



## Commonwealth Care Alliance

# Corporate Fraud, Waste and Abuse Program Program Description

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## ***Introduction***

Commonwealth Care Alliance (“CCA”) is committed to conducting its business operations in compliance with ethical standards, internal policies and procedures, contractual obligations and all applicable federal and state statutes, regulations and rules, including those pertaining to the Centers for Medicare and Medicaid Services (“CMS”) Part C and D programs; the Massachusetts Executive Office of Health and Human Services (“EOHHS”); MassHealth (the Massachusetts Medicaid program) and the Office of Inspector General (“OIG”). This Fraud, Waste and Abuse (“FWA”) Program Description applies to all lines of business in which Commonwealth Care Alliance is involved. Commonwealth Care Alliance’s commitment to guard against fraud, waste and abuse extends to its own internal business operations, as well as, its oversight and monitoring responsibilities related to its contracted entities (including First-tier, Downstream and Related Entities).

CCA has formalized its fraud, waste and abuse activities through a comprehensive FWA Program. The FWA Program Description is reviewed on a regular basis and revised as necessary.

All CCA Workforce and contracted entities are obligated to report any suspicion of fraud, waste and abuse in a timely manner.

The FWA Program Description does not address every aspect of CCA’s activities and all applicable legal issues that may result. If any Workforce member, Board member and/or contracted entity has a question about the FWA Program, he/she should seek guidance from his/her Commonwealth Care Alliance contact or Commonwealth Care Alliance’s Compliance Officer. The FWA Program Description is available to all Workforce via the company-wide intranet, CommonGround.

## *Definitions*

<b>Abuse</b>	Includes actions that may, directly or indirectly, result in: unnecessary costs to any health care benefit program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence among other factors.
<b>CMS</b>	Centers for Medicare and Medicaid Services: Federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
<b>DHHS</b>	Department of Health and Human Services: CMS is an agency within the DHHS that administers the Medicare Program.
<b>Downstream Entities</b>	A party that enters into a written arrangement, acceptable to CMS and EOHHS with persons or entities involved with a Medicare Part C, or Part D benefit, below the level of the arrangement between Commonwealth Care Alliance and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
<b>EOHHS</b>	Executive Office of Health and Human Services: Massachusetts department which oversees the Massachusetts Medicaid Program, MassHealth.
<b>FCA</b>	False Claims Act is a federal law that imposes liability on persons and companies who defraud governmental programs. It is the federal Government's primary tool in combating fraud against the Government.

<b>First Tier Entity</b>	A party that enters into a written arrangement, acceptable to CMS, with CCA to provide administrative services or health care services to a CCA member for Medicare Part C and/or Part D benefits
<b>Fraud</b>	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (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.
<b>FWACC</b>	Fraud, Waste, and Abuse Case Coordinator: an employee within the Department of Regulatory Affairs and Compliance who coordinates the investigation of reported incidents of suspected fraud, waste or abuse.
<b>GSA</b>	Government Services Administration: the GSA is an independent agency of the United States government, established to help manage and support the basic functioning of federal agencies.
<b>HPMS</b>	Health Plan Management System is CMS' web-enabled information system that serves a critical role in the ongoing operations of the Medicare Advantage (MA), Part D and MMP programs. HPMS functionality facilitates the numerous data collection and reporting activities mandated for these entities by legislation. HPMS also provides support for the ongoing operations of the plan enrollment and plan compliance business functions.
<b>LEIE</b>	List of Excluded Individuals and Entities: OIG's List of Excluded Individuals/Entities (LEIE) provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.
<b>MassHealth</b>	Massachusetts Medicaid program
<b>MMP</b>	Medicare-Medicaid Plans participating in CMS' Financial Alignment Demonstration for Medicare-Medicaid enrollees.

<b>Monitoring</b>	Regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
<b>NBI MEDIC</b>	National Benefit Integrity Medicare Drug Integrity Contractor: An organization that CMS has contracted with to perform specific program integrity functions for Parts C and D, and MMPs under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.
<b>Non-Compliance</b>	Failure or refusal to act in accordance with the organization's Compliance Program, or other standards or procedures, or with federal or state laws or regulations.
<b>OIG</b>	Office of the Inspector General ("OIG"): The OIG is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.
<b>Related Entity</b>	An entity that is related to Commonwealth Care Alliance by common ownership or control, and either performs some of Commonwealth Care Alliance's management functions (contract or delegation) or furnishes services to Commonwealth Care Alliance members (under an oral or written arrangement) or leases real property or sells materials to Commonwealth Care Alliance at a cost of more than \$2,500 during a contract period.
<b>Waste</b>	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to any health care benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather a misuse of resources.
<b>Workforce</b>	All persons directly engaged in work on behalf of Commonwealth Care Alliance including employees, volunteers, interns, trainees, and non-service provider independent contractors. Exclusions include visitors, vendors who do not interact directly with Commonwealth Care Alliance members, and any other business partner entity who is engaged as a service provider.

