DEFICIT REDUCTION ACT (DRA) INFORMATION FOR EMPLOYEES

On February 8, 2006, the President signed the federal Deficit Reduction Act of 2005. This sweeping legislation affects many aspects of domestic entitlement programs, including both Medicare and Medicaid.

Provisions of the Deficit Reduction Act

The Deficit Reduction Act is a crucial step forward in bringing mandatory spending under control. In the long run, the biggest challenge to the budget is mandatory spending - or entitlement programs like Medicare, Medicaid, and Social Security. Together, these programs are now growing faster than the economy and the population - and nearly three times the rate of inflation. By 2030, spending for Medicare, Medicaid, and Social Security alone will be almost 60 percent of the entire Federal budget. The annual growth of entitlement programs needs to be slowed to affordable levels, but these programs do not need to be cut. Through reforms that will reduce the annual growth of mandatory spending, the Deficit Reduction Act saves taxpayers nearly $40 billion over the next five years - about $300 per taxpayer.

- **The Deficit Reduction Act is estimated to slow the pace of spending growth in both Medicare and Medicaid while maintaining our commitment to beneficiaries.** These two programs provide vital services to millions of Americans, but their costs are straining budgets at both the Federal and state levels. The Deficit Reduction Act restrains spending for entitlement programs while ensuring that Americans who rely on these programs continue to get needed care.
- **Taxpayers will save more than an estimated $6 Billion on Medicare over the next 5 years.** The Deficit Reduction Act, together with the Medicare Act of 2003, requires wealthier seniors to pay higher premiums for their Medicare coverage. The savings created by this reform and others will make it possible to increase Federal funding for important areas like kidney dialysis and rural hospitals.
- **The Deficit Reduction Act will also reduce the growth in Medicaid by nearly $5 Billion over the next 5 years.** The Deficit Reduction Act helps restrain Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not have to pay inflated markups. The bill also gives governors more flexibility to design Medicaid benefits that efficiently and affordably meet their states' needs, and tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits.
- **The President is committed to finding additional ways to make Medicare and Medicaid more efficient.** The President's FY 2007 budget proposes another $36 billion in savings on Medicare and more than $1 billion in savings on Medicaid. The President's proposals slow the average annual growth in Medicare over the next five years from 8.1 percent a year to 7.7 percent a year. Together with the Deficit Reduction Act, the President's budget will slow Medicaid's average annual growth over the next five years from 6.9 percent a year to 6.6 percent a year.
- **In the long run, ensuring the stability of Medicare and Medicaid requires structural reform.** In his State of the Union Address, the President proposed a bipartisan

commission to examine the full impact of Baby Boomer retirements on Medicare, Medicaid, and Social Security. This commission will include members of Congress from both parties and will recommend long-term solutions.

Providing new resources for those with the greatest needs.

- The Deficit Reduction Act includes $1 billion in additional mandatory spending for the Low-Income Home Energy Assistance Program (LIHEAP) to help low-income Americans pay heating bills; $2 billion in new funding to cover health care costs for Hurricane Katrina victims; and more than $1 billion in new funding for low-income disabled children.

Health Opportunity Accounts

Effective January 1, 2007, Public Law No. 109-171 Deficit Reduction Act of 2005 Section 6082 Health Opportunity Accounts (HOAs) provides for ten States to operate Medicaid demonstrations programs to test alternative systems to deliver Medicaid benefits through an HOA in combination with a high deductible health plan (HDHP).

Additional information regarding the statute and grant application instructions is forthcoming.

Medicaid Drug Rebate Program

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations (CMSO). The drug rebate program was amended by the Veterans Health Care Act of 1992 (VHCA). Under VHCA, drug manufacturers are required to enter a pricing agreement with HHS for the Section 340B Drug Pricing Program, which is administered by the Health Resources and Services Administration. To obtain a copy of this pricing agreement, click on the download links listed below. In addition, VHCA requires drug manufacturers to enter into various agreements with the Department of Veterans Affairs. For more information regarding Section 603 of the VHCA's requirements, please contact Carole O'Brien at (708)786-4957 or carole.obrien@med.va.gov. A drug manufacturer must sign an agreement with these two programs in order to have its drugs covered by Medicaid.

Approximately 550 pharmaceutical companies currently participate in this program. Forty-nine states, (Arizona is excluded), and the District of Columbia cover drugs under the Medicaid Drug Rebate Program.

