Washington Apple Health Integrated Managed Care & Medicare Advantage Provider Training 2022

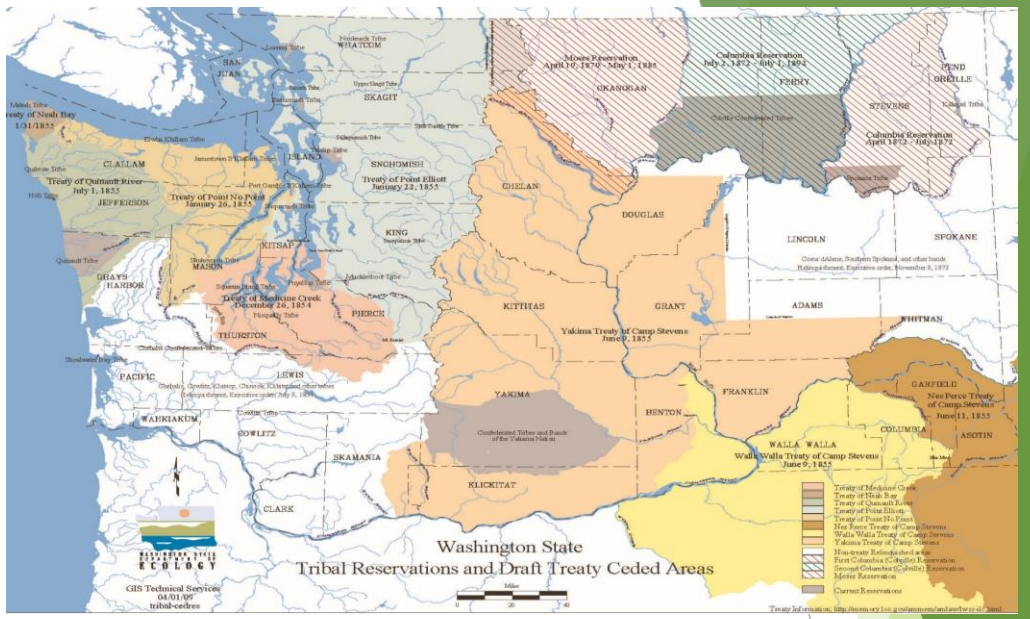
WAAGP-CD-0110002-22 October 2022

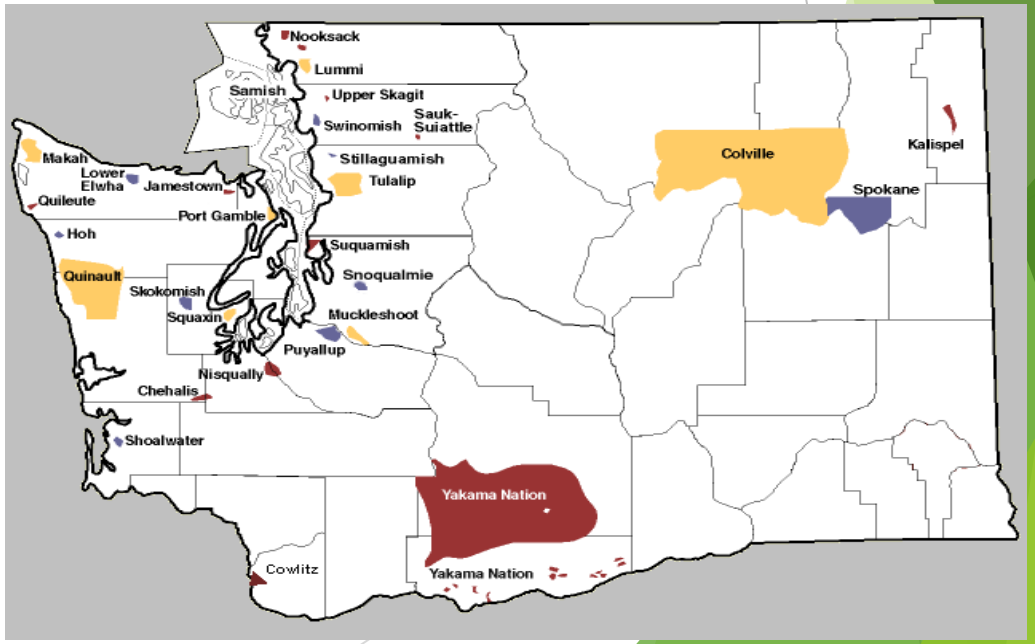
Tribal Land Acknowledgement

As we gather virtually from various locations across the state of Washington, we humbly acknowledge that we are all meeting on the traditional territories of many Indigenous Nations.

