

Fraud, Waste, and Abuse Training

Welcome to the Community Care Plan

Fraud, Waste, and Abuse (FWA) & Compliance Training

Training Objectives

- Meet the regulatory requirement for training and education.
- Provide information on the scope of fraud, waste, and abuse.
- Explain obligation of everyone to detect, prevent and correct fraud, waste, and abuse.
- Provide information on how to report and prevent fraud, waste, and abuse.
- Provide information on laws pertaining to fraud, waste, and abuse.
- Provide information on reporting fraud, waste, and abuse training and documentation requirements.

Why Do I Need Training?

- Every year millions of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone, including you. This training will help you detect, correct, and prevent fraud, waste, and abuse. You are part of the solution.

Fraud, Waste, and Abuse

Fraud:

Knowingly submitting false statements or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist.

Waste:

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

Abuse:

Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid Program. Abuse involves payment for items or services when there is not legal entitlement to that payment, and the provider has not knowingly, and or/intentionally misrepresented facts to obtain payment.

Where Do I Fit In?

- As a person or entity that provides health or administration services to a Medicaid enrollee you are either:
- Medicaid Plan Sponsor (Managed Care Organization and/or Prescription Drug Plan) Employee.
- First Tier Entity: Examples: Pharmacy Benefit Manager (PBM), a Claims Processing Company)
- Downstream Entity: Pharmacy
- Related Entity: Entity that has a common ownership or control of a Medicaid Plan Sponsor.

Requirements

- According to state and federal regulations, CCP is ultimately responsible for oversight and monitoring of education and training for first tier, downstream and related entities.
- First tier, downstream and related entities should maintain records of training including copies of training material, sign-in sheets, and employee attestations.
- Training should be provided within 30 days of a new employee hire, then annually thereafter, and when training requirements change.

Examples of Medicaid Fraud:

Provider Fraud

- Billing Medicaid for non-rendered services or supplies.
- Billing for services at a level of complexity higher than the service actually provided or documented in the medical records.
- Prescribing drugs that are not medically necessary. (Pill Mills)

Member Fraud

- Loaning a Medicaid Identification card to another person.
- Forging or altering a prescription.
- Doctor Shopping for narcotics.

How to Detect, Prevent and Correct Fraud, Waste, and Abuse

- Make sure you are up to date with laws, regulations, policies.
- Ensure you coordinate with other payers.
- Ensure data/billing is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity.

How to Detect, Prevent and Correct Fraud, Waste, and Abuse

- Everyone has the right and responsibility to report possible fraud, waste, and abuse.
- Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or Plan Sponsor Compliance Hotline.
- Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves Medicaid money and ensures that you are in compliance with State and Federal laws.

Important Numbers

- **AHCA Consumer Complaint Hotline:**
  1-888-419-3456
- **Florida Attorney General's Office:**
  1-866-966-7226
- **The Florida Medicaid Program Integrity Office:**
  1-850-412-4600
- **Complaint Form:**
  https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.asp

Consequences of Committing Fraud, Waste, or Abuse

- Civil Monetary penalties
- Criminal Convictions
- Exclusion from Federal/State Health Care Programs

CCP Ethics and Compliance Hotline

- CCP has a telephone and web based compliance hotline in place through which employees, contractors, and vendors are able to report compliance matters on a confidential and/or anonymous basis.
- **Hotline telephone number:** 855-843-1106
- **Hotline website:** www.lighthouse-services.com/ccpcares
- **E-mail:** reports@lighthouse-services.com

Health Care Laws- False Claims Act

Enacted after the Civil war, the Federal False Claims Act (FCA) prohibits anyone form knowingly submitting a false claim to the government. The act does not require proof of intent to defraud, only a reckless disregard of the truth or falsity of the information.

Under the Federal False Claims Act, a person, provider, or entity is liable for up to triple damages and penalties of $5,500 to $11,000 for each false claim it knowingly submits or causes to be submitted to a Federal Program.

Health Care Laws– False Claims Act (Cont.)