By signing into law the Deficit Reduction Act of 2005, which among other provisions places severe new restrictions on the ability of the elderly to transfer assets before qualifying for Medicaid coverage of nursing home care.

In addition, the law incorporates provisions in the original budget bill passed by the Senate closing certain asset transfer "loopholes," among them:

- The purchase of a life estate will be included in the definition of "assets" unless the purchaser resides in the home for at least one year after the date of purchase.
- Funds to purchase a promissory note, loan or mortgage will be included among assets unless the repayment terms are actuarially sound, provide for equal payments and prohibit the cancellation of the balance upon the death of the lender.
- States will be barred for "rounding down" fractional periods of ineligibility when determining ineligibility periods resulting from asset transfers.
- States will be permitted to treat multiple transfers of assets as a single transfer and begin any penalty period on the earliest date that would apply to such transfers.

Medicaid

Many of the changes to the Medicaid program are established as options for the states. Regardless of the effective dates indicated in the Act, those provisions that create new state options for Medicaid will no be come effective until the state has fulfilled the requirements under state law for changes to its Medicaid state plan. Where possible, some states will likely prepare their state plan amendments in advance, so that new options are in effect on the first possible date under federal law. As we learn details of the Administration's plans regarding implementation, including rulemaking and issuance of policy guidance, we will update the information below with relevant information.

Eliminating Waste, Fraud, and Abuse in Medicaid

Of interest to people with disabilities, their families, and their service providers are a number of provisions that were added to the Medicaid program to help prevent or detect waste, fraud, and abuse, including:

Section 6032: Encouraging the Enactment of State False Claims Acts

- Section 6032 provides financial encouragement to states to have in effect a law dealing with false of fraudulent claims that meets certain federal requirements. If state have such a law in place, when recoveries are made for Medicaid funds improperly paid, the share owed to the federal government will be decreased by 10 percentage points. (effective January1, 2007)

Section 6033: Employee Education About False Claims Recovery

- Section 6033 requires states to ensure that any entity receiving Medicaid payments of at least $5 million per year must establish written policies with information about the federal False Claims Act; state laws regarding civil or criminal penalties for false claims and statements; and whistleblower protections with respect to preventing and detecting fraud, waste, and abuse in federal health care programs. (effective January 1, 2007)

Section 6035: Medicaid Integrity Program

- Section 6035 would establish a Medicaid Integrity Program in which the Secretary of the Department of Health and Human Services contracts with eligible entities to: review actions of individuals or organizations providing items and services reimbursed by Medicaid; audit payment claims; identify Medicaid overpayments to individuals or organizations; and educate service providers, managed care organizations, beneficiaries, and other individuals regarding payment integrity and benefit quality assurance issues.

Eligible entities must:

- Have demonstrated capability to carry out the activities
- Agree to cooperate with the Inspector General of HHS, the Attorney General, and other law enforcement agencies in investigation and deterrence of fraud and abuse
- Comply with federal acquisition and procurement conflict of interest standards
- Meet other requirements specified by the Secretary.

Funds are appropriated as follows:

- $5 million for fiscal year 2006;
- $50 million each for fiscal years 2007 and 2008; and
- $75 million for each fiscal year thereafter.

Amounts are available until expended.

The Secretary of HHS must increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program by providing support and assistance to states.

The HHS Office of Inspector General is to receive an additional $25 million for each of fiscal years 2006 through 2010 for Medicaid integrity work and such amounts remain available until expended.

In addition, the Secretary shall ensure that, beginning in 2006, the Medicare-Medicaid Data Match Program (commonly known as the Medi-Medi Program) is conducted to identify program vulnerabilities, coordinate activities to protect the federal and state share of expenditures; and increase the effectiveness and efficiency of both programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures. Funds are appropriated for expansion of the Medi-Medi Program as follows:

- $12 million for fiscal year 2006;
- $24 million for fiscal year 2007;
- $36 million for fiscal year 2008;
- $48 million for fiscal year 2009; and
- $60 million for fiscal year 2010 and each fiscal year thereafter.

Where the Secretary determines that a state requires legislative action to comply with requirements of the new fraud and abuse provisions, the state will not be found non-compliant before the first quarter after the next regular session of the state legislature that begins after enactment. (Where a state has a two-year legislative session, each year will be considered a separate regular session of the state legislature.)

