Policies and Procedures

Policy Title Medicare Advantage and Part D Fraud, Waste, and Abuse			
Department Responsible Compliance and Integrity	**Policy Code** HTA – 1.20	**Effective Date** December 2015	**Next Review Date** July 2018
Title of Person Responsible Compliance Officer	**Approval Council** HTA Board of Directors		**Approved Date** December 10, 2015

PURPOSE

HTA recognizes that violations of its compliance and integrity program, applicable federal and state laws and regulations and other types of noncompliance impact HTA's status as a reliable and trustworthy organization. This policy outlines the Care N' Care Insurance Company of North Carolina, Inc.'s, d/b/a Healthteam Advantage (HTA) fraud, waste and abuse program and its dedication to helping reduce or eliminate fraud, waste and abuse, preventing illegal activities, referring potential cases to and supporting the Centers for Medicare & Medicaid Services (CMS) in investigations.

DEFINITIONS

Abuse: Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare 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.

Downstream Entity: Any party that enters into a written agreement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between the Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity.

First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the Medicare Advantage program or Part D program.

Fraud: 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. 18 U.S.C. § 1347.

FWA: Fraud, waste and abuse

NBI MEDIC: NBI MEDIC means National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.

Related Entity: Any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and Performs some of the Medicare Advantage or Part D 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 Medicare Advantage Organization or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See 42 C.F.R. §423.501).

Waste: Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

POLICY

HTA will establish and implement procedures and a system for promptly responding to compliance issues, including those involving fraud, waste or abuse as they are raised, investigating potential problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

1. If HTA discovers evidence of misconduct related to payment or delivery of items or services under the contract, it will conduct a reasonable inquiry into that conduct.
2. HTA will conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible individuals) in response to the potential violations.
3. HTA will establish and maintain procedures to voluntarily self-report potential fraud or misconduct related to the Medicare program to CMS or its designee (such as the NBI MEDIC).

RESPONSIBILITIES

HTA's Compliance and Integrity Office will establish and implement procedures for promptly responding to FWA and noncompliance. It is responsible for the identification of potential FWA, timely initiation of investigations, and, where potential FWA is identified, reporting such to the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), law enforcement as warranted, and CMS. HTA will take the appropriate corrective action in response to the issues.

The Compliance and Integrity Office provides various methods for reporting of FWA concerns. Criteria used in the evaluation process include, but are not limited to:

- Impact to members obtaining care or prescription drugs;
- Number of members potentially impacted or impacted by the issue; and
- Dollar impact of the issue.

REFERENCE DOCUMENTS/LINKS

- 42 CFR § 422.503(b)(4)(vi)
- 42 CFR § 423.504(b)(4)(vi)(H)
- Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines
- Anti-kickback Regulations
- Stark Law Amendments
- False Claims Act
- HIPAA/HITECH

PREVIOUS REVISION/REVIEW DATES

Date	Reviewed	Revised	Notes
N/A	N/A	N/A	This is a new policy.
July 2017	X	N/A	