- Liability can also be created by improper retention of an overpayment.
  - Overpayments or any funds received or retained under Medicare or Medicaid that a person or organization is not entitled to must be reported and returned within 60 days of identification.

- Whistleblower and Whistleblower protections.
  - The false claims act permits private citizens with knowledge of fraud against the U.S. or state governments to file suit on behalf of the government against the person or business that committed the fraud.
  - Individuals who file such suites are known as 'whistleblowers'. Whistleblowers are entitled to a percentage of dollars recovered by the government as a result of the suite brought by the Whistleblower. The false claims act prohibits retaliation against individuals for investigating, filing or participating in a whistleblower action.

Health Care Laws- The Anti-Kickback Statute

The Anti-Kickback Statute makes it illegal for providers to knowingly and willfully offer, provide, solicit or accept any monetary or non-monetary remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.

- Fines of up to $25,000, or imprisonment up to five (5) years, or both fine and imprisonment.
- The statue ascribes criminal liability to parties on both sides of an impermissible transaction.
- Exceptions to the Anti-Kickback Statute are called Safe Harbors which are financial arrangements unlikely to result in fraud and abuse.

Health Care Laws- Stark Law

The purpose of the Stark Law is to prohibit physician self-referrals. The law applies to any physician who provides health care services to Medicare, Medicaid or other federal health care recipients, and says that physicians cannot refer patients for certain designated health services to any entity with which the physician has a financial interest. Unless one of the Stark Law exceptions apply.

Up to $15,000, for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

The Deficit Reduction Act of 2005

- The Federal Deficit Reduction Act (DRA) of 2005, signed into law on February 8, 2006, and effective January 1, 2007, requires any entity receiving or making annual Medicaid payments of $5 million or more to establish and adopt written policies about federal and state false claims laws for all its employees, contractors and agents.

- Healthcare entitles are also required to establish written policies on whistleblower protections and for detecting and preventing fraud, waste and abuse.

HIPAA

- Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI).
- If you become aware of a potential breach or inappropriate disclosure of protected information, you must comply with the security breach and disclosure provision under HIPAA and if applicable, with any business associate agreement.

Excluded Individuals/Entities Employer Responsibilities

- First Tier, downstream, and related entities must review federal exclusion lists at the time of hire/contracting and monthly thereafter to ensure that no Medicaid dollars are paid to employees, providers, or vendors who are excluded from participating in State or Federal health care programs.
- For more information or access to the publically-accessible, excluded-party online databases, please see the following links:
  - List of excluded individuals/entities: http://exclusion.oig.hhs.gov
  - General Services Administration (GSA) list of parties excluded from federal procurement and non-procurement programs: https://www.epis.gov

What is a Compliance Program?

Fundamental elements of a compliance program:

- Implementing written policies and procedures and standards of conduct.
- Designating a compliance officer.
- Effective training and education.
- Conducting internal monitoring.
- Open lines of communication.
- Enforcing standards through well publicized disciplinary guidelines.
- Responding promptly to detected offenses, developing corrective actions, and reporting to the State & Government.

Benefits of a Compliance Program

- Compliance programs help raise awareness and provide mechanisms to detect, prevent, correct non-compliance & FWA.

- Creates an environment that encourages employees to report potential problems so that the problem can be corrected.

Implementing written policies and procedures and standards of conduct

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These policies and procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with your entity's policies and procedures.

Designating a Compliance Officer

The compliance officer is responsible for the development, implementation, and day-to day monitoring and maintenance of the compliance program.

Employees should seek clarification from the compliance officer in the event of any confusion or question regarding compliance issues or a company policy, practice or procedure.

Training

- All employees will receive annual training and new employees will receive training at new employee orientation.
- Fraud, waste, and abuse training and education.
- Training on compliance program.
- HIPAA privacy and security training.
- Specialized training depending on job description.

Open Lines of Communication

In order for a compliance program to work, employees must have access to the Compliance Officer and be able to ask questions and report compliance problems.

The results of all compliance investigations will be included in reports to the governing body, and the Audit and Compliance Committee.