Section 6036: Enhancing Third Party Identification and Payment

- Section 6036 would require states to determine if third party liability exists (in order to avoid the use of Medicaid funds) for additional entities: self-insured health plans; pharmacy benefit managers; and other parties legally liable by statute, contract, or agreement for payment of a health care claim or services. These organizations would be prohibited from taking an individual's Medicaid status into account in enrollment or making payments.

Section 6037: Improved Enforcement of Documentation Requirements

- This section requires individuals to present documentation of citizenship or nationality when they apply for Medicaid benefits. Failure to present such documentation will make them ineligible for Medicaid services. Documentation includes: a U.S. passport, Certificate of Naturalization (or other document specified in Immigration and Nationality Act), a birth certificate, valid driver's license, or other documentation which the U.S. Secretary of Health and Human Services specifies is proof of U.S. citizenship or naturalization.

Section 6037 becomes effective for eligibility determinations made on or after July 1, 2006. It requires the HHS Secretary to develop an outreach plan to educate individuals who are likely to be affected by these provisions.

Long Term Services and Supports

The Deficit Reduction Act includes a number of provisions affecting long term services and supports. The provisions of most interest to people with disabilities include the following:

Section 6086: Expanded Access to Home & Community-Based Services for the Elderly & Disabled

- Section 6086 contains the provisions from Title II of S. 1602, the Improving Long-Term Care Choices Act, introduced by Senators Charles Grassley (R-IA), Evan Bayh (D-IN), and Hillary Clinton (D-NY) with the support of the disability community. These provisions of Section 6086 will: establish a new option for states to provide home- and community-based services (HCBS) without states needing to use a waiver process; allow states to provide any of the services now covered under HCBS waivers; and require states to establish stricter eligibility (level of care) criteria for institutional services than for community-based services. In addition, states may continue to provide services through their existing waiver programs.

However, this section is overshadowed by new state flexibility provisions. Section 6086 allows states to cap the number of people to be served under the new home and community services Medicaid option. It allows states to provide these services in limited areas of the state and explicitly allows states to maintain waiting lists for these services. If the state decides to establish new eligibility criteria in the future, HCBS beneficiaries who do not meet new criteria would have grandfathering protection, but for as little as one year from the date the beneficiary first received the service.

Essentially, this combination of new state flexibility provisions maintains the states' entitlement for federal reimbursement for allowed expenditures while it eliminates the individual's entitlement to these services. Since the services will be state-plan option services, rather than waiver services, the federal government will no longer have a role in periodically approving these services.

It is unclear whether the states' new authority to establish cost-sharing for services will also apply to these non-institutional long term services and supports.

Section 6087: Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling)

- Section 6087 establishes a new state option for self-directed personal assistance services, also known as "cash and counseling." This provision requires that self-directed personal assistance services be provided based on a written plan of care and budget for people who would otherwise be eligible for personal care services under the State's Medicaid plan or home- and community-based waiver services. The section prohibits use of self-directed personal services for beneficiaries who live in homes or property owned, operated, or controlled by a service provider. Individuals using this new option are allowed to hire, fire, supervise, and manage the people providing the services and, if the state allows, may use family members to provide the services.

False Claims Act

Under the False Claims Act, 31 U.S.C. $$3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

The False Claims Act contains *qui tam*, or whistleblower, provisions. *Qui tam* is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, in order to recover the stolen funds. In compensation for the risk and effort of filing a qui tam case, the citizen whistleblower or "relator" may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A *qui tam* suit initially remains under seal for at least 60 days during which the Department of Justice can investigate and decide whether to join the action.

The False Claims Act provides protection to employees who are retaliated against by an employer because of the employee's participation in a qui tam action. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his of her employer because the employee investigates files or participates in a qui tam action.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

The following are the more common types of fraud:

- Upcoding/unbundling
- Kickbacks
- Submitting false cost reports
- Billing for services not rendered

Overall, the DRA provides states with much of the flexibility states have been seeking over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states will be able to reconnect their healthy populations to the larger health insurance system, transform long-term care from an institutionally-based, provide-driven system to a person-centered and consumer-controlled model. There are great opportunities for covering more people at a lower cost, and with greater continuity of coverage.

