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Provider Compliance Training

Vision & Purpose

Community Care Plan (CCP), the health plan with a heart, is an entity owned by Broward Health (North Broward Hospital District) and Memorial Healthcare System (South Broward Hospital District). CCP serves enrollees enrolled in Medicaid; Healthy Kids; commercial, self-insured employee health plans; and sponsored programs.

CCP's mission is driven by our community responsibility to positively impact the health and wellness of those we serve with a vision to be the vehicle for population health. This is done through Community Care Plan's 6 Core Principles of Excellence:

- Quality
- Customer Service
- Community
- People
- Finance
- Growth

Through its mission, vision and core principles of excellence, Community Care Plan works with local physicians and providers, like you, to offer local access to a high standard of healthcare and community resources. CCP provides this Provider Compliance Training to assist our physicians and providers in the mission to provide the best care to the community we serve.

Effective Compliance Program

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

As a provider of health and administrative services in Community Care Plan programs, you are:

- a vital part of the effort to prevent, detect, and report Medicaid, Healthy Kids and other CCP healthcare program noncompliance as well as possible fraud, waste and abuse;
- required to comply with all applicable statutory, regulatory and Medicaid and Healthy Kids as well as other CCP healthcare program requirements, including adopting and implementing an effective compliance program;
- obligated to report any violations of laws that you may be aware of; and
- essential in following your organization's Code of Conduct, a tool that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

An effective compliance program:

- Is essential to prevent, detect, and correct Medicaid, Healthy Kids and other CCP healthcare non-compliance as well as fraud, waste and abuse.
- Must, at a minimum, include the seven core compliance program requirements. (42 C.F.R. §438.608)

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Fraud, Waste, Abuse & Overpayment

- **Fraud** - An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.
- **Waste** – Mismanagement of resources, including incurring unnecessary costs because of inefficient or ineffective practices or systems.
- **Abuse** - Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or any other CCP Program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care, or recipient practices that result in unnecessary cost to the Medicaid program or any other CCP program.
- **Overpayment** – Any amount that is not authorized to be paid by the Medicaid program (s. 409.913, F.S.) or any other CCP healthcare program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

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Report Fraud, Waste and Abuse (FWA)

Everyone is *required to report suspected instances of Fraud, Waste and Abuse*. Your organization's Code of Conduct and Ethics should clearly state this obligation. Retaliation against you for making a good faith effort in reporting may not occur.

Do not be concerned about whether it is fraud, waste or abuse. Report any concerns and Compliance will investigate and make the proper determination.

Your organization should have mechanisms in place to report potential fraud, waste or abuse. Your organization must be able to accept *anonymous reports* and *cannot retaliate* against you for reporting.

You can report suspected instances of Fraud, Waste and Abuse directly to Community Care Plan. This can be done anonymously by calling 855-843-1106 or going to www.lighthouse-services.com/ccpcares. You can also contact the Community Care Plan Compliance Officer at 954-622-3489 or via email at CCP.Compliance@ccpcares.org or CCP.SIU@ccpcares.org

Direct Reporting of FWA

To direct report suspected fraud, waste, or abuse in the Medicaid Program or any other CCP program, please use one of the following avenues:

- The Florida Medicaid Program Integrity (MPI) Office: 1-850-412-4600 or
- AHCA-MPI Consumer Complaint Hotline: 1-888-419-3456 or
- AHCA-MPI Medicaid Fraud and Abuse Complaint form https://apps.ahca.myflorida.com/mpi-complaintform/ or
- Florida Attorney General's Office: 1-866-966-7226 or
- Report Insurance Fraud to Florida's Chief Financial Officer at https://first.fldfs.com/ or 1-800-378-0445
- Department of Health and Human Services Office of Inspector General (HHS-OIG) Hotline: 1-800-447-8477.
- Member Fraud Related to Public Assistance https://www.myflfamilies.com/service-programs/public-benefits-integrity/

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Laws & Penalties

Laws You Need to Know About – S. 6032 of Federal Deficit Reduction (DRA) Act of 2005 including the Whistleblower Protection (Qui Tam) Act

Under the Deficit Reduction Act, Community Care Plan is required by law to establish certain policies and provide information including but not limited to the federal and state False Claims Act; right to be protected as a whistleblower; and policies and procedures for detecting, preventing and reporting fraud, waste and abuse in state and federal health care programs.

