



# MEDICAID AND MEDICARE FRAUD, WASTE AND ABUSE TRAINING

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# Why do I need training/ where do I fit



## 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.

## Where Do I Fit In?

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

# Objectives and requirements

## 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 fraud, waste, and abuse.
- Provide information on laws pertaining to fraud, waste, and abuse.

## Requirements:

- Statute, regulations, and policy govern both the Medicaid and Medicare (Parts A, B, C, and D) programs.
- Medicaid or Medicare contractors must have an effective compliance program which includes measures to prevent, detect and correct Medicaid or Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- In addition, contractors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. § 422.503 and 42 C.F.R. § 423.504).
- Obtain copies of **Attestations** from its first tier, downstream and related entities to comply with this requirement, upon request.

# Objectives and requirements

## Education Requirements:

According to state and federal regulations, Sunshine Health is ultimately responsible for oversight and monitoring of education and training for first tier, downstream and related entities. In order to be compliant with the Fraud, Waste and Abuse training requirements, Medicaid and Medicare Plan Sponsors may either provide training directly or provide training materials to its delegated and contracted entities.

Maintain records of training –

- Copies of sign-in sheets
- Employee Attestations
- Electronic Certificates of employees taking and completing the training

Training should be provided -

- Within 30 days(90 days for Medicare) of a new hire, then annually (preferably January of each year) thereafter
- When requirements change
- When employees are found to be non-compliant
- When an employee works in an area implicated in past FWA activity

# Complying with requirements



## How Can Plan Sponsors, First Tier, Downstream, and Related Entities comply with the requirements?

### Two Options:

- Complete the training provided by Sunshine Health
- \*Take training from another Medicare Plan Sponsor, including a Prescription Drug Plan (PDP – Part D), or other source, (i.e. <http://www.cms.gov/MLNProducts>)

*\* Applicable to Medicare Line of Business Only.*

# Responsibilities and effective compliance program

## What are my responsibilities as an employee or a person who provides health and administrative services in the Medicaid and/or Medicare programs?

- ❑ You are a vital part of the effort to prevent, detect, and report Medicaid or Medicare non-compliance as well as possible fraud, waste, and abuse.
  - FIRST you are required to comply with all applicable statutory, regulatory, and other Medicaid and/or Medicare requirements, including adopting and implementing an effective compliance program.
  - SECOND you have a duty to the Medicaid/Medicare Programs to report any violations of laws that you may be aware of.
  - THIRD you have a duty to follow your organization's Code of Conduct 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/Medicare non-compliance as well as fraud, waste and abuse.
- ❑ Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. § 438.608; 42 C.F.R. § 422.503 and 42 C.F.R. § 423.504)

# Fraud, Waste and Abuse prevention



## How do I prevent Fraud Waste and Abuse ?

- Make sure you are up to date with laws, regulations, and 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.

## Policies and Procedures –

- Every plan sponsor, first tier, downstream, and related entity (FDR) must have an effective compliance plan, anti-fraud plan, and fraud and abuse policies and procedures in place to address fraud, waste, abuse and recovery. These procedures should assist you in detecting, correcting, preventing and reporting fraud, waste, and abuse.
- During new hire employee, agent, contractor and provider orientations, all plan sponsors and FDRs must disseminate copies of its organization's compliance and anti-fraud plans, employee and provider handbooks respectively, and reference the FWA section as well as the tip-line information notated in the handbooks.