COMPLIANCE & FRAUD, WASTE & ABUSE AWARENESS TRAINING

First Tier, Downstream, and Related Entities

Overview

- The Centers for Medicare and Medicaid Services (CMS) spends over $756 billion a year providing medical and pharmacy benefits to individuals.
- Medica has a relationship with CMS to provide medical and pharmacy benefits to individuals.
- Medica provides these medical and pharmacy benefits as a contracted Medicare Advantage Organization and a Part D plan sponsor.
- Medica, as a Medicare Advantage (MA) and Part D Plan Sponsor, must implement an effective compliance program to prevent, detect, and correct:
  - fraud, waste, and abuse (FWA)
  - noncompliance with Centers for Medicare and Medicaid (CMS) program requirements.
- Regulations require that Medica's compliance program include seven core elements.
- Written policies and procedures
- Designation of a Compliance Officer and Committee
- Training and education
- Effective lines of communication
- Well-publicized disciplinary standards
- Routine monitoring and identification of risks
- System for prompt response to issues

Purpose of these training materials:

- New CMS regulations require Medica to establish, implement, and provide effective training and education to any entity that it contracts with to provide administrative or health care services for Medicare eligible individuals under a Medicare Advantage or Part D program.
- The CMS regulations define these contracted entities as *first tier, downstream, and related entities.*

Definition of Contracted Entities

First Tier Entity

Any party that enters into a written arrangement, acceptable to CMS, with a MA or Part D plan sponsor or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA or Part D programs.

Downstream Entity

Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA or Part D benefit, below the level of the arrangement between a MA or Part D plan sponsor and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services

Related Entity

An entity that is related to the Plan Sponsor by common ownership or control and performs some of the Plan Sponsor's management functions under contract or delegation; furnishes services to Medicare enrollees under

an oral or written agreement; or leases real property or sells materials to the Plan Sponsor at a cost of more than $2,500 during a contract period.

- This training must be completed by 12/31/2010 and annually thereafter. Your organization must maintain records of this training. Records must include:
  A) **Materials used for training,**
  B) **Dates training was provided,**
  C) **Methods training was provided,**
  D) **Training logs identifying trained employees**
- Medica, CMS, or agents of CMS may request such records to verify that training occurred.
- If you or your organization has contracted with other entities (downstream entities) to provide health or administrative services to Medicare beneficiaries covered by Medica, you must provide this training material or training material that complies with CMS regulations to your subcontractor or downstream entity. You must ensure records of training are maintained by the subcontractor and any other entity that it may have contracted with to provide health or administrative services.

What does an Effective Compliance Program Look Like?

Compliance programs are framed on the seven elements of an effective program. Medica implements the seven elements through collaboration with the Corporate Compliance department and the business unit compliance leads throughout the organization. If Medica delegates any of its compliance activities to an entity that provide administrative or health services to Medicare members, effective oversight of those delegated activities must occur.

Element 1 of an Effective Compliance Program

Written Standards of Conduct and Policies & Procedures that:

- Describe an organization's commitment to comply with all Federal and State standards
- Provide guidance to employees and others on dealing with potential compliance issues
- Describe expectations as embodied in the standards of conduct

You should know that:

- ✓ ***Medica's Standards of Conduct booklet and corporate policies can be found on the Medica intranet. Medica is in the process of making some of these materials available on Medica.com.***
- ✓ ***Each Standard within the Medica Standards of Conduct booklet has a Related Resources section that lists the policies that support that standard.***

Element 2 of an Effective Compliance Program

Designation of a Compliance Officer and Committee that is:

- Accountable to senior management
- Employed by the organization
- Periodically reports to the governing body
- Responsible for oversight of the compliance program

You should know that:

- ✓ ***Medica is committed to complying with CMS regulations and preventing detecting and correcting FWA.***
- ✓ ***The Vice President of Compliance and Privacy reports compliance activity to the Board of Director's Audit Committee every quarter.***

Element 3 of an Effective Compliance Program

Training and Education that:

- Is provided to employees including, the chief executive and managers; governing body; and entities Medica partners with to provide administrative or health services to Medicare members.

- Must occur at least annually and as part of orientation of new employees; governing body members; and entities that Medica partners with to provide administrative or health services to Medicare members.

