Compliance and fraud, waste and abuse training

Medicaid and Florida Healthy Kids

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Medicaid Managed Care

Purpose

Why do I need training?

Every year, billions of dollars are improperly spent because of fraud, waste and abuse (FWA). It affects everyone — **including you**. This training will help you detect, correct and prevent FWA. **You** are part of the solution.

Compliance is everyone's responsibility. As an individual who provides health or administrative services for Medicaid enrollees, your every action potentially affects Medicaid and Medicare enrollees, the Medicare program, and the Medicaid program.

Without programs to prevent, detect and correct noncompliance, we all risk:

- High insurance copayments.
- Higher premiums.
- Lower benefits for individuals and employers.
- Lower performance ratings.

Objectives

- Meet regulatory requirements for FWA training and education.
- Provide the definition and scope of compliance and FWA.
- Explain the obligation of detecting, preventing and correcting FWA.
- Provide information on how to report potential noncompliance and FWA.
- Provide information on FWA laws.

Training requirements

- Medicaid and Florida Healthy Kids contractors must have an effective compliance program that includes measures to prevent, detect and correct Medicaid or Medicare noncompliance, as well as measures to prevent, detect and correct FWA.
- The Agency for Health Care Administration (AHCA) requires all Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA) plan-contracted providers and subcontractors to receive compliance/FWA training when contracting with an SMMC MMA plan and annually.
- The AHCA requires that plans apply their training requirements and *effective lines of communication* to their contracted providers and subcontracted vendors.
    - Having *effective lines of communication* means that employees of the plan, the plan's providers and the plan's subcontractors have several avenues to report compliance concerns.
- Contracted providers are also required to ensure their staff complete FWA training.

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Code of Conduct

- Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their operational principles and values.
- Plan-contracted providers are required to adopt the Code of Conduct for Simply Healthcare Plans, Inc. and Clear Health Alliance (Simply), which may only be tailored to your individual organization's business operations. You can find the Code of Conduct on our provider websites.
- Reporting Code of Conduct violations and suspected noncompliance is everyone's responsibility.
    - An organization's Code of Conduct and policies and procedures should identify this obligation and tell you how to report suspected noncompliance.

Seven core compliance program requirements

An effective compliance program must include the below seven core requirements:

Core requirement	Description
Written policies, procedures and standards of conduct	These articulate the plan's commitment to comply with all applicable federal and state standards and describe compliance expectations according to the Standards of Conduct.
Compliance officer, compliance committee and high-level oversight	The plan must designate a compliance officer and a compliance committee that will be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated and resolved by the compliance program. The plan's senior management and governing body must be engaged and exercise reasonable oversight of the plan's compliance program.
Effective training and education	This covers the elements of the compliance plan as well as prevention, detection and reporting of FWA. This training and education should be tailored to the different responsibilities and job functions of employees.
Effective lines of communication	Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good-faith reporting of compliance issues at the plan and at the provider levels.
Well-publicized disciplinary standards	The plan must enforce standards through well-publicized disciplinary guidelines.
Effective system for routine monitoring, auditing and identifying compliance risks	Conduct routine monitoring and auditing of the plan's and subcontractor's operations to evaluate compliance with CMS and Medicaid requirements as well as the overall effectiveness of the compliance program.[1]
Procedures and system for prompt response to compliance issues	The plan must use effective measures to respond promptly to noncompliance and undertake appropriate corrective action.

1. The plan must ensure that subcontractors performing delegated administrative or health care service functions concerning the plan's Medicaid and/or Medicare program comply with program requirements.

What is noncompliance?

Noncompliance: conduct that does not conform to the law, federal health care program requirements, or an organization's professional and ethical policies. Standards of Conduct (or Code of Conduct) state the organization's compliance expectations as well as their operational principles and values. Examples of some provider risk areas include:

- Conflicts of interest.
- Ethics.
- Quality of care.
- Claims submission.
- Medical record documentation.

Consequences of noncompliance

Failure to follow the health plan and the Medicaid program requirements, guidance received from the AHCA and the health plan can lead to serious consequences including:

- Contract termination.
- Criminal penalties.
- Exclusion from participating in all federal health care programs.
- Civil monetary penalties.