As a manage care organization, we are committed to upholding tribal sovereignty through our dedication to addressing the health disparities amongst American Indian and Alaska Native communities.

To learn more about the tribal lands you occupy, you can visit: https://native-land.ca/ or you can Text 855-917-5263, enter Zip Code.





Introduction

The five (5) Managed Care Organizations (MCOs) collaborated to develop the following webinar-based training with the intent to reduce the burden on the provider to complete multiple MCO Compliance and Fraud, Waste and Abuse training. This will satisfy the provider and plans obligations to ensure provider training is completed, as required by the Health Care Authority (HCA) and the Centers for Medicare & Medicaid Services (CMS)) for Medicare Advantage. Training will focus on:

- Enrollee Rights and Responsibilities
  - ✓ Rights
  - ✓ Responsibilities
  - ✓ Advance Directives
- Cultural Awareness
- Program Integrity
  - ✓ Disclosure of Ownership, Business Transactions/Reporting
  - ✓ Exclusion Screening
  - ✓ Fraud, Waste and Abuse (FWA)
  - ✓ Provider Payment Suspension
  - ✓ False Claims Act (FCA), Whistleblower, Penalties

At the completion of this program, you will be emailed a link to take a survey and receive confirmation of taking this training. Slides will also be attached for your reference.

Attending this webinar will satisfy your annual attendance requirement under 42 CFR 438.608(a)(1)(iv).

CITATIONS: 42 CFR 438.608, 438.100, 489.100, WAC 182.501.0125, 182.503.0100

Enrollee Rights and Protections

The Washington Apple Health Integrated Managed Care (WAHIMC) and the Medicare Advantage Organizations (MAOs) referred to as "Plans" throughout this document must comply with applicable laws governing enrollee rights and responsibilities.

- It is important that employees, providers and enrollees understand the Enrollee Rights and Responsibilities.

- Enrollees are free to exercise these rights. Exercising these rights must not adversely affect the way the Plans, contracted providers, or other subcontractors treat enrollees.

Enrollee Rights

Enrollees have the **right** to:

- Participate in decisions regarding their health care, including the right to refuse care. This includes physical and behavioral health issues
- Receive information presented in a manner that is understandable about available treatment options, and alternatives, regardless of cost.
- Choose and change their Primary Care Provider.
- Request a second opinion from another contracted provider.
- Obtain services within specified appointment standards.
- Be treated with respect and with the consideration of their dignity and privacy. Discrimination based on race, color, national origin, gender, sex, sexual preference, age, religion, creed or disability is not tolerated.
- Speak freely about their health care and concerns about adverse results.
- Have their privacy and protected health information (PHI) remain confidential.
- Request and receive a copy of their medical records, and to request that they be amended, or corrected.

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/complaint about their care.
  - Their Plan's organizational structure, policies and procedures, practice guidelines and how to recommend changes.
  - Their Rights and Responsibilities (at least annually).
- Receive a list of Crisis Services phone numbers.
- Receive assistance in completing an Advance Directive.

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 schedule appointments and be on time.
- Call their provider's office if they will be late or need to cancel an appointment.
- Present their ProviderOne (WAHIMC) and Health Plan ID cards to the provider's staff.
- Be respectful to providers.
- Learn about their plan, including covered and excluded services.
- Access care, when necessary.
- Learn about their health and take part in making agreed upon treatment plans/goals, whenever possible.
- Provide complete and accurate information about their health to Providers and Health Plans to ensure appropriate care

Enrollee Responsibilities (cont.)

- Follow the provider's advice and instructions.
- Use health care services, appropriately.
- Renew their health plan coverage annually.
- Inform the Health Care Authority (HCA) when there are changes to the following:
  - ✓ Family size
  - ✓ Address
  - ✓ Income
  - ✓ Other insurance
  - ✓ Medicare eligibility
- Inform the Social Security Administration when there are changes to the following:
  - ✓ Address
  - ✓ Income
  - ✓ Other insurance
  - ✓ Medicare eligibility

Advance Directives

Health Plans must comply with all applicable laws governing Advance Directives.

- It is important that our employees, providers and enrollees understand their rights regarding Advance Directives.
- Our enrollees are free to exercise their right to establish an Advance Directive and revoke their Directive at any time.

What is an Advance Directive?

An Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated.

The Advance Directive documents an individual's health care choices. The Advance Directive informs the 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 is unable to tell (incapacitated) their providers or family members what type of care they do or do not wish to receive.
- The enrollee wishes to donate organs after their death.