You should know that:

- ✓ *Medica requires first tier, downstream, and related entities to take general compliance and FWA Awareness training as part of becoming a new partner with Medica and annually thereafter.*

Element 4 of an Effective Compliance Program

Effective Lines of Communication must exist:

- Between the compliance officer, compliance committee, employees, managers and governing body
- That maintain confidentiality and allow anonymity if desired (e.g. telephone hotlines or
- mail drops)
- That are available to entities that Medica partners with to provide administrative or health services to Medicare members

You should know that:

- ✓ *You are encouraged to discuss any suspected compliance issue with appropriate individuals within your organization.*
- ✓ *Any suspected noncompliance or fraud, waste and abuse should be reported to your Medica business contact.*
- ✓ *If you prefer to remain unknown call Medica's Integrity Line: 1-866-595-8495*
- ✓ *No business partner will suffer any penalty or retribution for reporting in good faith any suspected misconduct or noncompliance.*

Element 5 of an Effective Compliance Program

Well-Publicized Disciplinary Standards that:

- Articulate expectations for reporting compliance issues and assist in their resolution;
- Provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined; and
- Encourage good faith participation in the compliance program

You should know that:

- ✓ *Medica has a progressive discipline policy to address employee misconduct. The policy is available on Medica's intranet.*
- ✓ *Medica may alter or terminate business relationships as a result of a violation of Medica's Standards of Conduct.*
- ✓ *No business partner will suffer any penalty or retribution for reporting in good faith any suspected misconduct or noncompliance.*

Element 6 of an Effective Compliance Program

Routine Monitoring and Identification of Risks by:

- Conducting internal monitoring and auditing
- Obtaining external audits when appropriate
- Auditing and monitoring entities that Medica partners with to provide administrative or health services to Medicare members
- Evaluation of overall effectiveness of the compliance program

You should know that:

- ✓ *Proactive monitoring of business practices by management is vital to identifying potential compliance issues.*
- ✓ *Medica has an Internal Audit department that assesses the adequacy and effectiveness of Medica's financial controls.*
- ✓ *Corporate Compliance also has an audit function that assesses Medica's compliance with State and Federal laws.*

Element 7 of an Effective Compliance Program

System for Prompt Response to Issues that:

- Acknowledges issues as they are raised
- Requires appropriate investigation of potential compliance problems
- Corrects such problems promptly and thoroughly to reduce the potential for recurrence
- Includes procedures to voluntarily self report potential fraud or misconduct to CMS or its designee

You should know that:

- ✓ ***Medica is required by law to respond timely to incidents of noncompliance. Examples include:***
  - Privacy incidents
  - Inquiries from regulators
- ✓ ***You are encouraged to inquire about any compliance issues you may have reported.***
- ✓ ***Call corporate compliance to discuss any questions you might have.***
- ✓ ***No business partner will suffer any penalty or retribution for reporting in good faith any suspected misconduct or noncompliance.***

Oversight of compliance activities

Compliance Oversight

- Regulations state that Medica is ultimately responsible for oversight of any compliance activities delegated to entities that Medica partners with to provide administrative or health services to Medicare members.

You should know that:

- ✓ ***As an entity contracted with Medica, you are responsible for maintaining a relationship that supports compliance with CMS regulations. The effectiveness of the compliance program is impacted by how you manage your business relationship with Medica.***

Examples of how Medica may establish oversight include:

- Requiring attestations to evidence compliance with specific activities
- Requesting copies of training logs
- Cooperation with auditing and monitoring activities

Purpose of a Compliance Program

The purpose of a compliance program is to prevent, detect, and correct:

- Noncompliance with CMS' program requirements; and
- Instances of Fraud, Waste, and Abuse

Examples of noncompliance with CMS' program requirements include:

- Not cooperating with CMS auditors
- Untimely submission of data to CMS
- Violating member privacy

The following section is designed to train you on what types of fraud, waste, and abuse you may encounter

What are Fraud Waste and Abuse?

Fraud:

- An intentional act of deception, misrepresentation or concealment in order to gain something of value. Examples include:
  - Billing for services that were never rendered
  - Billing for services at a higher rate than is justified
  - Deliberately misrepresenting services, resulting in unnecessary costs to the Medicare program, improper payments to providers or overpayments

Waste:

- Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources

Abuse:

- Excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. Examples include:
  - Charging in excess for services or supplies
  - Providing medically unnecessary services
  - Billing for items or services that should not be paid for by Medicare

Laws Created in Response to FWA

The False Claims Act:

- Prohibits any person from knowingly presenting or causing a fraudulent claim for payment.
- Protects individuals who report noncompliance or FWA.

