important to understand the definitions of **Fraud, Waste, and Abuse**.
**Error**

**Definition:**
An error is simply a mistake made by someone where there is no apparent intent to make a misrepresentation or attempting to gain from the misrepresentation. An error typically does not result in waste.

**Examples:**
- A typo during data entry
- A mathematical miscalculation
- Accidental omission of information
Waste

Definition:
Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a health benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples:
- Unnecessary spending to purchase supplies or equipment
- Overutilization of items (e.g., prescription drugs) or healthcare services without criminal intent.
- Failure to correctly follow procedures that result in performing additional medical services that would not otherwise be necessary or required.
Fraud, Waste, and Abuse Defined

Abuse

Definition:
Abuse cannot be differentiated categorically from fraud because the distinction between “fraud” and “abuse” depends on the specific facts and circumstances, intent, prior knowledge, and available evidence, among other factors.

Examples:
• Billing for services/items in excess of those that are medically necessary for the patient
• Routinely filing duplicate claims, even if it does not result in duplicate payment
• Doctor shopping for the purpose of inappropriately obtaining multiple prescriptions
Fraud

Definition:
Knowingly and willfully executing or attempting to execute a scheme to obtain money or property from a health benefit program. Fraud involves false representation and promises that are knowingly made.

Examples:
- Knowingly paying claims for services that were not provided or were intentionally miscoded
- Making false statements or misrepresentations on applications in order to participate in a government healthcare program
- Intentionally billing for prescriptions that are never picked up
- Obtaining and storing large quantities of drugs and then disenrolling from the plan
You can help to prevent fraud, waste, and abuse simply by learning what it looks like, especially in your business area. Understanding the laws and regulations prepares you and your employees to respond appropriately when noncompliance or fraud, waste, or abuse is suspected.

The laws effect everybody in the healthcare system and are important to providing services in a safe, secure, and efficient manner.
Medicare Modernization Act

This act has several parts. Most notably are the following:

**Title I** (Medicare Prescription Drug Benefit) governs every aspect of a Medicare Prescription Drug (Part D) plan’s activities, including marketing, access, appeals, networks, formularies, and reporting costs.

**Title III** (Combating Waste, Fraud, and Abuse) implemented a project using recovery audit contractors to identify under and overpayments in Medicare, and correct overpayments. The RAC program was made permanent under The Tax Relief and Health Care Act of 2006.

**What you should know:**
We must ensure that our billing and payments are accurate. Contracted auditors are actively looking for overpayments from Medicare and Medicaid.
Physician Self -Referral Law (STARK)

This law prohibits physicians from making a referral for designated health services to an entity in which the physician (or a member of his or her family) has an ownership, investment interest, or a compensation arrangement. Some exceptions apply.

What you should know:
Physicians can’t refer beneficiaries to an entity where the physician would get financial gain.
**Anti-Kickback Statute**

This statute prohibits soliciting, receiving, offering, or paying for referrals where services are paid under a federal health care system. This includes kickbacks, bribes, or rebates.

**What you should know:**
We cannot encourage nor reward others for referrals of items or services.
HIPAA (Health Insurance Portability and Accountability Act)

This act created greater access to health insurance while strengthening privacy and protection of health care data. It promoted standardization and efficiency in the health care industry. It also established programs to coordinate and strengthen efforts to prevent healthcare fraud.

What you should know:
We are responsible to protect the privacy of all member information.
**The False Claims Act**

This act prohibits presenting false claims for payment or approval; it prohibits using a false record or statement in support of a false claim.

The act addresses the certification, receipt, and purchase of property involving the government and the concealment or avoidance of an obligation to pay the government.

Specific provisions to protect “whistle blowers” from retaliation by their employers are also included.

**What you should know:**
We cannot present a claim for payment that we know to be incorrect.
Relevant Laws and Regulations

**HITECH Act**

This act promotes adoption of electronic health records and development of a national health information network. It creates incentives for health information technology use by physicians and hospitals. It also imposes new HIPAA privacy and security requirements.

**What you should know:**
Hospitals and physicians are being incentivized to use electronic health systems. As these entities start using new systems, we need to watch for inadvertent electronic data errors.
Beneficiary Inducement Act

This statute prohibits offering a payment or any inducement that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier.

What you should know:
We cannot influence a beneficiary in their selection of a provider or supplier.
Relevant Laws and Regulations

Medicare Modernization Act
Physician Self-referral Statute
The Anti-kickback Statute
HIPAA
The False Claims Act
HITECH Act
Beneficiary Inducement Statute
Exclusion from Participation
Prohibition on Gifts

Exclusion of Certain Individuals and Entities From Participating in Medicare

The Office of Inspector General (OIG) maintains a List of Excluded Individuals and Entities (LEIE). Individuals and entities on this list are excluded from federally funded health care programs. Federal health care programs are prohibited from paying for items or services provided, ordered, or prescribed by individuals on the list.

