Apple Health Medicaid Provider Training

INTRODUCTION

- The Apple Health Medicaid Plans collaborated to develop webinar training to satisfy Medicaid requirements at 42 CFR 438.608 – Program Integrity Requirements under the contract:
  - Enrollee Rights and Responsibilities
  - Advance Directives
  - Fraud, Waste and Abuse
  - False Claims Act
- Participation in this training satisfies requirements for all five Medicaid plans in Washington state, reducing the number of trainings providers and their staff need to attend.
- This training is for Apple Health providers which includes both the Physical health (AHMC) as well as the integrated managed care (IMC).
- This on-line webinar eliminates the need to attend an in-person session on the topics covered.
- Attendance will be tracked through the webinar.
- For proof of attendance, please complete the brief questionnaire at the end of the webinar to provide feedback.

CITATION: 42 CFR 438.608

ENROLLEE RIGHTS AND RESPONSIBILITIES

- The Apple Health Managed Care Plans comply with applicable laws governing enrollee rights and responsibilities.
  - It is important that employees, providers and enrollees understand enrollee rights and responsibilities.
  - Enrollees are free to exercise their rights. Exercising these rights must not adversely affect the way our organizations or any contracted providers or other subcontractors treat enrollees.

- CITATIONS: 42 CFR 438.100; 45 CFR 164

ENROLLEE RIGHTS

- Enrollees have the **right** to:
  - Make decisions about their health care, including refusal of care. This include physical and behavioral health issues
  - Be informed about all available treatment options, regardless of cost.
  - Choose or change their Primary Care Provider.
  - Request a second opinion from another contracted provider.
  - Obtain services within specified appointment standards.
  - Be treated with dignity and respect. Discrimination on the basis of race, color, national origin, gender, sex, sexual preference, age, religion, creed or disability will not be tolerated.
  - Speak freely about their health care and concerns about adverse results.
  - Have their privacy protected and information about care remain confidential.
  - Request and receive copies of their medical records.
  - Request and have corrections made to medical records if an error has been made.

CITATIONS: 42 CFR 438.100; 42 CFR 438.6; 42 CFR 438.206; 42 CFR 438.3; 45 CFR 164; USC 18116; WAC 182-538-060; WAC 284-170-360

ENROLLEE RIGHTS (CONT.)

- Receive mental health and substance use disorder services.
- Request and receive information about:
  - Their health care and covered services.
  - Their provider and how referrals are made to specialists and other providers.
  - How their Managed Care Plan pays providers for care provided.
  - All options for care and why they are receiving certain types of care.
  - Assistance with filing a grievance or complaint about their care.
  - Their Apple Health Managed Care Plan's organizational structure, policies and procedures, practice guidelines and how to recommend changes.
  - Enrollee Rights and Responsibilities at least annually.
- Receive a list of crisis telephone numbers.
- Receive help completing mental or medical health advance directive forms.

ENROLLEE RESPONSIBILITIES

- Enrollees have the **responsibility** to:
  - Talk with their providers about their health and health care needs.
  - Help make decisions about their health care, including refusal of treatment.
  - Keep and be on time to their appointments.
  - Call their provider's office if they will be late or need to cancel an appointment.
  - Present their ProviderOne and Apple Health Managed Care Plan ID cards to their provider for billing purposes.
  - Be respectful to providers.
  - Learn about their plan, including covered and excluded services.
  - Access care when necessary.
  - Learn about their health problems and take part in making agreed upon treatment goals whenever possible.
  - Provide to their provider and health plan complete information about their health to ensure appropriate care.

ENROLLEE RESPONSIBILITIES (CONT.)

- Follow their provider's instructions.
- Use health care services appropriately.
- Renew their Apple Health coverage annually.
- Inform the HCA of the following changes:
  - Family size
  - Address
  - Income
  - Other insurance
  - Medicare eligibility

A PATIENT'S BILL OF RIGHTS*

Another person chosen by the patient can exercise these rights on the patient's behalf. A proxy decision maker can exercise these rights if the patient lacks decision-making ability, is legally incompetent, or is a minor.

