MEDICARE PART D ARTICLE FOR MEDICAL PROVIDERS

Medicare Part D is a federal program used to subsidize the cost of prescription medication to Medicare beneficiaries. It was enacted as a part of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) that became effective January 1, 2006. The MMA requires Rocky Mountain Health Plans (RMHP) create and distribute Part D fraud, waste and abuse (FWA) training information. That training is required to be completed by RMHP employees as well as downstream and first-tier entities no later than December 31, 2011, upon hire or contract, and annually thereafter.

Definitions:

- Fraud – the intentional use of deception for unjust gain and/or enrichment
- Waste – careless or needless expenditures of supplies or other resources
- Abuse – medical practices and services that result in unnecessary costs to the Medicare program
- First-tier entity – any party that enters into a written arrangement to provide administrative services for a Medicare-eligible individual (an example would be a pharmacy benefit manager 'PBM' or a physician group)
- Downstream entity – any party that enters into a written arrangement with persons or entities involved with Medicare benefits, below the level of the arrangement between a plan sponsor (RMHP) and a first-tier entity, that continues down to the level of the ultimate provider of both health and administrative services (examples would include a physician or a pharmacy contracted through the PBM)

Each entity involved with Part D benefits faces its own risks which may or may not be unique to the type of entity. Some of the fraud risks faced by different entities are listed but not limited to the following:

Plan Sponsor

- Failure to provide medically necessary services
- Marketing schemes
  - Offering beneficiaries inducement to enroll
  - Unsolicited marketing
  - Misrepresenting Part D products
- Payment for excluded drugs
- Multiple billing
- Inaccurate data submission

PBM

- Prescription drug switching
- Steering a beneficiary to a certain plan or drug
- Inappropriate formulary decisions
- Failure to offer negotiated prices

Pharmacy

- Inappropriate billing practices
- Prescription drug shorting

- Bait and switch pricing
- Prescription drug forging or altering
- Dispensing expired or adulterated drugs
- Prescription refill errors
- Failure to offer negotiated prices

Prescriber
- Prescription drug switching
- "Script" mills
- Provision of false information
- Theft of DEA number or prescription pad

Wholesaler
- Counterfeit or adulterated drugs through black markets
- Drug diversions
- Inappropriate/false documentation of pricing information

Manufacturer
- Lack of data integrity to establish payment or determine reimbursement
- Kickbacks, inducement, or other illegal remuneration
- Inappropriate relations with formulary committee members
- Inappropriate relations with physicians
- Illegal "off-label" promotion
- Illegal use of free samples

Beneficiary
- Misrepresentation of enrollment status
- Identity theft
- Prescription forging or altering
- Drug diversion or inappropriate use
- Prescription stockpiling
- Doctor "shopping" for drugs

Medicare Part D is affected by multiple laws and regulations. The MMA requires CMS to have a comprehensive program in the Medicare Prescription Drug Program to detect, correct and prevent FWA. It also requires FWA programs for Medicare plans.

It is a violation of the Federal False Claims Act (FCA) to knowingly present, or cause to be presented, a false or fraudulent claim to the federal government. Penalties under the FCA include civil fines up to $11,000 per claim and three times the amount of the false claim(s). In addition to the above, the FCA allows individuals or entities to bring suit in the name of the government for instances of FWA. The suit is referred to as a "whistleblower" suit or *qui tam* suit. The FCA allows for protection of the "whistleblower" from any type of retaliation for reporting instances of FWA. If the whistleblower suit is successful, the person or entity bringing the suit may be entitled to a percentage of amounts recovered by the government.

The Stark Law, also known as the Federal Anti-kickback Statute, prohibits self-referral or remuneration that is directly tied to patient referral, or recommending purchase of supplies or services. Violating the Stark Law is considered a felony with penalties of up to $25,000 and/or five years' imprisonment.

The Health Insurance Portability and Accountability Act (HIPAA) established standards and requirements for electronic data submission of certain health information and requires patient information to be kept confidential. HIPAA violations can result in penalties of up to $250,000 and/or imprisonment for up to ten years for knowingly misusing individually identifiable health information.

Violations of the above can result in dual liability in some states with similar statutes as well as exclusion from the Medicare program. CMS publishes a database containing the names of persons or entities that are excluded from receiving payment by any federal health care program. The exclusion applies to items or services furnished, ordered or prescribed by an excluded individual or entity. For more information on exclusions or to search for an excluded individual or entity, visit http://exclusions.oig.hhs.gov/.

To help ensure compliance with federal programs guidelines, the Office of the Inspector General (OIG) has outlined seven suggested components for an effective compliance program that physicians can implement within their practices that includes the following:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing corrective action;
- Developing open lines of communication; and,
- Enforcing disciplinary standards through well-publicized guidelines. Further information regarding an effective compliance program can be found at: http://oig.hhs.gov/authorities/docs/physician.pdf.

The following is a list of some government agencies involved in curbing FWA:

- Centers for Medicare and Medicaid Services (CMS)
- MEDICs – the contractors responsible for monitoring FWA in the Medicare prescription drug program
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Federal and State Attorneys General

In closing, RMHP remains committed to complying with FWA requirements outlined by CMS. You may report FWA through the following resources:

- Rocky Mountain Health Plans (RMHP)
  - Hotline – 800-447-8477
  - Email – fraudauditor@rmhp.org

- Mail reports to: Fraud Investigator, 2775 Crossroads Blvd, Grand Junction, CO 81506

- CMS
  - Hotline
  - Fax – 800-223-8164
  - Email – HHSTips@oig.hhs.gov
  - Mail reports to: Office of the Inspector General, HHS Tips Hotline, PO Box 23489, Washington, D.C. 20026