An Advance Directive:

- Allows an enrollee to designate someone to represent them or speak on their behalf if they are incapacitated.
- Helps protect the enrollee's loved ones or their providers from having to make difficult medical decisions on their behalf.

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 Health Plans Customer Service team, and plan website
  - ✓ Their provider(s)
  - ✓ An attorney
  - ✓ Their Member Handbook (WAHIMC)
  - ✓ Their Evidence of Coverage (MA)
- An enrollee may:
  - ✓ Ask to review Plans policies related to Advance Directives.
  - ✓ File a grievance with their Health Plan, the HCA, or Medicare if an Advance Directive is not followed.

Advance Directives – Provider Responsibilities

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

- Maintain written Advance Directive policies and procedures.
- Provide information to the enrollee (or authorized person) in writing and orally in a language the enrollee understands, their right to an Advance Directive, if the enrollee is incapacitated when admitted to a facility.
- Reviewing enrollee medical records prior to admittance to determine if a member has an Advance Directive.
- Not refusing care, discriminating or placing conditions on care based on Advance Directive.
- Maintain the enrollees' Advance Directives in their medical record.

Advance Directives – Provider Responsibilities (cont.)

Providers must honor an Advance Directive.

In the event a facility or individual practitioner has a policy or practice that would keep them 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, an enrollee's 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 (4) types** 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 decisions themselves.

2) **Healthcare Directive (Living Will)** - 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. (Refer to Slide 15)

4) **Organ Donation Request** - Allows an enrollee to donate their organs after death.

Forms of Advance Directives (cont.)

***A valid Mental Health (MH) 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;
- Substantially conform to the statutory format

Providers must know and follow applicable regulations regarding Advance Directives (WAC 182-501-0125) 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 an Advance Directive or are requesting assistance in creating an Advance Directive.

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, etc.,.
- The enrollee's medical record must clearly document, in a prominent part, whether the individual has executed an Advance Directive or received a POLST.
- WAHIMC Plans are required to have policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure they are distributed in the same manner as those governing Advance Directives.

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

Knowledge Check

An Advanced Directive gives written instructions about:

A. A person's financial information in the event of incapacity

B. A member's future medical care in the event the member unable to express their medical wishes

C. A member's Last Will and Testament

D. A person's marital status

E. All the above

Knowledge Check

Answer is B

An Advanced Directive gives written instructions about:

A. A person's financial information in the event of incapacity

B. **A member's future medical care in the event the member unable to express their medical wishes**

C. A member's Last Will and Testament

D. A person's marital status

E. All the above

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.

Providers 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/MAO Cultural Training Resources

Amerigroup Washington, Inc. - https://provider.amerigroup.com/washington-provider/resources/training-academy

Community Health Plan of Washington - https://www.chpw.org/wp-content/uploads/content/provider-center/training/CLAS_Provider_Training_508.pdf

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 HCA and the Centers for Medicare & Medicaid Services (CMS)

Plans are committed to combating Medicaid and Medicare Program fraud, waste, and abuse, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid and Medicare enrollees. We have a responsibility to:

- Review Medicaid/Medicare provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid and Medicare program integrity issues.
- 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 oversees 7 state health care programs. The HCA is committed to whole person care, integrating physical, and behavioral health services for better and healthier residents.

CMS – The Centers for Medicare & Medicaid Services oversee the Medicare Advantage and Special Needs Plans.

LEIE – List of Excluded Individuals and Entities maintained by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) at http://oig.hhs.gov/exclusions/index.asp. Provides information to the health care industry, patients, and the public regarding individuals and entities excluded from participation in Medicare, Medicaid, and all other federal health care programs.

SAM – System for Award Management maintained by the U.S. General Services Administration (GSA) at https://www.sam.gov/ is a Federal Contractor Registry with multiple functions including a database of providers, individuals and entities who are excluded from participation in Federal Programs.

Program Integrity Definitions

(cont'd)

OIG – Office of the Inspector General conducts independent and objective audits and investigations related to DHS programs and operations to prevent, detect waste fraud and abuse.

MFCD – Medicaid Fraud Control Division investigates and prosecutes abuse of clients of fraud committed by any individual or entity, facility, agency, health care professional, primary care provider.

I-MEDIC – Investigations Medicare Drug Integrity Contractor – CMS contracts with an I-MEDIC to detect, prevent and proactively deter fraud, waste, and abuse in the Medicare Programs (Part C and D).

MAO – Medicare Advantage Organization which includes Community Health Plan of WA, Molina Healthcare, UnitedHealthcare, Coordinated Care, and Amerigroup.