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from doctors and other direct caregivers appropriate, current, and understandable information about diagnosis, treatment, and prognosis. Except in emergencies when the patient lacks decision-making ability and the need for treatment is urgent, the patient is entitled to the chance to discuss and request information about the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their risks and benefits. Patients have the right to know the identity of doctors, nurses, and others involved in their care, as well as when those involved are students, patients, or other trainees. The patient also has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.
- The patient has the right to make decisions about the plan of care before and during treatment. The patient has the right to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy and to be informed of the medical consequences of this action. The patient is entitled to other appropriate care and services that the hospital provides or transfers to another hospital. The hospital should notify patients of any policy that might affect patient choice within the institution.
- The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that the hospital will honor the intent of that directive to the extent permitted by law and hospital policy. Health care institutions must tell patients of their rights under state law and hospital policy to make informed medical choices, ask if the patient has an advance directive, and include that information in patient records. The patient has the right to timely information about hospital policy that may limit its ability to implement fully a legally valid advance directive.
- The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.
- The patient has the right to expect that all communications and records related to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will stress the confidentiality of this information when it releases it to any other parties entitled to review information in these records.
- The patient has the right to review the records about his/her care and to have the information explained or interpreted as necessary, except when restricted by law.
- The patient has the right to expect that, within its capacity and policies, a hospital will make reasonable response to a patient's request for appropriate and medically indicated care and services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permitted, or when a patient has requested, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.
- The patient has the right to ask and be informed of business relationships among the hospital, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.
- The patient has the right to consent to or decline to take part in research studies or human experimentation affecting care and treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. A patient who declines to take part in research or experimentation is entitled to the most effective care that the hospital can otherwise provide.
- The patient has the right to expect reasonable continuity of care when appropriate and to be informed by doctors and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.
- The patient has the right to be informed of hospital policies and practices that relate to patient care treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospital's charges for services and available payment methods.

PATIENT RESPONSIBILITIES

The partnership nature of health care requires that patients, or their families/surrogates, take part in their care. The effectiveness of care and patient satisfaction with the treatment depends, in part, on the patient fulfilling certain responsibilities. The following are patient responsibilities:

- Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients are take responsible for asking for additional information or explanation about their health status or treatment when they do not fully understand information and instructions.
- Patients are also responsible for ensuring that the health care institution has a copy of their written advance directive if they have one.
- Patients are responsible for telling their doctors and other caregivers if they expect problems in following prescribed treatment.
- Patients should be aware of the hospital's duty to be reasonably efficient and fair in providing care to other patients and the community. The hospital's rules and regulations are intended to help the hospital meet this responsibility. Patients and their families are responsible for making reasonable accommodations to the needs of the hospital, other patients, medical staff, and hospital employees.
- Patients are responsible for giving necessary information for insurance claims and for working with the hospital to make payment arrangements, when necessary.
- A person's health depends on much more than health care services. Patients are responsible for recognizing the impact of their lifestyle on their personal health.

The following information was adapted from the American Hospital Association's "A Patient's Bill of Rights". It is not a State law.

ADVANCE DIRECTIVES

THE APPLE HEALTH MANAGED CARE PLANS COMPLY WITH ALL APPLICABLE LAWS GOVERNING ADVANCE DIRECTIVES.

- It is important that our employees, providers and enrollees understand enrollees' rights regarding Advance Directives.

- Our enrollees are free to exercise the right to establish an Advance Directive and revoke their Directive at any time.

- CITATION: 42 CFR 422.128

WHAT IS AN ADVANCE DIRECTIVE?

- An Advance Directive documents an individual's health care choices. The Advance Directive tells providers and family members the type of care the enrollee does or does not wish to receive in the event:
  - The enrollee loses consciousness.
  - The enrollee can no longer make health care decisions.
  - The enrollee can not tell their providers or family member what type of care they do or do not wish to receive.
  - The enrollee wishes to donate organ(s) after their death
- An Advance Directive also:
  - Allows an enrollee to designate someone to represent them or speak on their behalf if they are not able to represent or speak for themselves.
  - Helps protect the enrollee's loved ones or their providers from having to make difficult medical decisions for them without their guidance.