## *Examples of Healthcare Fraud, Waste and Abuse*

### By Members:

- Allowing someone else to use his/her health insurance/membership identification card to receive medical care, medications, supplies or equipment, etc.
- Agreeing to let a healthcare provider bill CCA for services he/she never received
- Misrepresenting a medical condition to obtain services
- Knowingly providing false information (wrong date of birth, address etc.) on enrollment forms

### By Providers:

- Billing for medically unnecessary services/procedures
- Not billing according to the American Medical Association (“AMA”), American Association of Professional Coders (“AAPC”) and/or Centers of Medicare and Medicaid Services (“CMS”)
  - Billing for services not rendered
  - Upcoding (using procedure or diagnosis codes that pay at a higher rate)
  - Unbundling of claims
  - Routinely submitting duplicate claims
- Receiving kickbacks for referrals

### By Workforce members:

- Misrepresenting facts in order to deny or approve benefits
- Obtaining kickbacks for referrals
- Creating a fictitious provider in order to pay false claims
- Forging member’s signature for enrollment purposes
- Misrepresenting benefits
- Impersonating a government employee

### By Pharmacies:

- Inappropriately billing
  - Billing multiple payers for the same prescription
  - Billing for non-existent prescriptions
  - Billing for brand drugs when generics are dispensed
  - Billing for an item not dispensed
- Shorting prescription drugs
- Dispensing expired prescription drugs

### ***Policy Statement of Fraud, Waste and Abuse***

Commonwealth Care Alliance (“CCA”) and its Workforce are committed to upholding high standards of honesty and integrity in all areas of practice. CCA believes that it is in the best interest of its members, participating providers and the community to prevent fraud, waste and abuse, which can have a significant impact on the quality of healthcare and costs.

CCA has designed specific activities in addition to routine operational activities which may result in the detection, prevention and reporting of fraud, waste and abuse. All members of the CCA workforce and contracted entities are obligated to immediately report any suspicion of fraud, waste and abuse. Internal and external reporting mechanisms are available to anyone who suspects fraud, waste or abuse within CCA or its network.

The Department of Regulatory Affairs and Compliance provides education related to the detection, prevention, investigation and reporting of fraud, waste and abuse.

### ***Mission and Goals of the Fraud, Waste and Abuse Program***

The mission of CCA's FWA Program is to protect the integrity of CCA, along with federal and state programs by actively detecting, preventing, investigating and reporting suspected cases of fraud, waste and/or abuse.

The goals of CCA's Fraud, Waste and Abuse Program are to:

- Detect, prevent, investigate and report incidents of fraud, waste and abuse;
- Implement internal policies and procedures to accomplish the mission and to mitigate the risk for recurrence;
- Report instances of substantiated fraud, waste or abuse to the appropriate government agencies and/or law enforcement;
- Cooperate fully with all investigations of fraud, waste or abuse conducted by government agencies and/or law enforcement;
- Recover payments lost to fraudulent, wasteful and/or abusive billings;
- Provide communication and education regarding fraud, waste and abuse;
- Educate CCA Workforce and contracted entities about identifying fraud, waste and abuse; and
- Provide methods for internal and external individuals to report suspected incidents of fraud, waste or abuse to CCA.

### ***Fraud, Waste and Abuse Program Staff Organization***

The development and ongoing monitoring of the FWA Program is charged to the Department of Regulatory Affairs and Compliance. The roles and responsibilities listed below include specific functions related to fraud, waste and abuse and routine operational activities that may contribute to the detection, prevention, investigation and reporting of fraud, waste and abuse.

The **Department of Regulatory Affairs and Compliance**'s responsibilities regarding fraud, waste and abuse include, but are not limited to:

- Leading a cross-functional Program Integrity Workgroup;
- Implementing and managing CCA's FWA Program;
- Developing policies and procedures to a) prevent fraud, waste and abuse and b) assure internal controls are in place to address risk areas;
- Monitoring and researching laws and regulations impacting CCA's FWA Program,
- Investigating reported cases of suspected fraud, waste and abuse;
- Reporting all substantiated cases of FWA to appropriate external agencies;
- Maintaining documentation of all investigations;
- Conducting ongoing fraud, waste and abuse training;
- Researching all fraud alerts issued by CMS, OIG or the Massachusetts Attorney General to determine impact to CCA;
- Providing training materials to members and contracted entities; and
- Annually reviewing the FWA Program Description. If any revisions are required, the Department may present those changes to the Internal Compliance Committee and the Board Compliance Committee.

