

FRAUD, WASTE AND ABUSE TRAINING FIRST TIER, DOWNSTREAM AND RELATED ENTITIES

December 23, 2009
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Dear Care1st and ONECare Practitioners and Office Staff:

Medicare Part D – Fraud, Waste and Abuse (FWA):

On October 20, 2008, the Centers for Medicare & Medicaid Services (CMS) released the memo, “Fraud, Waste, and Abuse Training Requirements”. The memo mandated that all Health Plans provide compliance training, including fraud, waste and abuse to first-tier, downstream, and related entities (contracted provider network, etc.).

The CMS training requirements became effective January 1, 2009 and CMS requires that we ensure that you complete training of the staff within your practice/facility by December 31, 2009. Following this initial training, ongoing annual training will occur.

Please consider the information contained within these 4 pages as official training that can and should be used by your practice or facility to provide training and information to your team on Fraud, Waste and Abuse. Care1st Health Plan Arizona, Inc. and ONECare by Care1st Health Plan Arizona, Inc. need your help to disseminate this information and to provide it to everyone within your practice/facility. You may make copies of this material and it is also available on our website at www.care1st.com/az. If you need any additional information or require assistance to complete training with your employees, please contact Provider Network Operations at the numbers below or our Compliance Officer at (602) 778-8318. **We are here to help!**

Fraud, Waste and Abuse Training Material:

The fraud control game is dynamic, not static. Fraud control is played against opponents: opponents who think creatively and adapt continuously and who relish devising complex strategies; this means that a set of fraud controls that is perfectly satisfactory today may be of no use at all tomorrow, once the game has progressed a little. — Malcolm K. Sparrow

Components of a Comprehensive Program to Detect, Prevent and Control Fraud, Waste and Abuse (FWA) as part of the General Compliance Plan Requirements

Care1st Health Plan Arizona, Inc. and ONECare by Care1st Health Plan Arizona, Inc. prohibit fraud, waste, or abuse and is committed to respond appropriately in the event—potential or suspected – fraud, waste, or abuse is committed by its employees, vendors, subcontractors, contracted providers, or business associates.

Our FWA Compliance Program is organized to follow in sequence core elements in accordance with the Office of the Inspector General’s (OIG) Guidelines.

The core elements involved in developing the fraud, waste and abuse component of our Compliance Program include:

1. **Written Policies and Procedures** – has written policies, procedures and standards of conduct that articulate our commitment to comply with all applicable Federal and State standards.
2. **Compliance Officer and Compliance Committee** – We have a designated compliance officer and compliance committee who are accountable to senior management and the Board of Directors.
 - a. The appointed Compliance Officer can be reached directly at (602) 778-8318.
 - b. Our Compliance Committee meets quarterly. The Compliance Committee assists in the implementation of the Compliance Program and annual Audit Work Plan. The Committee addresses, identifies, and resolves compliance issues, auditing requirements, in addition to other federal, state and local laws, regulations, licensing and contractual requirements, and accreditation standards.
3. **Training and Education** – We provide effective ongoing training and education to our employees, subcontractors, agents, and directors.
 - a. Computer-Based-Training (CBT) is provided to employees to ensure compliance with regulations and to assist in fraud, waste and abuse efforts. CBT training addresses pertinent laws related to fraud and abuse (e.g., Anti-Kickback Statute, False Claims Act, etc.) and includes a discussion of Part D vulnerabilities identified by CMS, the OIG, the Department of Justice, and other organizations.
4. **Effective Lines of Communication** –A system is in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees, contractors, agents and directors while maintaining confidentiality, allowing anonymity if desired (e.g. through telephone hotlines or mail drops), and ensuring non-retaliation against callers.
 - a. A toll-free Hotline is available to receive, monitor, process, and resolve non-compliant activities. Any suspected cases of potential fraud, waste, or abuse can be reported to our Hotline by calling toll-free (877) 837-6057 or by contacting the corporate Compliance Officer directly at (602) 778-8318.
5. **Enforcement Standards through well publicized disciplinary guidelines** –We use several methods to encourage the reporting of incidents of unethical or non-compliant behavior under the direction of our corporate Compliance Officer including during new hire orientation, the annual mandatory general compliance training, employee newsletters, and department staff and committee meetings where compliance guidelines and issues are being included as regular topics.
6. **Monitoring and Auditing** –Procedures are in place for effective internal monitoring and auditing.
 - a. We develop an annual compliance and auditing program that protects the Medicaid and Medicare programs and beneficiaries from fraud, waste and abuse. The programs may also mitigate our first-tier entities, downstream entities, and related entities' liability resulting from potentially fraudulent, abusive or wasteful activities.
 - b. Our Compliance Officer works in coordination with all company departmental / functional areas within our organization to investigate, monitor, or audit potential or suspected noncompliant activities related to fraud, waste, or abuse.
7. **Corrective Action Procedures** – We correct and mitigate non-compliant activities or violations committed and identified within set timelines. Detailed Corrective Action Plans (CAPs) describe the actions that will be taken, including a target timeframe, to rectify and complete the identified violation.