ADVANCE DIRECTIVES – ENROLLEE RIGHTS

- An enrollee may create or revoke an Advance Directive at any time.
- An enrollee should speak with their providers, family, friends, and those close to them prior to documenting their health care wishes.
- An enrollee can obtain additional information about Advance Directives from:
  - Their Apple Health Managed Care Plan
  - Their provider(s)
  - An attorney
  - Their Member Handbook
- An enrollee may:
  - Ask to review our policies related to Advance Directives.
  - File a grievance with their Apple Health Managed Care Plan or the Health Care Authority (HCA) if an Advance Directive is not followed.

ADVANCE DIRECTIVES – PROVIDER RESPONSIBILITIES

Providers, including hospitals and nursing facilities, have obligations relating to Advance Directives, including:

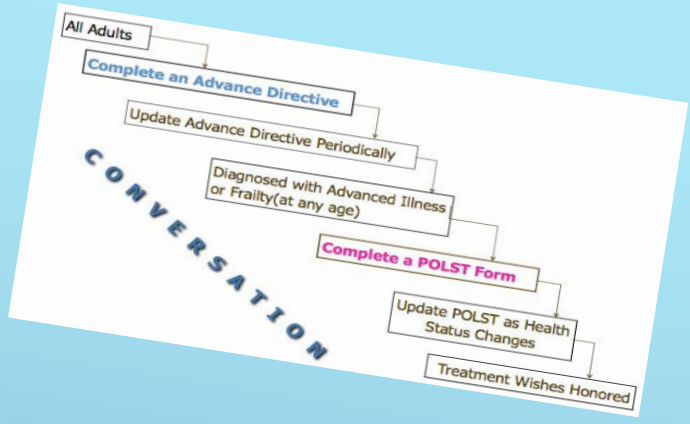
- Maintaining written policies and procedures around Advance Directives.
- Providing information about the right to an Advance Directive to enrollees, or an authorized person if an enrollee is incapacitated when admitted to a facility, in writing and orally in a language the enrollee understands.
- Reviewing enrollee medical records prior to admittance to determine if a member has an advance directive.
- Not refusing care, discriminating or putting conditions on care based on whether or not an enrollee has an Advance Directive.
- Keeping and maintaining enrollees' Advance Directives in their medical record.

ADVANCE DIRECTIVES – PROVIDER RESPONSIBILITIES (CONT.)

- **Providers must honor Advance Directives.**
- **In the event a facility or individual practitioner has a policy or practice that would keep it from honoring an advance directive:**
  - Advise the enrollee in advance, or when admitted, of existing conscientious objections.
  - Prepare and keep a written plan of intended actions if the enrollee chooses to stay.
  - Make a good faith effort to transfer the enrollee to another provider who will honor the directive.

CITATIONS: 42 USC 1396a(w); 42 CFR 417.436; 42 CFR 489 Subpart I; RCW 70.122; WAC 182-501-0125

FORMS OF ADVANCE DIRECTIVES



An advance directive is a document that indicates, in writing, your choices about the treatments **you want** or **do not want** and**/**or **who will make healthcare decisions for you** if you become incapacitated and cannot express your wishes.

- There are four forms of Advance Directives:

1) Durable Power of Attorney (POA) for Health Care

- This names another person to make medical decisions for the enrollee if they are unable to make the decision themselves.

2) Healthcare Directive (Living Will)

- This is a written document that states whether or not an enrollee wants treatment to prolong their life. An enrollee may document their request to die naturally.

3) Mental Health (MH) Advance Directive

- Allows a person with capacity to state mental health treatment preferences in a legal document that will govern during periods of incapacity (see section below for more information on MH Advance Directive).

4) Organ Donation Request

- This allows an enrollee to donate their organs after their death.

FORMS OF ADVANCE DIRECTIVES

To be valid, a Mental Health Advance Directive must:

- Be in writing;
- Include language indicating a clear intent to create a directive;
- Be dated and signed by the patient, or be dated and signed in the patient's presence at his or her direction;
- State whether the directive may or may not be revoked during a period of incapacity;
- Be witnessed in writing by at least two adult witnesses;
- Conform substantially to the statutory format.

Providers must know and follow applicable regulations regarding Advance Directives (per WAC and/or RCW) and are expected to comply with a member's Advance Directive appropriate to their available services. MCOs may request provider assistance in obtaining copies of Advance Directives when a member indicates they have them or request assistance in creating them.

PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST)

What is a POLST?

- A physician's order that outlines a plan of care reflecting a patient's wishes concerning care at life's end.
- The orders contained within a POLST must be honored across care settings and may be used by EMTs, physicians, nurses in the emergency department, hospitals, nursing facilities, and so forth.
- Apple Health Medicaid Plans are required to have policies and procedures to ensure POLST are distributed in the same manner as advance directives.

POLST complements the **Advance Directive** and is not intended to replace it.

CULTURAL AWARENESS

What is Culture?

- Culture refers to integrated patterns of human behavior including language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people.
- We use it to create standards for how we act and behave socially.

Provider and their staff are expected to gain and continually increase in knowledge of, skill with, improved attitudes about and sensitivities to diverse cultures.

This results in effective care and services for all people by considering each person's values, reality conditions and linguistic needs.

LINKS TO MCO CULTURAL TRAINING RESOURCES

- **Amerigroup -** https://provider.amerigroup.com/docs/gpp/WAWA_CulturalCompetencyPresentation.pdf?v=202008260003
- **Community Health Plan -** https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html
- **Coordinated Care -** https://www.coordinatedcarehealth.com/providers/resources/forms-resources.html
- **Molina Healthcare -** https://www.molinahealthcare.com/providers/wa/medicaid/resource/cme.aspx
- **UnitedHealthcare-** https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html

Program Integrity -- Required by the State of WA

The Apple Health Managed Care Plans are committed to combating Medicaid fraud, waste, and abuse, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees. Per Federal CMS requirements, we have a responsibility:

- To review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
- To eliminate and recover improper payments in accordance with the Improper Payments Information Act of 2002.

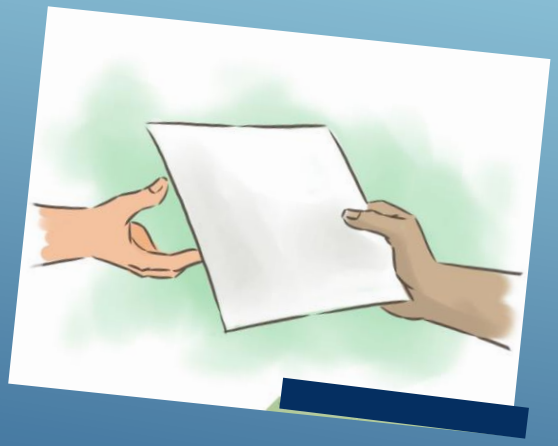
For additional information: 42 CFR 455 Medicaid Integrity Program

PROGRAM INTEGRITY DEFINITIONS

- **HCA** – Health Care Authority
- **LEIE** – List of Excluded Individuals and Entities - means an Office of Inspector General's List of Excluded Individuals/Entities and provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.
- **SAM** – System for Award Management is a Federal Contractor Registry with multiple functions including a database of providers, individuals and entities who are excluded from participation in Federal Programs (formerly known as EPLS).
- **MFCD** – also sometimes called the "Medicaid Fraud Control Unit (MFCU)" means the Washington State Attorney General's Office (AGO), Medicaid Fraud Control Division that investigates and prosecutes abuse of clients of fraud committed by any entity, facility, agency, health care professional, health care provider, primary care provider, provider or individual.
- **MCO** – Managed Care Organization - currently includes Community Health Plan of WA, Molina Healthcare, UnitedHealthcare, Coordinated Care, and Amerigroup.

DISCLOSURE OF OWNERSHIP AND CONTROL

- Providers must complete a Disclosure of Ownership and Control Statement with the HCA as part of the Medicaid provider enrollment process.
- Apple Health Medicaid Plans are required to collect detailed Disclosure of Ownership and Control Interest Statements from provider groups and individual providers and maintain a list of all individuals and entities, including subcontractors, with an ownership or control interest of more than 5%.



