Apple Health Medicaid Provider Training
Introduction

The Apple Health Medicaid Plans collaborated to develop webinar training to satisfy Medicaid requirements for providers on:

- 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 online 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.
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.
Enrollee Rights

Enrollees have the right to:

- Make decisions about their health care, including refusal of care.
- Be informed about all available treatment options, regardless of cost.
- A second opinion from another contracted provider.
- Obtain services within specified appointment standards.
- Be treated with dignity and respect. Discrimination on the bases of race, color, national origin, 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.
- Receive mental health and substance use disorder services.
Enrollee Rights (cont.)

- 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:

- 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
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.
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 members what type of care they do or do not wish to receive.

- An Advance Directive also:
  - Allows and 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 against 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:

- Maintenance of written policies and procedures around Advance Directives.
- To provide 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.
- To review 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 a enrollee has an Advance Directive.
- Keep and maintain 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 three 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) **Organ Donation Request**
   - This allows an enrollee to donate their organs after their death.
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 EMT's, physicians, nurse's 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.
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.

Program Integrity Definitions

**HCA** – Health Care Authority

**LEIE** – List of Excluded Individuals and Entities Database - contains names of providers and other individuals and entities who are excluded from participation in Federal programs.

**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).

**MFCU** – Medicaid Fraud Control Unit is the Washington State Medicaid Fraud Control Unit that investigates and prosecutes fraud by health care providers. This unit is part of the Criminal Justice Division of the Attorney General’s Office.

**MCO** – Managed Care Organization - currently include Community Health Plan of WA, Molina Healthcare, UnitedHealthcare, Coordinated Care, and Amerigroup.
Disclosure of Ownership and Control

- Apple Health Medicaid Plans are required to collect detailed Disclosure of Ownership and 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.

- We are also required to maintain a list of subcontractor individuals and entities with an ownership or control interest of more than 5%.
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.
Excluded Individuals and Entities

- HCA contracted managed care plans are required to immediately 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 10-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 credible allegation of fraud has been accepted by the MFCU for investigation.
- Notices must be provided under the following time frames:
  - Within 5 calendar days of suspension unless requested, in writing, by the MFCU or law enforcement to temporarily withhold notice
  - Within 30 calendar days if a delay notice is requested by the HCA MFCU or law enforcement in writing.
  - 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.
Payment Suspension

“Good Cause” Exception:

- **Good Cause** may exist not to 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.
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 10-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 within 10-days, upon request.

- All instances of alleged cases of fraud and abuse by employees, subcontractors, subcontractor employees or enrollees within 7-days of becoming aware of the allegation.
Fraud, Waste and Abuse

Definitions:

**Fraud** is generally defined as knowingly and willfully executing, or attempting to execute, a scheme to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

**Waste** is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.
Fraud, Waste and Abuse

Definitions (cont.)

**Abuse** includes any action(s) that may, directly or indirectly, result in one or more of the following:

- Unnecessary costs to the health care system, including Medicare and Medicaid
- Improper payment for services
- Payment for services that fail to meet professionally recognized standards of care
- Services that are medically unnecessary
Fraud, Waste and Abuse

Who Commits Fraud, Waste and Abuse?

Anyone with a motive, means, and opportunity can commit fraud, waste, and abuse.

- Fraud, waste, and abuse can be committed by:
  - Beneficiaries/Members
  - Pharmacies
  - Physicians
  - 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-9 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, 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 Claim 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.
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 $5,500.00 to $11,000.00 per claim.

The FCA recovered nearly $16.5 billion in health care fraud since January 2009 to the end of fiscal year 2015.
Anti-Kickback Statute and Stark Law

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

Following defines the difference between these sometime confusing laws:

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<thead>
<tr>
<th></th>
<th>Anti-Kickback Statute</th>
<th>Stark Law</th>
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<tbody>
<tr>
<td><strong>Prohibition</strong></td>
<td>Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate federal health care program business</td>
<td>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</td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
<td>Referrals from anyone</td>
<td>Referrals from a Physician</td>
</tr>
<tr>
<td><strong>Items/Services</strong></td>
<td>Any items or services</td>
<td>Designated health services</td>
</tr>
<tr>
<td><strong>Intent</strong></td>
<td>Intent must be proven</td>
<td>No intent standard for overpayment (strict liability)</td>
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## Anti-Kickback Statute and Stark Law (cont.)

### Anti-Kickback Statute

**Criminal:**
- Fines up to $25,000 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 $50,000 CMP per violation
- Civil assessment of up to three times amount of kickback

### Stark Law

**Civil:**
- Overpayment/refund obligation
- False Claims Act liability
- CMPs and program exclusion for knowing violations
- Potential $15,000 CMP for each service
- Civil assessment of up to three times the amount claimed

### Penalties

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### Exceptions

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<tr>
<td>Voluntary safe harbors (All)</td>
<td>Mandatory exceptions (Medicare/Medicaid)</td>
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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.

- Community Health Plan of WA: 1-800-440-1561
  www.chpw.org

- UnitedHealthcare Community Plan: 1-866-242-7727
  www.uhccommunityplan.com/WA

- 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://providers.amerigroup.com
Recent Changes and Updates

Effective April 1, 2016 the HCA implemented the following change:

**Earlier Enrollment**
- Newly eligible Medicaid clients are now enrolled in managed care effective the first of the current month, rather than prospectively to the first of the next month.
- Existing enrollees who change plans, or who lose then regain eligibility, will be enrolled in the new plan the first of the following month.

**Single Managed Care plan for Foster Care**
- Coordinated Care of Washington provides continuity and coordination of services statewide for children and youth in foster care and adoption support, and young adult (18-26) “alumni” of the foster care system.
Recent Changes and Updates

Behavioral Health Organizations replaced Regional Support Networks:

- BHOs provide managed mental health and substance use disorder services through nine BHOs.
- Regional Support Networks are no longer in existence.
- BHO’s operate statewide except in Clark and Skamania Counties.

Clark And Skamania Counties – Fully Integrated Managed Care (FIMC):

- Community Health Plan of Washington (CHPW), and Molina Healthcare of Washington (MHW) provide and coordinate all covered services, including medical, inpatient and outpatient mental health services, and substance use disorder services.
- Beacon Health Options (BH-ASO) provides crisis services for non-Medicaid individuals to include inpatient and outpatient mental health and substance abuse disorder services.
Recent Changes and Updates

The HCA extended the following requirement in 2016 from July 1 to Oct 1 and recently announced that it has been delayed until further notice.

In order to provide services to Apple Health enrollees, providers must maintain an NPI on file with the HCA.

- A provider must have either a valid CPA or a Nonbilling Individual Provider Agreement (“nonbilling agreement”).
- A completed CPA or nonbilling agreement registers your NPI with the state.

To enroll with Medicaid as a provider, go to http://www.hca.wa.gov/medicaid/providerenroll/pages/enroll.aspx#provider

To establish an HCA nonbilling provider agreement (you do not bill FFS through ProviderOne), you still need to take action and to: http://www.hca.wa.gov/medicaid/providerenroll/Pages/nonbilling.aspx.

Although the HCA has delayed this requirement, we encourage providers without an agreement to pursue a CPA or non-billing agreement with the HCA.
Questions?