# Fraud, Waste and Abuse prevention



## Policies and Procedures (Continued) -

- ❑ Sunshine Health and its FDR's annual compliance/fraud, waste and abuse training must emphasize the importance of detecting, preventing and reporting fraud, waste and abuse in healthcare.
- ❑ All plan sponsors must ensure the compliance and anti-fraud plans as well as the fraud and abuse policies and procedures, are easily accessible to all employees, agents, contractors and providers, and they must be made aware of its location during the orientation and annual compliance and FWA trainings.
- ❑ All plan sponsors must ensure their organization's member handbook contain fraud, waste and abuse language, including internal confidential tip-line information and direct reporting to federal and state agencies.
- ❑ **\*\*Make sure you are familiar with your entity's compliance/fraud and abuse policies and procedures and tip-line information including its location within your organization.**

*\*\* Sunshine Health's compliance/anti-fraud plans, FWA policies & procedures, employee, member and provider handbooks and tip-line information can be accessed through the Plan's RSA Archer system and the Plan's website.*



# Fraud, Waste and Abuse detection



## What is Fraud, Waste, Abuse, and Overpayment?

In order to detect fraud, waste, abuse and overpayment, you need to know the Law.

**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 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.

**Overpayment** – As per 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.

# Differences between and indicators of potential FWA



## Differences Between Fraud, Waste, and Abuse (FWA) –

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. **Fraud** requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. **Waste and Abuse** may involve obtaining an improper payment, but does not require the same intent and knowledge.

## Indicators of Potential Fraud, Waste and Abuse (FWA) –

Now that you know what fraud, waste and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a plan sponsor, pharmacy, or other entity involved in the Medicaid or Medicare programs.

# Key indicators



## Potential Beneficiary Issues -

- 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?

## Potential Provider Issues –

- 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?

# Key indicators



## Potential Pharmacy Issues –

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?
- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

## Potential Wholesaler Issues –

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

# Key indicators



## Potential Manufacturer Issues –

- Does the manufacturer promote off label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a state or federal health care program?

## Potential Plan Sponsor Issues –

- Does the sponsor offer cash inducements for beneficiaries to join the plan?
- Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

# Reporting FWA



## How Do I Report Fraud, Waste or Abuse?

Everyone is required to report suspected instances of Fraud, Waste, and Abuse. Your sponsor's or Employer's Code of Conduct and Ethics should clearly state this obligation. Sponsors or Employers may not retaliate against you for making a good faith effort in reporting.

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or your plan sponsor's compliance department. Your sponsor's compliance department area will investigate and make the proper determination.

Every Medicaid or Medicare plan is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review your sponsor's materials for ways to report fraud, waste, and abuse.

When in doubt, contact the Plan's Medicaid/Medicare Compliance hotline at **1-800-345-1642** or Sunshine Health's anonymous and confidential hotline at **1-866-685-8664** or the Sunshine Health Compliance & Privacy Officer, **Tamela Perdue** at [tamela.i.perdue@centene.com](mailto:tamela.i.perdue@centene.com); telephone number **1-866-796-0530**, or you may send an email to [Compliancefl@centene.com](mailto:Compliancefl@centene.com)

# Direct reporting – Medicaid and Medicare



To report suspected fraud, waste or abuse in the Medicaid or Medicare programs, please use one of the following applicable avenues:

## **Medicaid:**

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/mpi-complaintform>

## **And**

**Department of Financial Services – Division of Investigative and Forensic Services(DIFS)**

Complaint Form: <https://first.fldfs.com/>

## **Medicare:**

Office of Inspector General (OIG): 1-800-447-8477 TTY: 1-800-377-4950

Fax: 1-800-223-8164

Online: <http://oig.hhs.gov/fraud/hotline/>

E-Mail: [HHSTips@oig.hhs.gov](mailto:HHSTips@oig.hhs.gov)

NBI MEDIC: 1-877-7SafeRX (1-877-772-3379)

## **Medicare's Florida Fraud Hotline:**

By Phone: 1-866-417-2078 or

By E-Mail: [floridamedicarefraud@hp.com](mailto:floridamedicarefraud@hp.com)

# Correction



## How Do I Correct Issues?

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government and the plan money, and ensures you are in compliance with AHCA and/or CMS requirements.

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your employer's compliance officer or your sponsor's compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.