The Anti-Kickback Statute:

- Makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a Federal health care program.

Self-Referral Prohibition Statute (Stark Law):

- Prohibits physicians from referring Medicare patients to an entity with which the physician or a physician's immediate family member has a financial relationship – unless an exception applies.

Who commits fraud, waste, and abuse?

Unfortunately, FWA may be present in all corners of the health care system. Here are some examples:

- Beneficiaries
- Employees of health plans
- Home health agencies
- Hospitals
- Laboratories
- Medical equipment suppliers
- Pharmacies
- Pharmaceutical manufacturers
- Pharmacy benefit managers
- Physicians, nurses, and other health care providers

Examples of FWA (Prescriber)

Illegal Payment Schemes:

- Prescriber is offered, paid, solicits or receives unlawful payment to induce or reward the prescriber to write prescription for drugs or products.

Script Mills:

- Prescribers write prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the prescriber.

Theft of Prescriber's Drug Enforcement Agency Number or Prescription Pad:

- Prescription pads and/or DEA numbers stolen from prescribers. This information could illegally be used to write prescriptions for controlled substances or other medications.

Examples of FWA (Wholesaler)

Counterfeit, Impure Drugs through Black Market:

- Black Market includes fake, diluted, expired, illegally imported drugs, etc.

Diverters:

- Individuals who illegally gain control of discounted medicines and mark up the prices and move them to small wholesalers.

Inappropriate Documentation of Pricing Information:

- Submitting false or inaccurate pricing or rebate information.

Examples of FWA (Beneficiary)

Identity Theft:

- Using a member's I.D. card that does not belong to that person to obtain prescriptions, services, equipment, supplies, doctor visits, and/or hospital stays.

Doctor Shopping:

- Visiting a number of doctors to obtain multiple prescriptions for painkillers or other drugs. Might point to an underlying scheme (stockpiling or black market resale).

Examples of FWA (Pharmaceutical Manufacturer)

Illegal Off-label Promotion:

- Promotion of off-label drug use.

Illegal Usage of Free Samples:

- Providing free samples to prescribers knowing and expecting prescriber to bill Medicare for the sample.

Kickbacks, Inducements, Other Illegal Payments:

- Inappropriate marketing or promotion of products reimbursable by federal health care programs or inappropriate discounts or educational grants

Examples of FWA (Plan Sponsor)

Payments for Excluded Drugs:

- Receiving payment for drugs not covered by the Plan sponsor's formulary

Marketing Schemes:

- Offering beneficiaries a cash payment as an encouragement to enroll in a Medicare Plan, Unsolicited door-to-door marketing, Use of unlicensed agents, Enrollment of individual in a Medicare Plan without such individual's knowledge or consent. stating that a marketing agent/broker works for or is contracted with the Social Security Administration or CMS

Examples of FWA (Pharmacy Benefit Manager)

Prescription Drug Switching:

- PBM receives a payment to switch a beneficiary from one drug to another or influence prescriber to switch patient to a different drug.

Prescription Drug Splitting or Shorting:

- PBM mail order pharmacy intentionally provides less than the prescribed quantity, does not inform the patient or make arrangements to provide the balance and bills for the fully-prescribed amount; Splits prescription to receive additional dispensing fees.

Examples of FWA (Billing)

Inappropriate Billing Practices

- Billing for services not provided
- Misrepresenting the service that was provided
- Billing for a higher level than the service actually delivered
- Billing for non-covered services or prescriptions as covered items

Reporting Suspected or Actual FWA

- Report all suspected or actual Fraud, Waste, and Abuse.
- Report all suspected or actual noncompliance with regulations
- No business partner will suffer any penalty or retribution for reporting in good faith any suspected misconduct or noncompliance

You should know that:

- ✓ *You are encouraged to speak to your manager, HR representative, or compliance lead about suspect noncompliance or FWA*
- ✓ *Medica's department for handling FWA is the Special Investigations Unit.*
  - **952-992-1736**
  - **1-800-458-5512 (option 1, option 8, ext. 28478)**
  - **Or go to the Fraud and Abuse page on Medica.com**
  - **If you prefer to remain anonymous call the Medica Integrity Line 1-866-595-8495**

Additional Resources

Laws, regulations and organizational policies can be complex and can sometimes be confusing. While Medica believes that employees and business partners try to do what is right, the right thing to do may not always be clear.