Additionally, each health plan provider and subcontractor must have disciplinary standards for noncompliant behavior. Those who engage in noncompliant behavior may be subject to any of the following:

- Mandatory training or retraining
- Disciplinary action
- Termination

Compliance is everyone's responsibility

- All health plan providers are required conduct themselves in an ethical and legal manner. It's about doing the right thing!
  - Act fairly and honestly.
  - Adhere to high ethical standards in all you do.
  - Comply with all applicable laws, regulations, and SMMC MMA and CMS requirements.
  - Report suspected violations.
- An effective compliance program fosters a culture of compliance.
- To help ensure compliance, behave ethically and follow your organization's and plan's Standards of Conduct. Watch for common instances of noncompliance and report suspected noncompliance.
- Know the consequences of noncompliance and help correct any noncompliance with a corrective action plan that includes ongoing monitoring and auditing.

FWA definitions

Fraud: knowingly and intentionally 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. 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. Overusing services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare and Medicaid programs.

Abuse: provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicare or Medicaid programs 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. 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.

Overpayment: overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Provider FWA examples

Category	Provider FWA examples (not limited to below examples)
Fraud	• Knowingly billing for services not furnished or supplies not provided, including billing for appointments that the patient failed to keep • Billing for non-existent prescriptions • Knowingly altering claim forms, medical records or receipts to receive a higher payment • Making false statements on a credentialing application
Waste	• Conducting excessive office visits or writing excessive prescriptions • Prescribing more medications than necessary for the treatment of a specific condition • Ordering excessive laboratory tests
Abuse	• Billing for unnecessary medical services • Billing for brand name drugs when generics are dispensed • Charging excessively for services or supplies • Misusing codes on a claim, such as upcoding or unbundling codes • Double billing • Charging enrollees for Plan covered services

Member FWA examples

- Benefit sharing
- Collusion
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation and/or misrepresentation
- Subrogation and/or third-party liability fraud
- Falsification of information
- Forging or selling prescription drugs (drug trafficking)
- Using transportation benefit for non-medical related business
- Adding an ineligible dependent to the plan
- **Loaning** or using another person's insurance card
- Identity theft

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How to prevent FWA

- Make sure you are up to date with laws, regulations and policies.
- Ensure you coordinate with other payers.
- Ensure data and billing are both accurate and timely.
- Ensure the services rendered are medically necessary and accurately documented.
- Verify information provided to you.
- Be on the lookout for suspicious activity.
- Educate members about the types of fraud and the penalties levied.
- Spend time with patients and review their records for prescription administration to minimize drug FWA.
- Review member ID cards to ensure the cardholder is the person named on the card.

Potential indicators of FWA

Type of issue	Potential key indicators
Beneficiary (member)	• Does the prescription look altered or possibly forged? • Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors? • Is the person receiving the service/picking up the prescription the actual beneficiary (identity theft)? • Is the prescription appropriate based on beneficiary's other prescriptions? • Does the beneficiary's medical history support the services being requested?
Provider	• Does the provider write for diverse drugs or primarily only for controlled substances? • Are the provider's prescriptions appropriate for the member's health condition (medically necessary)? • Is the provider writing for a higher quantity than medically necessary for the condition? • Is the provider performing unnecessary services for the member? • Is the provider's diagnosis for the member supported in the medical record? • Does the provider bill the sponsor for services not provided?

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Effects of noncompliance

Without programs to prevent, detect and correct noncompliance, we all risk harm to enrollees, such as:

- Delayed services.
- Denial of benefits.
- Difficulty in using providers of choice.
- Other hurdles to care.

Other effects of noncompliance include:

- High insurance copays.
- Higher premiums.
- Lower benefits for individuals and employers.
- Lower performance ratings.
- Lower profits.

Reporting FWA

Help us prevent it and tell us if you suspect it! Be alert and report violations.

- The law prohibits retaliation against anyone for reporting suspected noncompliance/FWA in good faith.
- Simply is prohibited from retaliating against any provider or subcontractor and their employees for responsibly reporting noncompliance and fraud detected.
- The plan offers reporting methods that are anonymous, confidential and non-retaliatory.

