Fraud, Waste and Abuse Awareness and Reporting Policy

PURPOSE

To ensure Capital Health Plan has a comprehensive plan to detect, correct and prevent fraud, waste and abuse as required by CMS and are stipulated in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of Medicare Managed Care Manual.

POLICY

Capital Health Plan requires all of its work force to exercise due diligence in the prevention, detection and correction of fraud, waste and abuse. CHP promotes an ethical culture of compliance with all state and federal regulatory requirements, and mandates the reporting of any suspected fraud, waste and abuse to the Compliance Officer by any means including the use of an anonymous hotline at 850-383-3566.

In addition to work force reporting and prevention requirements, Capital Health Plan encourages members, affiliates, facilities, vendors, consultants and contractors to report any suspected fraud, waste or abuse to the Compliance Officer directly by calling (850) 383-3472 or anonymously through the hot line at (850) 383-3566.

DEFINITIONS

Abuse

Abuse includes actions that may directly or indirectly result in unnecessary cost to the Medicare Program, improper payment; payment of services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Centers for Medicare and Medicaid Services

CMS is an agency within the Department of Health and Human Services that is responsible for directing the national Medicare program.

Formulary

The entire list of Part D drugs that are covered by CHP for our Medicare beneficiaries, administered by our PBM, and dispensed through participating pharmacies to covered enrollees.

Fraud

Means an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person.

MA Prescription Drug Plan (MA-PD)
A Medicare Advantage Organization that provides qualified prescription drug coverage to Medicare beneficiaries (42CFR 423.4)

Medicare Drug Integrity
MEDIC is an organization that CMS has contracted with to perform specific program integrity functions for Part D under the Medicare Integrity Program. The MEDIC is the CMS designee to manage CMS audit, oversight, and antifraud and abuse efforts in the Part D benefit.

Part D
Portion of the Medicare Drug Improvement and Modernization Act of 2003 that provides prescription drugs for Medicare beneficiaries.

MA Prescription Drug Plan (MA-PD) MA
A Medicare Advantage Organization that provides qualified prescription drug coverage to Medicare beneficiaries (42CFR 423-4).

Medication Management ~~Pharmacy~~ Committee
A Capital Health Plan committee consisting of practicing physicians and pharmacists. They are charged with developing drug criteria unique to Capital Health Plan, reviewing and monitoring drug utilization and trends, and identifying potential areas at risk for fraud, waste and abuse in conjunction with our contracted PBM and its P&T Committee.

Special Investigative Unit
SIU of Florida Blue assists Capital Health Plan in all investigative efforts regarding allegations of fraud, waste and abuse. This unit also assists with staff and network education of fraud, waste and abuse. This unit also may be called directly by members, network affiliate vendors, consultants or contractors for reporting any suspected fraud, waste or abuse.

Waste
The inappropriate utilization and/or inefficient use of resources.

PROCEDURE
The following is intended to be a high level overview of the implementation of a comprehensive plan to detect, correct and prevent fraud, waste, and abuse. The core elements of Capital Health Plan's Compliance program for the Medicare benefit include:

1. Written policies, procedures and standards of conduct as reflected in Capital Health Plan's Code of Conduct/Beacon for compliance;
2. Compliance Officer and Compliance Committee which meet quarterly (or more often as needed);
3. Annual required compliance training by all work force based on responsibilities and OIG identified risk areas.
4. Ongoing education of work force, network affiliates, vendors, consultants, contractors of regulatory changes and Fraud, Waste and Abuse Awareness through newsletters, web pages, meetings and mail-outs.

5. Effective lines of communication established with internal workforce and external entities through the internet, newsletters, meetings, and other modes of contact.
6. Disciplinary guidelines are published in the Code of Conduct/Beacon and enforced through the appropriate established internal or external processes.
7. Ongoing auditing and monitoring for compliance with Fraud, Waste and Abuse mandates will include, but not limited to, the resources of Capital Health Plan's:
    - Internal Audit Department,
    - Fraud, Waste and Abuse Work Group,
    - Special Investigation Unit (SIU) of Florida Blue,
    - Medication Management Committee,
    - Compliance Committee.
8. Corrective action plans will be implemented, documented and communicated upon discovery of Fraud, Waste and Abuse. Additional monitoring may be initiated as necessary to prevent any future occurrence.
9. An effective fraud, waste and abuse policy promotes:
    - Awareness and recognition of potential Fraud, Waste and Abuse;
    - Processes for reporting fraud, waste and abuse that would be non- retaliatory and;
    - Refining the existing policy as necessary to meet any corporate or regulatory changes.
10. An effective Fraud, Waste and Abuse program addresses the following, but is not limited to just the topics listed below.
    - Laws and regulations related to Medicare Advantage and Part D Fraud, Waste and Abuse (i.e., False Claims Act, Anti-Kickback statute, HIPAA, etc.);
    - Obligations of the first tier, downstream, and related entities to have appropriate policies, procedures and training to prevent, detect and correct fraud, waste, and abuse;
    - Process for reporting to Capital Health Plan suspected Fraud, Waste and Abuse in first tier, downstream, and related entities;
    - Protections for employees of first tier, downstream, and related entities who report suspected fraud, waste and abuse;
    - Awareness of types of Fraud, Waste and Abuse that can occur in first-tier, downstream, and related entities.

Capital Health Plan will collaborate with CMS and the MEDIC to deter any Fraud, Waste and Abuse of the Part D plan and report to the appropriate agencies or law enforcement authorities if such activity is determined to have occurred.

The guidance as described in Chapter 9 of the CMS Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual will be the primary reference source for Capital Health Plan's Fraud, Waste and Abuse initiatives.

Revision History
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