CITATIONS: 42 CFR 455.103; 42 CFR 455.104(b), 1903(m)(2)(A)(viii), 1124(a)(2)(A)

EXCLUDED INDIVIDUALS AND ENTITIES

- Apple Health Managed Care Plans are prohibited from paying funds received under the Apple Health Contract for goods and services ordered, prescribed or furnished by an excluded individual or entity.
  - Subcontractors include anyone we contract with to provide services on our behalf. Providers are subcontractors.
- Apple Health Managed Care Plans are required to monitor excluded individuals and entities on a monthly basis by screening the SAM and LEIE databases for:
  - Employees and subcontractor individuals with an ownership or control interest who may be debarred from participating in Federal programs.
  - Newly added and existing subcontractors with ownership or control interest who would directly or indirectly benefit from funds under the Apple Health contract.

CITATIONS: Section 1932(d)(1)(A) of the SSA (42 USC 1396u-2(d)(1)(A); 42 CFR 438.610

EXCLUDED INDIVIDUALS AND ENTITIES

- HCA contracted Managed Care Plans are required to immediately terminate any contractual and control relationship and recover any payments for goods and services that were paid to excluded individuals or entities.

- Apple Health Medicaid plans must also report:

  - Excluded individuals and entities discovered in the provider application, credentialing and recredentialing process within 5 business days of discovery.

  - Actions taken to terminate subcontractors with an ownership or control interest discovered in the SAM or LEIE screenings.

  - Any payments made that directly or indirectly benefit excluded individuals and entities to the HCA.

PROVIDER PAYMENT SUSPENSION

- Apple Health Medicaid Plans are required to suspend a provider's payment when directed to do so by the HCA.
- This may occur when a potential allegation of fraud has been accepted by the MFCD for investigation.
- Apple Health Medicaid Plans must send notice of the decision to suspend a provider's payment within the following time frames:
  - Within 5 calendar days unless a written request is received from HCA, MFCU, or law enforcement to temporarily withhold notice.
  - Within 30 calendar days if a written request is received from HCA, MFCU, or law enforcement to delay notice.
  - The delay may not exceed 90 calendar days.
- Apple Health Managed Care Plans must report summary information to the HCA about all payment suspensions and "good cause" exceptions.

▸CITATION: 42 CFR 455.23

PAYMENT SUSPENSION

Good Cause" Exception:

- **Good Cause** may exist to not suspend provider payments despite a provider being under investigation of fraud if:
  - An ongoing investigation may be jeopardized
  - Enrollee access may be jeopardized
  - Other remedies can be implemented more quickly

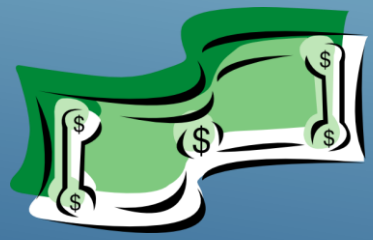
- **Record Retention:**
  - Payment suspension records are maintained for a minimum of 6 years from issuance of all materials documenting the lifecycle of the payment suspension.

CITATION: 42 CFR 455.23

SIGNIFICANT BUSINESS TRANSACTIONS

- Apple Health Managed Care Plans must report to the HCA, within 35-days of request, full and complete business transaction information for the following:

  - The ownership of any subcontractor with whom a Managed Care Plan or a subcontractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
  - Any significant business transactions between a Managed Care Plan subcontractor and any wholly owned supplier, or between a provider and any subcontractor, during the 5-year period ending on the date of the request.



ADDITIONAL REPORTING TO THE HCA

The Apple Health Managed Care Plans are required to report the following:

- Any employee or subcontractor individual with an ownership interest convicted of any criminal or civil offense within 5 days of becoming aware of the conviction.
- Any subcontractor terminated for cause within 10 days of the effective date of termination, including reason for the termination.
- A list of employees and subcontractors with an ownership or control interest of 5% or more.
- All instances of alleged cases of fraud and abuse by employees, subcontractors, subcontractor employees or enrollees.

- CITATION: 42 CFR 455.104

FRAUD, WASTE AND ABUSE

Definitions

- **Fraud** means an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Examples of fraud:

- Billing for services or supplies not provided
- Knowingly billing for medically unnecessary services or supplies
- Falsely reporting patient information to support otherwise unnecessary procedures

CITATION: 42 CFR 455.2

FRAUD, WASTE AND ABUSE

Definitions (cont.)

