



iCare

WellCare Corporate Compliance

Fraud, Waste & Abuse

Prevention

Awareness Training

What is Fraud, Waste and Abuse (FWA)

Upon completion of this training you should be able to:

- Recognize and understand the principles underlying state and federal laws related to fraud, waste and abuse (“FWA”)
- Understand the definitions of fraud, waste and abuse as they pertain to state and federal health care programs
- Understand the significance of your company’s obligations and duties under, the Anti-Kickback Act, False Claims Act(s), and the Civil Monetary Penalties Law
- Know what to do if you suspect FWA
- Understand that all WellCare vendors and contractors have an affirmative duty to report suspected health care fraud



WellCare's Commitment


WellCare is committed to complying with applicable federal and state laws, rules and regulations by adhering to high standards of business ethics as reflected in its Corporate Compliance Program.



FWA Training Topics


This training will address the following topics, among others:

- Obligations of first-tier, downstream and related entities, to have appropriate policies and procedures to address fraud, waste and abuse.
- Process for reporting suspected fraud, waste and abuse of first-tier, downstream and related entities to WellCare.
- Protections for employees of first-tier, downstream and related entities, who report suspected fraud, waste and abuse.
- Types of fraud, waste and abuse that can occur in first-tier, downstream and related entities.



CMS Training Requirement

- The Centers for Medicare & Medicaid Services (“CMS”) requires that all delegated and contracted providers that render benefits or services for Medicare Part C and Part D programs must meet annual fraud, waste and abuse (“FWA”) training requirements.
- This mandate applies to all health plans with Part C and Part D programs and to their vendors and contractors.
- Federal fraud, waste and abuse training requirements are found at 42 C.F.R. § 422.503(b) (4) (vi) and 42 C.F.R. § 423.504 (b) (4) (vi).



What is Fraud?

Fraud is an intentional deception or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.



How Common?

- The United States Department of Health and Human Services-Office of Inspector General (“HHS-OIG”) conservatively estimates that \$100 Billion is lost to healthcare fraud each year
 - That is \$273 Million a day ... and with healthcare costs escalating, this number is expected to rise
- Fraud can be committed by any person or entity in the healthcare delivery chain



Provider Fraud Examples

Billing for services not rendered

- Billing for individual therapy, where only group therapy was performed
- Billing for Durable Medical Equipment (“DME”) supplies never delivered
- “Phantom” provider obtains Medicaid ID number, and bills for supplies or services never rendered

Rendering and billing for non-medically necessary services

- Performing Magnetic Resonance Imaging with contrast although the contrast was not indicated or necessary
- Ordering higher-reimbursed, complete blood lab tests for every patient although specific or targeted tests are indicated

Upcoding - Billing a higher level service than provided

- Reporting CPT code 99245 (High Level Office Consultation) where services provided only warranted use of CPT code 99243 (Mid level Office Consultation)

Member and Agent Fraud - Examples

Member Pharmacy Fraud

- Members visiting multiple providers with feigned symptoms in order to obtain prescriptions for narcotics
- Members stealing prescription pads and forging provider's signature

Theft of ID/Services

- An unauthorized individual uses a member's Medicare/Medicaid card to receive medical care, supplies, pharmacy scripts, or equipment; often a family member or acquaintance

Falsification of Documentation/Forgery

- An agent forging a person's signature on an application

Misrepresentation of Benefits

- An agent misrepresenting benefits to persuade an individual to join a health plan

Health Plan and Provider Fraud - Examples

Encounter Data Falsification

- Health plans knowingly submitting falsified claims encounter data to gain a higher Healthcare Effectiveness Data and Information Set (“HEDIS”) score

Underutilization

- Providers or health plans deliberately and systematically deterring members from receiving medically necessary services in order to maximize service funds or capitation revenue

Attestations/Conditions of Participation

- Falsification of information provided to federal or state regulatory agencies in order to obtain government contracts or other business

Quality Access

- Falsification of network adequacy reporting in order to obtain government contracts



Associate/FWA Criminal Activity

WellCare's vendors' and contractors' employees have access to systems and information that touches many parts of WellCare's business. As a result, we must be alert to the possibility that associates could use such access for their own personal benefit, potentially with assistance from others within or outside the organization. Examples of associate fraud or fraud "red flags" could include:

- Creating a fictitious provider in the system, and submitting claims that result in checks going back to the associate's business or designated address, (i.e., to a "dummy" corporation)
- Selling or exchanging member information to sales agents with other plans
- Receiving a kickback or commission from an outside individual or entity in return for approving claims that should have been denied
- Falsifying enrollee signatures on any type of document
- Providing computer system log-in credentials to other employees or non-employees for purposes of allowing others to access member information
- Falsely inflating production-related statistics in order to meet personal or corporate goals
- Intentionally providing or concealing inaccurate data in a report to a government agency

What is Abuse?