MCO – Managed Care Organization which includes Community Health Plan of WA, Molina Healthcare, UnitedHealthcare, Coordinated Care, and Amerigroup.

Disclosure of Ownership and Control Interest Form

Providers must complete a Disclosure of Ownership and Control Interest Form with the HCA as part of the Medicaid provider enrollment process.

Plans are required to collect detailed Disclosure of Ownership and Control Interest Forms Provider groups, 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 455.104,

Significant Business Transactions

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 and CMS

Plans are required to report the following:

- Any employee or subcontractor individual with an ownership interest convicted of any criminal or civil offense within five (5) days of becoming aware of the conviction.
- Any subcontractor terminated for cause within ten (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

Excluded Individuals and Entities

Plans are prohibited from paying with funds received under the WAHIMC and Medicare Advantage contracts for goods and services ordered, prescribed or furnished by an excluded individual, entity, and subcontractor.

Plans are required to check individuals and entities against the LEIE and SAM exclusion lists (Refer to Slide 22) prior to entering in a contractual arrangement or hiring a workforce member.

Plans are required to check all individuals, entities, and subcontractors at least monthly, ongoing.

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

Excluded Individuals and Entities

Plans are required to immediately terminate any contractual and control relationship and recover any payments for goods and services that were paid to an excluded individual or entity.

Plans must also report:

- Excluded individuals and entities discovered in the provider application, credentialing and recredentialing process within five (5) business days of discovery.
- Actions taken to terminate subcontractors with an ownership or control interest discovered in the SAM or LEIE exclusion screenings.
- Any payments made that directly or indirectly benefit excluded individuals and entities to the HCA, CMS and the OIG.

Knowledge Check

No Federal 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 (OIG). The OIG has the authority to exclude individuals from federally funded health care programs.

A. True

B. False

Knowledge Check

No Federal 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 (OIG). The OIG has the authority to exclude individuals from federally funded health care programs.

A. **True**

B. False

Fraud, Waste and Abuse

Fraud is 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 themself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Examples of fraud:

- Misrepresenting the diagnosis to justify higher payments.
- Falsifying certificates of medical necessity, care plans, other records.
- Knowingly submitting duplicate claims for reimbursement.
- Soliciting, offering, or receiving kickbacks.
- Unbundling of services to increase reimbursement.
- Billing for services or supplies not provided.
- Knowingly billing for medically unnecessary services or supplies.

Fraud, Waste and Abuse

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:

- Submitting inaccurate claims that cause unnecessary rebilling or claims reprocessing.
- Overuse, underuse, and ineffective use of health care services.
- Falsely reporting patient information to support otherwise unnecessary procedures.

CITATION: 42 CFR 455.2

Fraud, Waste and Abuse

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

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.

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 not performed or provided. Examples include billing insurance companies for office visits where the patient did not show for a scheduled appointment, billing for an MRI "with contrast" when no contrast material was injected, pharmacies billing for non-existent prescriptions.

Up-coding: Billing for a higher-level treatment than what was provided. Commonly found to occur in the various Evaluation and Management (E/M) codes. An example would be a provider billing CPT 99215, when only CPT 99212 was justified by the service provided.

Unbundling: Billing separately for services that are included in the primary procedure. An 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 necessary. 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.

Knowledge Check

What is an example of Fraud?

A. Knowingly billing for non-existent prescription

B. Knowingly billing for services not rendered

C. Utilizing false or inflated diagnosis codes for encounter information to increase payment

D. All the above

Knowledge Check

Answer is D

What is an example of Fraud?

A. Knowingly billing for non-existent prescription

B. Knowingly billing for services not rendered

C. Utilizing false or inflated diagnosis codes for encounter information to increase payment

D. **All the above**

What is the False Claims Act (FCA)?

The False Claims Act (FCA) 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

Penalties Under the False Claims Act

Violations under the federal FCA can result in significant fines and penalties. Financial penalties to the person or organization includes recovery of three (3) times the amount of the false claim(s), plus an additional penalty of $11,803 to $23,607 per claim, as of 1/11/2021.

- The Department of Justice (DOJ) announced that it recovered more than $2.2 billion in settlements and judgments from civil cases involving fraud and the FCA in Fiscal Year (FY2020) (ending 9/30/2020). As the global pandemic delayed proceedings, the $2.2 billion in recoveries was DOJ's lowest recovery since 2008.
- Although the announcement and report revealed a significant decline in recoveries relative to FY2019, DOJ's 2020 fraud and FCA statistics confirmed that the FCA remains an effective enforcement tool.
- The Government Reported A Record Number of New Matters in FY2020, but with Substantially Reduced Monetary Recoveries.