- **Waste** means an act resulting in overutilization, inappropriate utilization of services or misuse of resources that result, directly or indirectly, in unnecessary costs to the Medicaid program.
  - Waste is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Examples of waste:

- Ordering excessive diagnostic tests
- Errors resulting in incorrect coding
- Dispensing medication or supplies refills without confirming continued need

CITATION: 42 CFR 455.2

FRAUD, WASTE AND ABUSE

Definitions (cont.)

- **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Examples of abuse:

- Improper billing practices (upcoding or unbundling)
- Payment for services that fail to meet professionally recognized standards of care
- Billing for services that are medically unnecessary

CITATION: 42 CFR 455.2

FRAUD, WASTE AND ABUSE

- **Who Commits Fraud, Waste and Abuse?**

  Anyone with a motive, means, and opportunity can commit fraud. Waste and abuse do not require intent and can be committed by anyone in any position.

- Fraud, waste, and abuse can be committed by:

  – Beneficiaries/Members
  – Pharmacies
  – Providers
  – Sales Agents/Brokers
  – Anyone
  – *or* any combination of the above

FRAUD, WASTE AND ABUSE EXAMPLES

Services Not Rendered*:* Billing for services and/or supplies that were never performed or provided. Examples include billing insurance companies for office visits even though the patient did not show up for a scheduled appointment, billing for an MRI with contrast even though there were no contrast materials injected, and pharmacies billing for non-existent prescriptions.

Up-coding: Billing for a higher-level treatment than was actually provided. This is most commonly found to occur in the various Evaluation and Management codes. An example would be a provider billing a CPT 99215, when only a 99212 was justified by the service provided.

Unbundling: Billing separately for services that are already included in the primary procedure. A common example is a physician billing a separate office visit for a follow up that was included in the global surgical code. By appending a modifier 25, the physician is indicating that the service was separate and distinct.

FRAUD, WASTE AND ABUSE EXAMPLES

Services Not Medically Necessary: Billing for services or procedures that are not needed. The most common example includes adding unrelated history and/or review of systems to office visits to drive the key components required to bill higher level E & M codes.

ICD-10 Up-coding: Utilizing false or inflated diagnosis codes for encounter information to increase premiums. An example is listing Dx 250.0, indicating diabetes, however the patient has never had this disease.

Formulary versus Brand: Writing scripts for brand name pharmaceuticals even though the generic is stated in the plan formulary. Brand name drugs can often carry costs five times as high as the generics, but results and effectiveness are the same.

FRAUD, WASTE AND ABUSE EXAMPLES

Medical Identity Theft and Theft of Services: Use of medical benefits by an unauthorized individual. This can be the result of outright theft or collusion between parties.

Tips to Battle Identity Theft:

- ***Ask for identification:*** Don't be afraid to ask the patient or party obtaining the prescriptions or receiving the medical service for identification and make a copy for your records.

- ***Ask for a signature:*** Don't be afraid to require a signature from the party obtaining the prescriptions or the medical service, even when one is not required.

- ***Report it:*** Call the local police and the impacted insurance company if you believe you have encountered a case of medical identity theft.

- ***Inform the Beneficiary:*** If you know who the true beneficiary is, immediately alert that individual so they can take steps to protect against further activity.

WHAT IS THE FALSE CLAIMS ACT (FCA)?

- The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which is funded directly, in whole or in part, by the United States Government or any State healthcare system.
- **Knowingly** includes having actual knowledge that a claim is false or acting with “reckless disregard” as to whether a claim is false.

FCA was enacted in 1863 by a Congress concerned that suppliers of goods to the Union Army during the Civil War were defrauding the Army.

CITATION: 31 U.S.C. 3729 - 3733

WHISTLEBLOWER PROTECTION UNDER THE FALSE CLAIMS ACT

As a result of reporting possible fraud, the federal False Claims Act protects employees who report a violation under the False Claims Act from:

- discrimination,
- harassment,
- suspension, or
- termination of employment.

Employees who report fraud and consequently suffer discrimination may be awarded:

- two times their back pay plus interest,
- reinstatement of their position without loss of seniority, and
- compensation for any costs or damages they incurred.

PENALTIES UNDER THE FALSE CLAIMS ACT

Violations under the federal False Claims Act can result in significant fines and penalties. Financial penalties to the person or organization includes recovery of three times the amount of the false claim(s), plus an additional penalty of $11,665 to $23,332 per claim.