Providers can report suspected FWA by contacting:

- The plan's confidential hotline: **1-866-847-8247**
- The plan's email addresses:
  - SIU@simplyhealthcareplans.com
  - noncompliance-incidents@simplyhealthcareplans.com
- Provider Services: **1-844-405-4296**
- AHCA Consumer Complaint Hotline: **1-888-419-3456**

Providers may also complete a *Medicaid Fraud and Abuse Complaint Form*, available online at:

- **https://apps.ahca.myflorida.com/mpi-complaintform**

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Reporting FWA — Open door policy

Simply maintains an open door policy for the reporting of compliance concerns and FWA.

Our Medicaid Compliance Officer:

JoAnn McDaniel-Chinn

Office address:

Simply Healthcare Plans, Inc.

9250 West Flagler St., Suite 600

Miami, FL 33174

Contact information:

Phone: **1-305-487-4047**

Email: JoAnn.McDaniel-Chinn@anthem.com

What happens after noncompliance is detected?

- It must be investigated immediately and promptly corrected.
- Internal monitoring should continue to ensure:
  - There is no recurrence of the same noncompliance.
  - Ongoing compliance with Medicaid, CMS, and other applicable state and federal requirements.
  - Efficient and effective internal controls.
  - Enrollees are protected.

Reward

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or health care provider, **you may be eligible for a reward** through the attorney general's fraud rewards program. You can contact the attorney general's fraud rewards program toll free at **1-866-966-7226** or **1-850-414-3990**.

The reward may be up to 25% of the amount recovered, or a maximum of $500,000 per case (Florida Statutes 409.9203). You can keep your identity confidential and protected.

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What are internal monitoring and auditing?

Internal monitoring

- Regular reviews that confirm ongoing compliance and ensure corrective actions are undertaken and effective.

Internal auditing

- A formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

Provider self-audits

- The health plan supports the CMS Compliance Program guidelines, which include a component on provider self-auditing. Self-auditing is a good tool to measure internal compliance and ensures compliance with regulations. We encourage the practice of self-reporting FWA.
- Visit this link for self-auditing resources: **https://ahca.myflorida.com/MCHQ/MPI/provider_selfaudit.shtml**.

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Summary

Prevent: Operate within your organization's ethical expectations to prevent noncompliance.

- Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.

Detect and report: If you detect potential noncompliance, report it.

- To help ensure compliance, behave ethically and follow your organization's Standards of Conduct. Watch for common instances of noncompliance and report suspected noncompliance.

Correct: Correct noncompliance to protect our members and save money.

- Know the consequences of noncompliance and help correct any noncompliance with a *Corrective Action Plan* that includes ongoing monitoring and auditing.

Applicable laws — Civil and Criminal False Claims (42 U.S.C. §1320a-7b(a))

Covered persons shall not knowingly and/or willfully make or cause to be made any false statement or representation of material fact in any claim or application for benefits under any federal health care program or health care benefit program. In addition, covered persons shall not, with knowledge and fraudulent intent, retain federal health care program of health care benefit program funds, which have not been properly paid.

Applicable laws — Anti-Kickback Act (42 U.S.C. §l320a-7b(b)) and Anti-Kickback Act of 1974 (74 O.S. 1991, §3401, et seq.)

Covered persons shall not knowingly and/or willfully solicit, offer to pay or receive, any remuneration, either directly or indirectly, overtly or covertly, in cash or in kind, in return for:

- Referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made, in whole or in part, under any federal health care program.
- Purchasing, leasing, ordering, or arranging for, or recommending the purchasing, leasing, or ordering of any goods, facility, service or item for which payment may be made in whole or in part, under any federal health care program.
- Remuneration may include kickback payments, bribes, or rebates.

Applicable laws — Civil Monetary Penalties Act (42 U.S.C. §1320a-7a)

- Covered persons shall not knowingly present a claim to any federal health care program or health care benefit program for an item or service the person knows or should have known, was not provided, was fraudulent, or was not medically necessary.
- Covered persons shall not give or cause to be given any information with respect to coverage of prescription services which that person knows is false and could influence the decision regarding when to discharge an individual from any health care facility. Covered persons shall not offer to transfer, or transfer, any remuneration to a beneficiary under a federal health care program, that the person knows or should know is likely to influence the beneficiary to order and/or receive any item or service from a particular provider, practitioner, or supplier, for which payment may be made, in whole or in part, under a federal health care program.
- Remuneration includes the waiver of coinsurance and deductible amounts except as otherwise provided, and transfers of items or services for free or for less than fair market value.