▸https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year

Whistleblower Protection Under the False Claims Act

As a result of reporting possible fraud, the federal FCA protects employees who report a violation under the FCA 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.

42 CFR 422.504(h)(1), 42 CFR 438.608(a)(6)

Knowledge Check

The False Claims Act make a person liable to pay damages to the Government if:

A. A person exposes information that is deemed illegal, dishonest, or violates professional or clinical standards

B. Presents a false claim for approval

C. He or she had an ownership interest in the organization

D. The physician received a kickback

Knowledge Check

Answer is B

The False Claims Act make a person liable to pay damages to the Government if:

A. A person exposes information that is deemed illegal, dishonest, or violates professional or clinical standards

B. Presents a false claim for approval

C. He or she had an ownership interest in the organization

D. The physician received a kickback

Anti-Kickback Statute and Stark Law

The Centers for Medicare & Medicaid Services (CMS) has begun intensifying 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)

Anti-Kickback Statute and Stark Law (cont.)

The Centers for Medicare & Medicaid Services (CMS) has begun intensifying 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
Penalties	**Criminal:** • Fines up to $25,000. Up to 3x each kickback and $50,000 per violation • Imprisonment up to a five-years or both **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:** • Denial of Payment • Overpayment/refund obligation • False Claims Act liability • CMPs and program exclusion for knowing violations • Imposed $15,000 per service CMP and imposition of $100,000 for ea. arrangement • 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:
  call 1-833-794-2345 or email **WAHEligibilityFraud@hca.wa.gov**
- Community Health Plan of WA: 1-800-440-1561;
  www.chpw.org/member-center/member-rights/fraud-waste-and-abuse/
- 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

Provider Payment Suspension

- Plans are required to suspend a provider's payment when directed to do so through notification by the HCA or CMS.
- This may occur when a potential allegation of fraud has been accepted by the MFCD for WAHIMC investigations, or the I-MEDIC for Medicare Advantage.
- For WAHIMC, Plans must send notice of the decision to suspend a provider's payment within the following time frames:
  - ✓ Within five (5) calendar days unless a written request is received from HCA, MFCU, or law enforcement to temporarily withhold notice.
  - ✓ Within thirty (30) calendar days if a written request is received from HCA, MFCD, or law enforcement to delay notice.
  - ✓ The delay may not exceed ninety (90) calendar days.
- Plans must report summary information to the HCA related to all payment suspensions and "good cause" exceptions.
- For MA, Plans must comply with I-MEDIC instructions outlined in the notice.

Provider Payment Suspension

WAHIMC "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 ten (10) years from issuance of all materials documenting the lifecycle of the payment suspension.

Plans and Providers must maintain records and information in an accurate and timely manner for ten (10) years.

CITATION: 42CFR 455.23, 42CFR §422.504(d), 42CFR §422.504(e)(2), 42CFR §422.504(d), 42CFR 438.608, 42CFR 438.3(h)

Knowledge Check

You can help prevent Fraud, Waste and Abuse by _____.

A. Providing only medically necessary, high-quality services to beneficiaries

B. Properly documenting all services provide to beneficiaries

C. Correctly billing and coding services provided to beneficiaries

D. All the above

Knowledge Check

Answer is D

You can help prevent Fraud, Waste and Abuse by _____.

A. Providing only medically necessary, high-quality services to beneficiaries

B. Properly documenting all services provide to beneficiaries

C. Correctly billing and coding services provided to beneficiaries

D. **All the above**

Important Reminders

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 to 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

Core Provider Agreement - NPI Registration

All providers are required to register their NPI number with the HCA in order to serve and be reimbursed for Medicaid patients.

MCO's may reject claims if you are not registered.

When you enroll a provider, please use the providers start date as the effective date.

How to enroll:

https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider#how-do-i

Apple Health PDL

WA Health Care Authority has continued to update the Preferred Drug List. Please see the agency's PDL page.

Important Reminders

Billing and Rendering Taxonomy Requirements

Billing Providers are required to include their taxonomy code on all claims.

Failure to include the billing taxonomy code may result in claim denial or rejection and require a corrected claim submission.

For more information for this requirement, please go to the following Washington State Health Care Authority link:

Taxonomy in ProviderOne (wa.gov)

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 criteria, 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.

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Thank you!

To receive credit for your participation, please remember to complete the survey. An email will be sent you within 1 day of the completion of this training with link to the survey.

You will also receive a copy of the slides for your reference.