- The FCA recovered $19.3 billion in health care fraud since January 2009 to the end of fiscal year 2016.

- Sources: HealthLawDiagnosis.com & The United States Department of Justice, 12/14/2016, Press Release Number 16-1469

ANTI-KICKBACK STATUTE AND STARK LAW

The Centers for Medicare & Medicaid Services has begun ratcheting up enforcement regarding billing and financial relationships. Among the laws implicated are the anti-kickback statute and the Stark law.

- **There are differences between these laws:**

	Anti-Kickback Statute	Stark Law
Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate federal health care program business	Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies
Referrals	Referrals from anyone	Referrals from a Physician
Items/Services	Any items or services	Designated health services
Intent	Intent must be proven	No intent standard for overpayment (strict liability)

CITATIONS: 42 USC 1320a-7b; 42 USC 1395nn

ANTI-KICKBACK STATUTE AND STARK LAW (CONT.)

	Anti-Kickback Statute	Stark Law
Penalties	**Criminal:** • Fines up to 3x each kickback and $50,000 per violation • Up to a five-year prison term per violation **Civil/Administrative:** • False Claims Act liability • Civil monetary penalties (CMPs) and program exclusion • Potential $74,792 CMP per violation • Civil assessment of up to three times amount of kickback	**Civil:** • Overpayment/refund obligation • False Claims Act liability • CMPs and program exclusion for knowing violations • Potential $25,372 per claim. • Civil assessment of up to three times the amount claimed
Exceptions	Voluntary safe harbors (All)	Mandatory exceptions (Medicare/Medicaid)

FRAUD, WASTE AND ABUSE

If you suspect a provider or a member has committed fraud, waste or abuse, you have a responsibility and a right to report it. You may choose to remain anonymous.

- WA Health Care Authority: 1-800-562-6906 email: hottips@hca.wa.gov
  For client eligibility fraud report to: 360-725-0934
  WAHEligibilityFraud@hca.wa.gov
- Community Health Plan of WA: 1-800-440-1561; www.chpw.org
- UnitedHealthcare Community Plan: 1-844-359-4436; https://www.uhc.com/fraud
- Molina Healthcare: 1-866-606-3889; www.molinahealthcare.alertline.com
- Coordinated Care: 1-866-685-8614; www.mycompliancereport.com/brand/centene
- Amerigroup: 1-800-454-3730; https://www.fighthealthcarefraud.com

IMPORTANT UPDATES – EFFECTIVE 1/1/2021

- **RHC Encounters**
  - MCOs are required to ensure that any RHC rate changes are updated and paid on eligible encounters within 30-day of the published effective date.
  - In order generate service based enhancements (SBEs) RHC encounter eligible claims must be billed with the RHC billing taxonomy (261QR1300X), as outlined in the RHC Billing Guide.
- **WISe**
  - WISe providers will be required to include information regarding WISE services on the provider's Website.
- **Non-IHCP**
  - Subject to the AI/AN Enrollee's release of information, non-IHCP are required to deliver progress notes, including any referrals made, to the AI/AN Enrollee's IHCP medical home.

IMPORTANT REMINDERS

- **Integrated Managed Care**
  - January 2020 all regions of Washington moved to Integrated Managed Care.
- **NPI registration reminder**
  - All providers are required to register their NPI(s) with the HCA in order to serve Medicaid patients.
- **Apple Health PDL**
  - WA Health Care Authority has continued to update the Preferred Drug List. Please see the agency's PDL page.

IMPORTANT REMINDERS

- **Clinical Data Repository (CDR)**
  - Providers with certified EHRs seeing Apple Health Managed Care members must send a care summary (CCDA) from the provider's EHR to the CDR. If your organization meets the following three criteria then you are required to participate in the CDR:
    - Your organization is part of a Managed Care Organization that serves Apple Health consumers
    - Your organization has a 2014 certified EHR system
    - You have received monies from either the Medicare or Medicaid EHR Incentive Program
  - Contact OneHealthPort for details on getting CDR access.
  - Users can complete training in one hour or less.
  - Reference materials are available on OneHealthPort's website.

Thank you!

To receive credit for your participation, please remember to complete the survey in your email following the closure of this training session.