**All CCA Operational, Administrative and Clinical departments'** duties include, but are not limited to:

- Alerting the Department of Regulatory Affairs and Compliance to any potential cases fraud, waste and abuse cases;
- When needed, working collaboratively with the Department of Regulatory Affairs and Compliance to investigate and resolve cases of fraud, waste, and abuse.

Additional **Pharmacy Services Department** duties include, but are not limited to:

- Overseeing CCA's Pharmacy Benefit Manager's fraud, waste and abuse program activities;
- Reviewing the Pharmacy Benefit Manager's fraud, waste and abuse activity reports and following up on actionable items;
- Alerting the Department of Regulatory Affairs and Compliance to any potential cases of fraud, waste and abuse;

- When needed, working collaboratively with Department of Regulatory Affairs and Compliance Department to investigate potential cases of pharmacy services

Additional **Enrollment Reconciliation and Retention Department** duties include, but are not limited to:

- Conducting member demographic and eligibility reconciliations with available CMS and MassHealth data;
- Pursuing external agencies for completing outstanding eligibility transactions; and
- Working collaboratively with the Department of Regulatory Affairs and Compliance to investigate and resolve any cases of fraud, waste or abuse.

Additional **Business Intelligence Department** duties include, but are not limited to:

- Generating necessary reports from the data warehouse and other sources needed to investigate, analyze and report suspected cases of fraud, waste and abuse;
- Conducting retrospective analysis of claims data; and
- Working collaboratively with the Department of Regulatory Affairs and Compliance to investigate and resolve any cases of fraud, waste or abuse.

Additional **Member Services** duties include, but are not limited to:

- Monitoring member calls, appeals and grievances reports for any patterns that may indicate potential fraud, waste or abuse incidents; and promptly reporting such incidents to the Department of Regulatory Affairs and Compliance.

## ***Fraud, Waste and Abuse Prevention Efforts***

CCA works to prevent fraud, waste and abuse in a number of ways, including routine operational activities that serve a dual purpose; and specific functions developed to assist in the prevention of fraud, waste and abuse.

### **Routine Operational Activities**

- Compliance Hotline:
  - CCA contracts with an external vendor to administer a toll-free compliance hotline which is available 24 hours a day, 7 days a week, 365 days a year; CCA's Workforce, contracted entities and members may call the Hotline at 1-800-826-6762 to anonymously report suspected fraud, waste and/or abuse cases.
- Identification of Debarred Individuals or Excluded Providers:
  - Ongoing review of the Office of the Inspector General ("OIG") List of Excluded Individuals and Entities ("LEIE") and the Government Services Administration (GSA) Excluded Parties list to :
    - Assure that Workforce members, have not been excluded;
    - Assure any contracted entity has not been excluded; and
    - Assure that members of CCA's Board of Directors are not excluded from participation.
  - Provider Contracting: CCA has a comprehensive credentialing and re-credentialing process in order to take necessary precautions to assure it does not contract with providers that do not meet the CCA standards.

### **Specific Fraud, Waste and Abuse Prevention Activities**

- CCA's Program Integrity Committee provides advice to and assists the Compliance Officer in developing and implementing CCA's FWA Program.
- Fraud Waste and Abuse Case Coordinator in collaboration with other staff as appropriate conducts the following activities:
  - Investigates reports of potential fraud, waste or abuse;
  - Conducts claims data analysis;
  - Conducts Pharmacy Benefit Manager data analysis;
  - Involves internal subject matter experts for assistance with investigations, when identified;
  - Processes fraud alerts and investigates to determine if there is CCA impact;
  - Reviews annual OIG work plan to identify current fraudulent schemes;
  - Summarizes and reports investigation results to appropriate internal CCA Committees; and
  - Reports cases to external regulatory authorities, when indicated.
- CCA's Compliance Training and Education Program. CCA's Department of Regulatory Affairs and Compliance is responsible to educate Workforce members on FWA, including the detection, prevention and reporting of suspected cases.

- Topics within FWA training and education include, but are not limited to:
  - Definitions of fraud, waste and abuse;
  - Examples of fraud, waste and abuse;
  - Review of specific industry scenarios and current schemes;
  - Current CCA practices to detect and prevent fraud, waste and abuse;
  - Review of key regulations concerning FWA including, but not limited to:
    - Deficit Reduction Act
    - False Claims Act (Federal and State)
    - Whistleblower Protections (Federal and State)
    - Anti-Kickback Statute
    - Stark Law
    - Civil monetary penalties of the Social Security Act
    - Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act
    - Fraud Enforcement and Recovery Act of 2009
    - Patient Protection and Affordable Care Act
- Compliance Tips of the Month;
- Posters displayed throughout common areas advising employees on how to report potential fraud, waste and abuse via the Compliance Hotline; and
- Specific operational department trainings, when requested.