The Whistleblower Protection (Qui Tam) Act protects employees from retaliation for making any disclosure that the employee reasonably believes reveals a violation of the law or witnesses gross mismanagement or an abuse of authority, etc. by government entities, agency or employer.

The Qui Tam lawsuit allows an individual to file suit on behalf of the government against an entity he/she deems is in violation of the False Claims Act, and receives a portion of the recovered funds, if the case is successful.

Laws & Penalties

The following slides provide very high level information about specific laws.

Civil Fraud – Civil False Claims Act Prohibits:

- Knowingly presenting a false claim for payment or approval
- Knowingly making or using a false record or statement in support of a false claim
- Conspiring to violate the False Claims Act
- Falsely certifying the type/amount of property to be used by the Government
- Certifying receipt of property without knowing if it's true
- Knowingly buying property from an unauthorized Government officer
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government

31 United States Code § 3729-3733

Laws & Penalties

Civil False Claims Act Damages and Penalties

- The statute provides for a civil penalty not less than $11,181 and not more than $22,363 per false claim (as adjusted annually) plus three times the amount of actual damage to the government resulting from any violation of the FCA.

Criminal Fraud Penalties

- If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

Anti-Kickback Statute Prohibits

- Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes Medicaid).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

- Criminal fines up to $25,000 per violation and up to five (5) year prison term per violation, or both
- fine and imprisonment.

Laws & Penalties

The Physician Self-Referral Law (Stark Law) prohibits:

- A physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/ investment interest or with which he or she has a compensation arrangement, unless an exception applies.

42 United States Code §1395nn

Stark Statute Damages and Penalties -

- Medicaid claims tainted by an arrangement that does not comply with Stark are not payable. Up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

Exclusions -

- No Federal / State health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General or the Office of Attorney General.

42 U.S.C. §1395(e)(1)
42 C.F.R. §1001.1901

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Laws & Penalties

HIPAA -Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

- Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
- Safeguards to prevent unauthorized access to protected health care information.
- As an individual who has access to protected health care information, you are responsible for adhering to HIPAA.

The Act or ARRA – The American Recovery and Reinvestment Act

- The Act made significant modifications to the HIPAA Privacy and Security Rules.
- Increased Penalty Provisions.
- National Breach Notification Law.
- Business Associates must comply with HIPAA Rules.
- Individuals affected by a HIPAA violation will be able to receive a percentage of any civil monetary penalty or monetary settlement collected with respect to such offense.

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Laws & Penalties

Consequences of Committing Fraud, Waste or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties;
- Criminal Conviction/Fines;
- Civil Prosecution;
- Imprisonment;
- Loss of Provider License; and
- Exclusion from Federal /State Health Care programs.

For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

What You Can Do

Just because someone else is doing it, doesn't mean you can or should.

- Make Compliance a priority now
- Know your Fraud and Abuse risk areas
- Keep up-to-date and user friendly policies and procedures
- Educate and train your staff
- Ask for feedback. Encourage your staff to speak up!
- Act promptly when issues arise. Take and document corrective action

Attestation of Medicaid Compliance, Privacy & Security and Fraud, Waste, Abuse & Overpayment Training

The undersigned organization/person certifies that it has obtained and/or conducted Compliance, Privacy & Security, and Fraud, Waste, Abuse & Overpayment awareness trainings for it and all of its personnel and employees, as applicable.

Please identify the method of training and education your organization used and return the completed attestation form via email to CCP.Compliance@ccpcares.org.

☐ Took training and education provided by Community Care Plan

☐ Took training and education provided by other source:_____ (identify other source and provide copy of training with this attestation

_____

Name of Organization/Person

_____

Name of Organization's Representative & Title (please print)

_____ _____

Signature Date

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