We are all responsible for compliance, and we are all responsible for ensuring that we follow the laws and regulations that govern our work.

- CMS' Prescription Drug Benefit Manual – Chapter 9; http://www.cms.gov/Manuals/IOM/list.asp
- Code of Federal Regulations,42 CFR 422.503 and 42 CFR 423.504; http://www.gpoaccess.gov/cfr/index.html
- Office of the Inspector General; http://oig.hhs.gov/fraud/hotline/

You have completed the training. Congratulations!!

DETECTION & PREVENTION OF FRAUD, WASTE & ABUSE

The company recognizes that there is potential for abuse and fraud of the Medicaid System. It is the policy of the company that all employees and clients have the right to report suspected abuse of the Medicaid System without fear of reprisals to their employment or personal cares provided by the company. It is the policy of the company to encourage and assist in reporting such claims. The company will not condition the care or otherwise discriminate against an individual or employee based on whether they have made such claims or not.

Definitions:

1. Deficit Reduction Act of 2005 (DRA) - a federal budget bill which established a requirement where an entity which receives or makes payments, under a State plan approved under title XIX or under any waiver or such plan, totaling at least $5,000,000 annually, must educate their employees about how false claims are handled and reported.

2. False Claims Act (31 U.S.C 3729 *ss et seq.*) – a civil statute which allows American citizens to file actions against federal contractors claiming fraud against the government.

3. Qui Tam actions – citizens may sue for mischarging, false negotiating of defective pricing, product and services substitution, and false certification of entitlement for benefits.

4. Employer – a person or institution that hires workers for a wage in exchange for the worker's labor power.

5. Employee – any person hired by an employer to do a specific task.

6. Whistleblower – a person who reports misconduct to people or entities that have the power and presumed willingness to take corrective action.

7. Waste – unwanted or undesired material left over after the completion of a process falling into a number of different waste types.

8. Fraud – a deception made for personal gain; a civil law violation.

9. Abuse – a general term for the use or treatment of something that causes some kind of harm or is unlawful or wrongful.

Applicable State and Federal Laws:

1. Section 6032 of the Deficit Reduction Act of 2005 (Public Law 109-171)
2. Civil Monetary Penalties Law, 42 USC 1320a-7a
3. False Claim Act: 31 USC sections 3729-3733
4. Minnesota Statutes 181.932 (Disclosure of information by employees)
5. Minnesota Statutes 626.5572 (Vulnerable Adults Act)
6. Minnesota Statutes 609.2335 (Financial exploitation of vulnerable adults)
7. Minnesota Statutes 609.466 9 (Medical Assistance fraud)

8. Minnesota Statutes 256B.121 (Treble damages)
9. Minnesota Statutes Ch. 15C (False Claims Against the State)

Procedure:

1. Provide the employee with written information as required by the act.
    - As part of the hiring process to the company, all new employees will be given written information on the policy and procedure required by the act.

2. Explain the responsibilities of and procedures for employees to report waste, fraud and abuse.
    - As part of the hiring process to the company, the staff member who conducts the process will explain the responsibilities and procedures of reporting suspected waste, fraud and abuse. This includes but is not limited to:
        - ✓ timesheet accuracy
        - ✓ client signature requirements
        - ✓ who to report suspected waste or fraud to:
            - Administrator (218) 727-0990
            - DHS – SIRS (800) 366-5411

3. Explain the rights of employees to be protected as whistleblowers.
    - As part of the hiring process to the company, all new employees will be given written information that will explain the rights of the employee as whistleblowers.

4. Detecting and preventing fraud, waste and abuse.
    - Upon receipt of employee time sheets, a staff member will examine the sheets and compare the days worked with the charting of cares for the client. They will also make sure the client or responsible party has signed the appropriate space to confirm the hours worked; the PCA has signed the time sheet; and all other documentation requirements are met.
    - All billing department staff will receive on the job training in order to accurately process medical assistance claims.
    - Internal audits will be conducted on all company claims at least annually to detect and prevent fraud, waste and abuse.

Documentation:

All Deficit Reduction Act required policies and information will become part of the employee handbook. New employees sign documents for their personnel file that affirm their receipt of the handbook.

Education:

Educational information will be given upon hire to new employees. Updates will be given out to all employees as they become available.

Updated 5/4/2017