# Laws and 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, Sunshine Health is required by law to establish certain policies and provide all employees and FDRs with information including but not limited to the federal and state False Claims Act; an employee's 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 and penalties



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

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; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

# Laws and penalties

## **Civil False Claims Act Damages and Penalties -**

The statute provides for a civil penalty not less than \$5,500 and not more than \$11,000 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 the Medicaid/Medicare programs).

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 and 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 or Medicare 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

# Laws and 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.

# Violations and consequences

## 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.

# Scenario #1



A person comes to your pharmacy to drop off a prescription for a beneficiary who is a “regular” customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

## What is your next step?

- A. Fill the prescription for 160
- B. Fill the prescription for 60
- C. Call the prescriber to verify quantity
- D. Call the sponsor’s compliance department
- E. Call law enforcement

## Answer: C

- Call the prescriber to verify
- If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor’s compliance hotline. The sponsor will provide next steps

# Scenario #2



Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the MCO's process and to adjust/add risk diagnosis codes for certain individuals.

## What do you do?

- A. Do what is asked of your immediate supervisor
- B. Report the incident to the compliance department (via compliance hotline or other mechanism)
- C. Discuss concerns with immediate supervisor
- D. Contact law enforcement

## Answer: B

- Report the incident to the compliance department (via compliance hotline or other mechanism)
- The compliance department is responsible for investigating and taking appropriate action.  
Your plan sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue



# Scenario #3



You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider (“Doe Diagnostics”) has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics’ claims far exceed any other provider that you reviewed.

## What do you do?

- A. Call Doe Diagnostics and request additional information for the claims
- B. Consult with your immediate supervisor for next steps
- C. Contact the compliance department
- D. Reject the claims
- E. Pay the claims

## Scenario #3 answer

### Answers B or C

Consult with your immediate supervisor for next steps or

Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

## Scenario #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy.

### What should you do?

- A. Call the local law enforcement
- B. Perform another review
- C. Contact your compliance department
- D. Discuss your concerns with your supervisor
- E. Follow your pharmacies procedures

### Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.



# Instructions on attestation

- If you are a participating broker please print the last page of this training and submit to the plan's sales manager. This is needed to complete your contract.
- If you are a contracted provider, complete and sign the attestation and return with your contracting and or credentialing/re-credentialing package to your account representative or the Sunshine Health Compliance & Privacy Officer, Tamela I. Perdue, via email to [Compliancefl@centene.com](mailto:Compliancefl@centene.com).
- If you have office personnel, temporary and /or sub-contractor they are also required to take this training and records must be maintained in your office for a period of ten (10) years for auditing purposes.
- 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 Compliance, HIPAA Privacy & Security and FWA Trainings for the 2020 calendar year for it and for all its personnel and employees, as applicable.
- Upon request by Sunshine Health, 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 Compliance, HIPAA Privacy & Security and FWA Trainings were completed.

# Attestation of Medicaid and Medicare Compliance, HIPAA Privacy & Security and Fraud, Waste and Abuse (FWA)



The undersigned organization/person (the “Organization/Person”) certifies and attests that as a first-tier entity, downstream entity or related entity (as such terms are defined by Centers for Medicare and Medicaid Services (“CMS”)), it has obtained and/or conducted Compliance, HIPAA Privacy & Security, and Fraud, Waste and Abuse awareness trainings (“Compliance/HIPAA/FWA Trainings”) for it and for all of its personnel and employees, as applicable, (including, the chief executive, senior administrators or managers, and governing body members), as required for the 2020 calendar year by the CMS final rules in 42 C.F.R. Parts 422 and 423; and 438 – Managed Care.

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 Sunshine Health by facsimile at 1-866-796-0540 or email a scanned copy to [Compliancefl@centene.com](mailto:Compliancefl@centene.com)

- Took training and education provided by Sunshine Health.
- Took training and education provided by a Medicaid and/or Medicare Plan Sponsor, or other source.

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**Name of Organization/Person**

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**Name of Organization’s Representative** *(please print)*

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**Representative’s title**

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**Signature**

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**Date signed**