### **Provider and Member Awareness and Education**

CCA's commitment to detection, prevention, investigation and reporting of fraud, waste and abuse is displayed in the following ways:

- FWA education and information contained within CCA's Provider Manual;
- Periodic FWA education and communication in Provider Newsletters;
- CCA makes CMS' Fraud, Waste and Abuse and General Compliance Training available on its external website  
<http://www.commonwealthcarealliance.org/providers/fraud-waste-abuse-program>
- FWA education and information contained within Member Newsletters; and
- Periodic attendance at CCA consumer meetings.

### **Fraud, Waste and Abuse Policies and Procedures**

CCA has policies and procedures in place to assist in detecting, preventing, investigating and reporting fraud, waste and abuse. CCA's Workforce is informed of these policies and procedures during fraud, waste and abuse training and periodically through the year. All of CCA Policies and Procedures can also be found on CCA's Intranet site, CommonGround, and are made available to contracted entities upon request.

## ***Fraud, Waste and Abuse Detection***

Being proactive in the detection of fraud, waste and abuse is a crucial element of an effective FWA Program. Fraud, waste and abuse can be detected through routine operational activities as well as activities specifically designed for the detection of fraud, waste and abuse.

### **Routine Operational Activities:**

Examples include, but are not limited to:

- Auto-Audit, a software system, generates reports to identify potential areas of fraud before each check run. Auto-Audit captures federal regulations and industry lessons learned. Examples include duplicate bills submitted by the same provider, improper date of service and missing information.
- Data Analysis of claim payments to identify trends in bills and payments.
- Utilization Management
  - The Committee meets regularly and is responsible for monitoring the quality, continuity and coordination of care as well as the overutilization and under-utilization of services.
  - The Committee's responsibilities include the review, monitoring and analysis of utilization and cost information associated with the delivery of care and services to CCA members, development and dissemination of clinical protocols and evidence based practice guidelines, identification and dissemination of best practice policies and procedures and assurance of standardized implementation of policies across the provider network.
  - The Committee evaluates and addresses systemic issues that impact quality of care and identify potential risk management issues.

### **Specific Fraud, Waste and Abuse Detection Activities**

Examples include, but are not limited to:

- Investigation of complaints made by members, contracted entities and/or CCA's Workforce regarding potential FWA; and
- CCA's Director of Pharmacy Services and Department of Regulatory Affairs and Compliance receive regular reports from the Pharmacy Benefit Manager about possible and/or active FWA investigations.

### **Sources of Fraud, Waste and Abuse Referrals**

Suspected incidents fraud, waste and/or abuse referrals may be identified from many different sources. Sources include, but are not limited to:

#### **Internal Sources**

- Workforce

- Compliance Hotline reports
- Data analysis
- Internal audits
- Provider site visits

External Sources

- Providers, Vendors, Contracted Entities
- Members and/or their families or caregivers
- Law enforcement
- Government agencies
- External auditors
- Fraud alerts
- News articles

### ***Response and Reporting of Fraud, Waste and Abuse***

Any suspected case of fraud, waste or abuse is to be reported promptly upon identification to CCA's Fraud, Waste and Abuse Case Coordinator ("FWACC"), or to the Department of Regulatory Affairs and Compliance,. CCA's Workforce may report the case directly to the FWACC, the Compliance Officer, their manager or supervisor, via the HR and Compliance Concerns Report on CommonGround, or through the Compliance Hotline.

An investigation of suspected FWA may involve a review of relevant documentation and records, interviews with Workforce and/or CCA member, and analysis of applicable laws and regulations. The investigation steps and results of any all investigations are documented in CCA's Regulatory Database.

Upon receipt of reports or reasonable indications of suspected fraud, waste and/or abuse, the FWACC investigates the allegation(s). The FWACC completes a case report on cases of suspected FWA for internal review and a referral is made to the NBI Medic and any applicable agency, when indicated. The FWACC works collaboratively with internal and external stakeholders, as necessary, to complete the investigation.

If an incident is determined to be a substantiated case of fraud, waste or abuse, the following actions may occur:

- Referral of any waste, abuse or potentially fraudulent conduct or inappropriate utilization activities for further investigation to MassHealth in relation to Medicaid activities or to the appropriate NBI MEDIC in relation to Medicare;
- Cooperation with law enforcement and NBI MEDIC;
- Reporting of potential violations of federal law to the OIG or to appropriate law enforcement authorities;
- Identification and repayment of any overpayments to the appropriate party; and
- Disciplinary actions for any of CCA's Workforce who is found to have engaged in fraudulent or abuse practices.

If necessary, a corrective action plan is developed and put into place. All corrective action plans are documented and include progress reports with respect to each error identified. Additional training for CCA's Workforce and/or others as identified is conducted as necessary.