Provider Network Operations

Phone 602.778.1800 or 866.560.4042 (Options in order: 5, 7)

Fax 602.778.1875

Visit our website at www.care1st.com/az

It is in our collective best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid and/or Private Insurers, increases everyone's health care costs. If we are to maintain and sustain a health care system, we must work together to reduce unnecessary costs.

Potential fraud, waste and abuse include but not limited to:

Member Fraud, Waste and Abuse Examples

1. Misrepresentation of medical condition
2. True-Out-Of-Pocket (TrOOP) manipulation
3. Prescription forging or altering
4. Prescription diversion and inappropriate use
5. Resale of drugs on black market
6. Prescription stockpiling
7. Falsifying eligibility applications
8. Using another person's health plan identification card to obtain medical care
9. Doctor shopping to obtain multiple prescriptions for controlled substances/ prescriptions drugs
10. Failing to report third party liability
11. Improper coordination of benefits

Prescriber Fraud, Waste and Abuse Examples

1. Script mills
2. Prescription drug switching
3. Illegal remuneration schemes
4. Provision of false information
5. Theft of prescriber's Drug Enforcement Agency's (DEA) number or prescription pad

Pharmacy Fraud, Waste and Abuse Examples

1. Inappropriate billing practices
2. Prescription Drug Shorting
3. Bait and switch pricing
4. Prescription forging or altering
5. Dispensing expired or adulterated prescription drugs
6. Prescription refill errors
7. True-Out-Of-Pocket (TrOOP) manipulation
8. Failure to offer negotiated prices

Provider/Facility Fraud Waste and Abuse Examples

1. Falsifying credentials
2. Double-billing for health care services or goods that were provided
3. Accepting kickbacks for referring patients
4. Conducting improper dis-/enrollment practices
5. Attracting healthy patients or refusing sicker patients
6. Persuading sicker patients to dis-enroll
7. Falsifying medical exemptions
8. Use of telemarketing/selling as marketing tools

9. Falsifying encounter data
10. Misrepresenting services to meet quality of care standards
11. Billing for “phantom patients” who did not receive services
12. Billing for services/supplies not provided
13. Upcoding charges and unbundling services
14. Excluding distinct groups of beneficiaries [e.g. patients with chronic conditions]
15. Engaging in under-utilization
16. Regularly denying treatment requests and specialist referrals without regard to proper medical evaluation
17. Concealing ownership in a related company.

What Can You Do?

1) Report potential fraud

- Medicare Fraud Hotline of the HHS office Inspector General
(800) 447-8477
- AHCCCS Office of Program Integrity
602-417-4045
- Care1st/ONECare Anonymous Compliance Hotline
(877) 837-6057

2) Establish office policies and procedures to address fraud and abuse issues.

3) Share this important information with your staff.

Additional Resources

1. 42 C.F.R. § 423.504(b)(4)(vi)(A)
2. 42 C.F.R. § 423.504(b)(4)(vi)(C)
3. 70 Fed. Reg. 4194, 4338 (January 28, 2005)
4. 42 C.F.R. § 423.504(b)(4)(vi)(F)
5. <http://www.cms.hhs.gov>
6. <http://www.azahcccs.gov/fraud/Default.aspx>

For additional training information please:

1. Go to www.care1st.com/az
2. Click on *Compliance/HIPAA/Fraud, Waste and Abuse* in the drop down menu under the “Providers” tab
3. Click on “2009 FWA Training”

If you have any questions regarding the information contained in this communication, please contact Provider Network Operations at the number below.

Thank you!

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