Applicable laws — Ethics in Patient Referrals Act of 1989 (42 U.S.C. §l395nn)

Covered persons who have an ownership and/or compensation relationship in non-excluded entities shall not refer a patient in need of designated health services for which payment may be made under Medicare or Medicaid to such entities with which they have a financial relationship.

Applicable laws — Health Care Fund (18 U.S.C. §1347)

Covered persons shall not knowingly or willfully execute or attempt to execute, a scheme or artifice to: defraud any health care benefit program or obtain, by means of false or fraudulent pretense, representation, or promise any of the money or property owned by or under the custody or control of any health care benefit program, in connection with the delivery of, or payment for, health care benefits, items, or services.

Applicable laws — Criminal False Statements Related to Health Care Matters (18 U.S.C. §1035)

Covered persons shall not knowingly and willfully make or use any false, fictitious, or fraudulent statements, representation, writings or documents regarding a material fact in connection with the delivery of, or payment for, health care benefits, items or services. Covered persons shall not knowingly and willfully falsify, conceal or cover up a material fact by any trick, scheme or device.

Applicable laws — Civil False Claims Act (31 U.S.C. §3729)

Covered persons shall not:

- Knowingly file a false or fraudulent claim for payments to a governmental agency or health care benefit program.
- Knowingly use a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency of health care benefit program.
- Conspire to defraud a governmental agency or health care benefit program by attempting to have a false or fraudulent claim paid.

Applicable laws — Criminal False Statement Act (18 U.S.C. §1001)

Covered persons shall not knowingly and willfully falsify or make any fraudulent, false or fictitious statement against a governmental agency or health care benefit program.

Applicable laws — Criminal Conspiracy (18 U.S.C. §371)

Covered persons shall not conspire to defraud any governmental agency or health care benefit program in any manner or for any purpose.

Applicable laws — Theft or Embezzlement in Connection with Health Care (18 U.S.C. §669)

Covered persons shall not embezzle, steal or otherwise, without authority, convert to the benefit of another person, or intentionally misapply money, funds, securities, premiums, credits, property, or other assets of a health care benefit program.

Applicable laws — Obstruction of Criminal Investigations of Health Care Offense (18 U.S.C. §1518)

Covered persons shall not willfully prevent, obstruct, mislead, delay, or attempt to prevent, obstruct, mislead or delay the communication of information or records relating to a violation of a federal health care offense to a criminal investigator.

Resources

To find copies of our provider manuals, a link to the provider website (Availity),* quick reference guides, forms and more, visit our provider websites:

- **https://provider.simplyhealthcareplans.com/florida-provider**
- **https://provider.clearhealthalliance.com/florida-provider**

For more information on SMMC MMA, visit:

- **https://ahca.myflorida.com/Medicaid/statewide_mc**

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Attestation of Medicaid and Florida Healthy Kids Compliance and Fraud, Waste & Abuse Training

The undersigned organization/person certifies and attests that as a first-tier entity, downstream entity or related entity (as such terms are defined by CMS), it has obtained and/or conducted compliance, *HIPAA* privacy and security, and FWA awareness trainings for it and for all of its personnel and employees, as applicable.

Please select the method of education and training that your organization chose to comply with the final rule requirement **and return the completed *Attestation Form* to Simply by emailing a copy to JoAnn.McDaniel-Chinn@anthem.com.**

- ❑ Took training and education provided by Simply
- ❑ Took training and education provided by a Medicaid and/or Medicare plan sponsor or other source.

_____
Name of group/practice

_____
Name of group/practice's representative (please print)

_____
Representative's title

_____ _____
Signature Date signed

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Thank you

* Availity, LLC is an independent company providing administrative support services on behalf of Simply Healthcare Plans, Inc. and Clear Health Alliance.

https://provider.simplyhealthcareplans.com/florida-provider

https://provider.clearhealthalliance.com/florida-provider

Simply Healthcare Plans, Inc. is a Managed Care Plan with a Florida Medicaid contract. Clear Health Alliance is a Managed Care Plan with a Florida Medicaid contract.

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