Compliance, Fraud, Waste and Abuse Training
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 helps 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.
Training Requirements

- The Agency for Healthcare Administration requires all MMA Plan contracted Providers to receive Compliance /FWA Training upon contracting with an MMA Plan.

- Plan contracted provider are also required to ensure that their staff complete FWA Training
Compliance Is Everyone’s Responsibility!

- An effective compliance program fosters a culture of compliance.
- To help ensure compliance, behave ethically and follow your organization’s and the Plan’s Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.
- Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.
DEFINITIONS

- **Fraud** — An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to that person or another person. The term includes any act that constitutes fraud under applicable federal or state law.

- **Waste**—An attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, but the outcome of a billing error caused unnecessary costs to the involved companies. Waste includes overutilization of services not caused by criminally negligent actions. Waste also involves the misuse of resources.

- **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** — 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.
The Agency for Healthcare Administration (AHCA) requires that an effective compliance program include the below seven core requirements:

1. **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.

2. **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.

3. **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.
Seven Core Compliance Program Requirements, continued

- **4. 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.

- **5. Well-Publicized Disciplinary Standards** The Plan must enforce standards through well-publicized disciplinary guidelines.

- **6. 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. 
  **NOTE:** 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 the Florida Medicaid and the Medicare Program requirements.

- **7. Procedures and System for Prompt Response to Compliance Issues** The Plan must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.
Compliance Training—Subcontractors

- The Agency for Health Care Administration 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, Plan providers, and Plan’s subcontractor’s have several avenues to report compliance concerns.
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 Florida Medicaid and CMS requirements; and
• Report suspected violations.
Know the Consequences of Non-Compliance

- Failure to follow Medicaid and Medicare Program requirements and AHCA guidance can lead to serious consequences including:
  - Contract termination;
  - Criminal penalties;
  - Exclusion from participation in all Federal health care programs; or
  - Civil monetary penalties.

- Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:
  - Mandatory training or re-training;
  - Disciplinary action; or
  - Termination.
The law prohibit retaliation against anyone for reporting suspected non-compliance/FWA in good faith.

The Plan offers reporting methods that are:

- Anonymous;
- Confidential; and
- Non-retaliatory
Examples of Fraud, Waste and Abuse

- Falsification of service reports and encounters
  - Upcoding
  - Altering, falsification or destroying medical records
  - Making false statements on a credentialing application
  - Misrepresenting medical information to justify a referral
  - Failure to render medically necessary covered services that are obligated according to contract with Plan
  - Charging enrollees for Plan covered services
  - Billing for services not rendered
  - Double billing
  - Billing for quantities of medications that were not dispensed
  - Drug Diversion Practices
How to Report Potential Non-Compliance / FWA to Plan

Plan Confidential Hot Line
1-877-253-9251

Plan E-Mail:

SIU@simplyhealthcareplans.com
SIU@betterhealthflorida.com
In writing to:

Simply Healthcare Plans, Inc.
9250 West Flagler Street, Suite 600
Miami, Florida 33174-3460

Better Health, Inc.
9250 West Flagler Street, Suite 600
Miami, Florida 33174-3460

Clear Health Alliance
9250 West Flagler Street, Suite 600
Miami, Florida 33174-3460
Providers can also report suspected cases of fraud and abuse via the Agency for Healthcare Administration’s (AHCA) Consumer Complaint Hotline:

- 1-888-419-3456

Providers may also complete a Medicaid Fraud and Abuse Complaint Form which is available online at:

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or healthcare provider, you may be eligible for a reward through the Attorney General’s Fraud Rewards Program.


The reward may be up to 25% of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can keep your identity confidential and protected.
Without programs to prevent, detect, and correct non-compliance, we all risk harm to enrollees, such as:

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

Less money for everyone, due to:

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
After non-compliance is detected, it must be investigated immediately and promptly corrected.

Internal monitoring should continue to ensure:

- There is no recurrence of the same non-compliance;
- Ongoing compliance with CMS requirements;
- Efficient and effective internal controls; and
- Enrollees are protected.
What Are Internal Monitorings and Audits?

- Internal monitoring activities are regular reviews that confirm ongoing compliance and ensure that corrective actions are undertaken and effective.

- Internal auditing is a formal review of compliance with a particular set of standards (for example, policies and procedures, laws, and regulations) used as base measures.
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.

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

Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.
Compliance Is Everyone’s Responsibility!

- **Prevent**: Operate within your organization’s ethical expectations to prevent non-compliance!

- **Detect & Report**: If you detect potential non-compliance, report it!

- **Correct**: Correct non-compliance to protect our members and save money!
Applicable Laws
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.
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:

- a. 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;
- b. 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; or
- c. Remuneration may include kickback payments, bribes, or rebates.

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 know 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.
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.
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.
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.
Covered Persons shall not:

- a. Knowingly file a false or fraudulent claim for payments to a governmental agency, or health care benefit program,

- b. 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, or

- Conspire to defraud a governmental agency or health care benefit program by attempting to have a false or fraudulent claim paid.
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.
Covered Persons shall not conspire to defraud any governmental agency or health care benefit program in any manner or for any purpose.
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.

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.
Questions