What is Waste?

- “Abuse” is sometimes defined as a practice that is inconsistent with accepted business or medical practices or standards and that results in unnecessary cost.
- “Abuse” can be thought of as potential fraud, where the provider’s intent may have been unclear.
- “Waste” includes any practice that results in an unnecessary use or consumption of financial or medical resource

Abuse - Examples

Abuse can include a range of improper behaviors or billing practices. For example:

Billing for a non-covered service

- **Fraud:** The provider knew that service was non-covered, but changed the ICD-9 diagnosis to obtain coverage
- **Abuse:** Provider suspected that service might not be covered, but figured that she would “test” and submit a claim anyway

Misusing codes on the claim

- **Fraud:** Provider sat down with billing policies and deliberately identified loop-holes
- **Abuse:** Provider assumed that must be billing correctly as long as claims paid

Inappropriately allocating costs on a cost report

- **Fraud:** Hospital personnel deliberately misclassified expense items
- **Abuse:** Hospital construes regulatory ambiguities guided solely by financial benefit to hospital



Waste Example

In a hospital setting, a patient needs 375 ml of medication. The pharmaceutical company does not make a 375 ml bottle but only 500 ml or 1000 ml bottles. Once the bottle is opened, the unused portion must be disposed of, i.e., “wasted.”

Greater waste would occur if the hospital consistently orders and uses the 1000 ml bottle when the 500 ml bottle is available.

Fraud may be occurring if the hospital’s choice to purchase 1000 ml bottles is influenced, for example, by favorable manufacturer rebates tied to 1000 ml bottles.



FWA Red Flags

- Medical claims that duplicate or unbundle procedures to maximize payment
- Dates of service not recorded in medical records or that do not match bill dates
- Different names or addresses of dependents and primary covered person
- Duplicate requests for authorization of a service that has been denied
- Changing documentation during the appeals and grievance process to overturn a denied authorization
- Multiple claims submitted on different dates for the same member, each showing same dates of services or overlapping dates of service
- Significant “spike” in provider’s claims activity or reimbursement in comparison to provider’s historical activity



Vendor and Contractor Responsibilities

- Learn and comply with WellCare FWA policies and procedures
- If you come across situations that do not make sense and you feel might involve fraud, waste or abuse, you can do any and all of the following:
 - Discuss the situation with your supervisor;
 - Report the situation to WellCare's Fraud Hotline;
 - Report the situation anonymously to WellCare's iCare Hotline;
 - Report the situation directly to your company's Compliance or Legal Department.
- Further details on WellCare's hotlines will be provided at the end of this training

Deficit Reduction Act of 2005

The Federal Deficit Reduction Act (“DRA”) of 2005, Section 6032, requires entities that make or receive annual Medicaid payments of \$5 million or more to provide, in written policies applicable to all employees, contractors and agents, detailed information about:

- The federal False Claims Act (“FCA”) and any state laws that pertain to civil or criminal penalties for making false claims and statements, as well as the “whistleblower” protection under such laws
- The rights of the employees to be protected as “whistleblowers” when they report suspected violations of such laws. Employers may not retaliate against employees who report potential misconduct in good faith.
- The organization’s methods for detecting and preventing FWA

Laws and Guidance

The Anti-Kickback Statute prohibits:

- The knowing and willful offer, payment, solicitation or receipt of any “remuneration,” in cash or in kind, direct or indirect...
- ...to induce someone to refer a patient or to purchase, order, or recommend any item or service which may be paid for under a Federal health care program.

CMS Marketing Guidelines require:

- All payments that plans make to providers for services must be fair market value, consistent with an arm's length transaction, for bona fide and necessary services.