What you should know:
We cannot pay for items or services to individuals who have been excluded from participation in federally funded health care programs.
Federal law prohibits giving anything of value to a federal employee with the intent of influencing the performance of an official act. This prohibition also applies to gifts from nongovernmental sources, which includes any gratuity, favor, discount, entertainment, hospitality, loan or any other item having monetary value.

**What you should know:**
Do not offer or make available to any federal employee monetary payments, gifts, services, or entertainment, or anything of value unless it meets one of the specific exceptions under the law.
**DETECT Fraud, Waste, and Abuse**

**Become** familiar with potential fraud, waste, and abuse and where it occurs.

Compare the roles on the left to the corresponding fraud, waste, and abuse example on the right.

- **Provider**
  - Adding coding modifiers to pass national coding edits when documentation does not support the use of the code.

- **Pharmacy**
  - Changing quantities, number of refills, or Dispense as Written instructions. Billing for a brand name drug when a generic is dispensed. Providing less than the prescribed quantity but billing for the full amount.

- **Member**
  - Using another person’s ID card to obtain healthcare or prescription drugs. Visiting a number of different doctors to obtain multiple prescriptions.

- **Agent**
  - Intentionally misleading a beneficiary by knowingly providing false information about the plan in order to persuade the member to enroll in a particular plan.

- **Plan or Plan Employee**
  - Offering cash payment as encouragement to enroll in a Medicare Advantage plan. Backdating an application to give coverage before the date of eligibility.
Be aware of the following **Red Flags** that may be potential Program Noncompliance or Fraud, Waste, or Abuse.

### Potential Beneficiary Issues
- The prescription looks altered or possibly forged
- The medical services being requested are not supported by the beneficiary’s medical history.
- The beneficiary has filled numerous identical prescriptions from different doctors

### Potential Pharmacy Issues
- The pharmacy provides the generic when the prescription requires the brand name drug be dispensed
- The pharmacy bills for prescriptions that are not filled or are not picked up
- Drugs intended for nursing homes and hospices are being sent elsewhere

### Potential Provider Issues
- The provider only writes prescriptions for controlled substances rather than for diverse drugs
- The provider consistently and frequently bills the highest code levels
- The provider “balance bills” patients for the difference between the billed charges and the amount that Medicare or a Medicare Advantage plan paid

### Potential Agent Issues
- The beneficiary requests to change plans because they have been offered a cash incentive to make the switch.
- The agent requests the enrollment date be back-dated and/or that premiums be waived for the beneficiary.
- The agent markets other products not identified in the Scope of Appointment.
Reporting is key in the prevention, detection, and correction of program noncompliance and FWA. Any individual who reports a legitimate concern in good faith will be protected from retaliation and intimidation.

To report suspected noncompliance or FWA, you can do any of the following:

- **Call** the SelectHealth 24-hour Compliance Hotline (optional anonymous reporting) or your organization’s Ethics/Compliance Help Line
- **Report** suspicious activity or concerns to the SelectHealth Compliance team or your organization’s compliance team in person, by phone, or via e-mail.
Your Responsibilities as an FDR

• **Comply** with applicable statutory, regulatory, and other Part C or Part D requirements.

• **Distribute Standards of Conduct** and compliance policies and procedures to employees and downstream entities within 90 days of hire/contracting and annually thereafter.

• **Complete Compliance and FWA Training** and make sure your employees and downstream entities complete required training within 90 days of hire/contracting and annually thereafter.

• **Report Suspected Noncompliance or FWA**. Distribute reporting mechanisms to your employees and downstream entities and inform them of the non-retaliation policy.

• **Check the Exclusion Lists**. Review the federal exclusions lists prior to hiring new employees or contracting with downstream entities and monthly thereafter to ensure individuals/entities are not excluded from federal programs.

• **Monitor Downstream Entities**. Distribute materials and information to downstream entities and monitor and audit the downstream entity’s performance to ensure they also comply with all applicable CMS requirements.

• **Identify Offshore Subcontractors**. Notify SelectHealth if you contract with an entity that performs services offshore that requires sharing of protected health information.

• **Retain Records for 10 years**. Maintain records for a minimum of 10 years, including records of employee and downstream training and education completion.
Thank you for completing the SelectHealth General compliance and FWA training.

For more information and additional resources, please visit:

- SelectHealth Broker Exchange
- SelectHealth Provider/Pharmacy Portal
- SelectHealth FDR Webpage

We all have the opportunity to get involved and be part of the solution.
Congratulations!

You have completed the 2014 SelectHealth Medicare Advantage General Compliance and FWA Training

________________________________________
Recipient’s Name

________________________________________
Date
Congratulations!

**Training Log**

Evidence of completion of training and education must be maintained for a period of 10 years and be produced upon request by SelectHealth or CMS, or a CMS designee. Evidence may include training logs with dates and certificates of completion (if applicable), sign-in sheets, attestations, or other methods to demonstrate fulfillment of the record retention obligation.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Title of Training Course</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>