Internal Monitoring and Risk Assessment

Proactive audits of:

- Claims
- Credentialing
- Wage and Hour
- Contract Compliance

Disciplinary Guidelines

- Disciplinary actions will be determined on a case-by-case basis and may include an oral warning, written warning, and/or termination of employment.

- If it is determined that a violation has included illegal activities State and Federal law enforcement will be notified.

Enforcing standards through well publicized disciplinary guidelines

- Providers will act promptly when compliance issues arise.
- Providers will hold employees accountable.
- Disciplinary actions will be taken against any employee, regardless of job title, who violates compliance policies.
- Disciplinary actions will be determined on a case-by-case basis and may include an oral warning, written warning, and/or termination of employment.

Complying with training Requirements

Plan Sponsors, First Tier, Downstream and Relate Entities can comply with the training requirements in the following ways.

Three Training Options:

- Complete CCP's Compliance Fraud, Waste and Abuse training and education program.
- Complete equivalent FWA training and education that meets CMS' FWA training requirements as outlined in Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines and or Prescriptions Drug Benefit Manual Chapter 9 – Compliance Program Guidelines, or
- FWA Certification (by enrolment into Parts A or B of the Medicare program) or accreditation as a supplier or DMEPOS by a First Tier, Downstream or Related Entity.

Attestation of Medicaid Fraud, Waste, and Abuse Training

- If you are a contracted provider, complete and sign the attestation and return to CCP via email, fax or mail.
- If you have office personnel, temporary and or subcontractor they are also required to take this training and records must be maintained in your office for the plan to audit for 10 years.
- In addition, the undersigned Organization/Person certifies and attests that it has required its downstream entities to certify and attest that they have obtained and conducted, as applicable, the required FWA training for the 2016 calendar year for it and for all its personnel and employees, as applicable
- Upon request from CCP, the organization/Person agrees that it will furnish training logs from its downstream entities, as well as the certifications or attestations it obtains from its downstream entities to validate that the required FWA training was completed.

2017 Annual Compliance and Fraud, Waste, and Abuse Training Program Attestation

This attestation serves as acknowledgement that your organization completed one of the following items indicated below as required by the Centers for Medicare and Medicaid Services (CMS), in accordance with 42 CFR 422.503, as amended, and understands that compliance with federal regulatory provisions regarding Fraud, Waste and Abuse (FWA) Training is mandatory:

☐ Completed CCP's FWA & Compliance training and education.

☐ Completed equivalent FWA & Compliance training and education provided by a Medicaid and/or Medicare Plan sponsor that meets CMS' FWA training requirements as outlined in Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines and or Prescriptions Drug Benefit Manual Chapter 9 – Compliance Program Guidelines, or

☐ FWA Certification (by enrolment into Parts A or B of the Medicare program) or accreditation as a supplier or DMEPOS by a First Tier, Downstream or Related Entity.

By signing below, your organization certified that all members of the organization understand and will abide by the provisions of CCP's Compliance Training Program and /or an equivalent FWA training and education program that meets CMS' FWA training requirements, as outlined in Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines and or Prescription Drug Benefit Manual Chapter 9 – Compliance Program Guideline. Additionally, the entity agrees to furnish training logs and certifications demonstrating completion of such programs at the request of CCP or CMS. You also attest that your organization will furnish training materials, including, but not limited to, training logs and training program material from third-party training or training you conducted to CCP upon request to validate that training was completed and documentation is retained for a minimum of 10 years. You also agree that your organization will obtain attestations from other entities with which you have contracted to provided health, prescriptions, and or administrative services to CCP, and upon request will obtain training logs and attestations to verify that Compliance Training Program and /or an equivalent FWA training and education program was completed by those other entities.

Signature: _____ Print Name: _____

Date: _____ Organization: _____

(*Please attach a list if you are attesting for multiple locations*)

Please return signed attestation via email to mmorgan@ccpcares.org or fax: 954-372-8354 or via U. S. Mail to:
Community Care Plan, Attn: Michael Morgan., 1643 Harrison Parkway (H200) Sunrise, Florida 33323

Compliance updated: 4/1/2016