Anti-Kickback: Suspect Arrangements

- Paying a physician for each patient who enrolls or remains enrolled in a plan
- Conditioning physician's compensation on minimum percentage of plan enrollees in physician's patient panel
- Offering enhanced fees, or fees clearly exceeding fair market value, to providers without any justification, such as enhanced quality or need for additional resources
- Accepting material gifts or perks from vendors in exchange for selecting vendor's products or services

Anti-Kickback Safe Harbors

- Limited “safe harbors” that may protect arrangements that might otherwise violate the Anti-Kickback Act
- Most important “safe harbors” for health plans
 - Discounts offered to health plans by providers
 - Price reductions offered to health plans by providers
 - Agreements with contractors with substantial financial risk
- Other relevant “safe harbors”
 - Management contracts
 - Increased coverage, reduced cost-sharing amounts or reduced premium amounts offered by health plans to beneficiaries
- No “safe harbors” for payments made in return for patient enrollment or retention

False Claims Laws

State and federal false claims laws impose significant penalties for knowingly:

- Submitting (or causing to be submitted) a false or fraudulent claim for payment or approval; or
- Making or using (or causing to be made or used) a false record or statement in support of a false or fraudulent claim; or
- Failing to return overpayments made by a government agency

“Knowingly” includes actions taken in “reckless disregard” or with “deliberate ignorance” of truth or falsity

The *qui tam* provisions of the federal False Claims Act (“FCA”)

- Lawsuit initiated by private individual (defined as “relator”)
- The government may choose to intervene in the private lawsuit
- *Qui tam* “relator” shares in civil monetary recovery, if any, with government

Potential False Claims Violations

- Misrepresentation of information presented in reports to Medicare or Medicaid
 - Pharmaceutical industry paid substantial sums to settle FCA cases based on prices reported to the Red Book and First Data Bank which did not reflect discounts the companies routinely gave customers.
- Misrepresentation of claims or eligibility data reported to Medicare or Medicaid
 - Humana paid \$14.5 million to settle allegations that it incorrectly claimed members as dually eligible for both Medicare and Medicaid, and entered into a broad five-year corporate integrity agreement with the OIG.


Civil Monetary Penalties Law

The Social Security Act authorizes the Secretary of HHS to seek civil monetary penalties (CMPs) and assessments for many types of illegal or unethical conduct. The Secretary of HHS has delegated many of these CMPs to the OIG. Types of prohibited conduct include, but are not limited to, the following:

- Offering inducements that one knows, or should know, are likely to influence Medicare or state health care program beneficiaries to order or receive items or services from a particular provider, practitioner or supplier
- Giving false or misleading information that might affect the decision to discharge a Medicare patient from the hospital
- Misusing Medicare and Medicaid program words, letters, symbols or emblems


Civil Monetary Penalties Law: Violation Examples

- Physicians who knowingly misrepresent that a Medicare beneficiary requires home health services
- Submitting a claim, or claims, for service not rendered
- Utilizing a CMS logo without approval
- Failing promptly to return a known overpayment
- Offering inducements to influence decisions related to Medicare or Medicaid funds
- Acting to expel or refusing to enroll a Medicaid recipient due to the individual's health status
- Hiring employees who have previously been excluded from participation in federal programs



Coordination with Law Enforcement

Through its Corporate Compliance Program, WellCare investigates suspected fraud, waste or abuse, and, as appropriate, reports and cooperates with both federal and State agencies, including law enforcement, CMS and Medicare Drug Integrity Contractors.



Auditing and Monitoring

To ensure compliance and to deter and detect fraud, waste and abuse, WellCare conducts regular and periodic compliance audits performed by both internal and external auditors and staff who have expertise in federal and state health care laws and regulations.



Reporting a Suspected Incident

All WellCare vendors and contractors are required to report suspected violations or conduct that appears to be fraudulent or in conflict with the principles of WellCare's Compliance Program.

Reports involving suspected fraud or misconduct by third parties (i.e., providers or members) may be made to WellCare's Fraud Hotline at 866-678-8355

Reports involving suspected fraud or misconduct by employees of WellCare, its vendors, or its contractors may be made anonymously to WellCare's iCare Hotline at 1-866-364-1350 or through the EthicsPoint website at: www.WellCare.EthicsPoint.com

No adverse or retaliatory actions may lawfully be taken against anyone who reports an issue in good faith

Attestation

Please sign your name below, to attest that you have understood the content of this training course, and agree to abide by all laws, policies and guidelines referenced in this program.

Signature: _____

Date: _____