SECTION XII: Fraud, Waste and Abuse

FRAUD AND ABUSE

Arizona Revised Statute ARS 36-2918.01 requires providers to immediately report suspected fraud and abuse. Members or providers who intentionally deceive or misrepresent in order to obtain a financial gain or benefit they are not entitled to must be reported to Care1st or directly to AHCCCS.

It is imperative that our providers continue to partner with us to ensure that the reported millions of dollars lost to Medicaid fraud and abuse does not originate with Arizona providers. Members and providers who act fraudulently hurt honest providers and exhaust limited resources available to serve those in need.

Examples of member fraud might include use of someone else's member ID card or failure to report other insurance. An example of provider fraud might include billing for services not provided, billing for a level of service not provided, or miscoding a claim to obtain reimbursement exceeding what a provider is entitled to receive.

To report any suspected provider or member fraud or abuse, the following options are available:

- Call the Care1st Fraud Hotline 866-685-8664
- Call the Care1st anonymous Compliance Hotline 866-364-1350
- Call the Care1st Compliance Officer at 602-778-1800 x8302
- Email fraud and abuse directly to AzCHFWA@azcompletehealth.com
- You may mail Care1st at:

Care1st Health Plan
Attention: Compliance Department
1850 W Rio Salado Parkway, Suite 211
Tempe, AZ 85281

- You may report direct to AHCCCS by completing the fraud and abuse referral available at https://azahcccs.gov/Fraud/ReportFraud/ and may be submitted online or mailed to:

Arizona Health Care Cost Containment System (AHCCCS)
Inspector General
Office of Inspector General (OIG)
801 E. Jefferson St., Mail Drop 4500
Phoenix, AZ, 85034

- Call the AHCCCS Provider Fraud Hotline:
  - In Maricopa County: 602-417-4045
  - Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686
- AHCCCS Member Fraud Hotline:
  - In Maricopa County: 602-417-4193
  - Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

The Health Plan providers are required to immediately report, but no later than 10 days, all suspected FWA involving any Title XIX/XXI and NTXIX/XXI funds, AHCCCS providers, or AHCCCS Members to the AHCCCS Office of Inspector General (OIG). Notification shall also be made to the Health Plan. Please remember to have as much information about the matter being reported as possible. You may remain anonymous if you choose to.

The Health Plan's providers are responsible for ensuring that mechanisms are in place for the identification, prevention, detection and reporting of fraud, waste and abuse. All employees of providers must be familiar with the types of FWA that could occur during their normal daily activities. AHCCCS has published e-learning training seminars on their website entitled "Fraud Awareness for Providers". The training discusses provider and member fraud.

The e-learning can be found at: https://azahcccs.gov/Fraud/Providers/

ANTI-FRAUD PLAN

Most of the initial legislation and enforcement of health care fraud and abuse has been in the Medicare/Medicaid and Hospital (Stark) areas. However, health care fraud and abuse in managed care is beginning to receive attention and inquiry.

The federal Deficit Reduction Act of 2005 requires any entity, including any Medicaid managed care organizations such as Care1st to establish written policies for its employees, subcontractors and agents that give detailed information about federal and state false claims laws and whistleblower protections, and the organization's (Care1st's) policies and procedures for detecting and preventing fraud, waste and abuse.

Care1st's Anti-Fraud Plan addresses these requirements of federal and state laws and is a useful tool on the subject of fraud, waste and abuse. The Anti-Fraud Plan is available at the following location: https://www.care1staz.com/az/providers/compliance.asp.

SECTION XII: Fraud, Waste and Abuse

DEFICIT REDUCTION ACT

Care1st providers are required to train their staff on the following aspects of the Federal False Claims Act provisions:

- The False Claims Act, Including Examples of False Claims and Remedies
- Federal Whistleblower Protections
- AHCCCS - Prohibited Acts and Remedies

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program including Medicaid and Medicare.

The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" means that a person, with respect to information:

- had actual knowledge of falsity of information in the claim, or
- acted in "deliberate ignorance" of whether or not the information was true, or
- acted in "reckless disregard" of the truth or falsity of the information in a claim.

It is not necessary that the person had a specific intent to defraud the government.

The False Claims Act prohibits seven types of conduct:

1. **False Claim:** Filing false or fraudulent claims. A Claim includes any request or demand for money that is submitted to the U.S. government or its contractors (like Care1st). So a provider or hospital claim, or a vendor billing, submitted to Care1st involving Medicaid or Medicare programs counts as a claim.
2. **False Statement:** Making or using false statements or records.
3. **Conspiracy:** Conspiring with others to submit false claims that are actually paid by the government.
4. **Delivery of Less Property:** Delivering less property than the amount stated on the receipt or certificate.
5. **Delivery of Improper Receipt:** Delivering a receipt for property without knowing whether the information on the receipt is true.
6. **Unauthorized Seller:** Knowingly buying or receiving property from a government employee or official who is not authorized to sell it.
7. **Reverse false claims:** A reverse false claim involves using a false statement to conceal, avoid or decrease the amount of an obligation.

EXAMPLES OF A FALSE CLAIM

- Billing for procedures not performed
- Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals)
- Falsifying information in the medical record or in a claim
- Improper bundling or coding of charges, and
- Misrepresentation by a member or provider to seek benefits provided by Care1st or other Medicaid or Medicare contractor/health plan.

REMEDIES

- Violation of the False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages that the Government sustains because of the violation
- A federal false claims action may be brought by the U.S Attorney General
- An individual also may bring what is called a qui tam action for violation of the False Claims Act. This means the individual files a civil action on behalf of the government
- An individual who files a qui tam action receives an award only if, and after, the Government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the Government's participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action
- A statute of limitations provides the amount of time that may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed

FEDERAL WHISTLEBLOWER PROTECTIONS

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would

have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for such relief. (31 USC 3730(h))

AHCCCS- Prohibited Acts

Prohibits the presentation to AHCCCS or a Program Contractor, such as Care1st, the following:

- A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed;
- A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent;
- A claim for payment that the person knows or has reason to know may not be made by the system because:
    a. The person was terminated or suspended from participation in the program on the date for which the claim is being made.
    b. The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.
    c. The patient was not a member on the date for which the claim is being made.
- A claim for a physician's service or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
    a. Was not licensed as a physician.
    b. Obtained the license through a misrepresentation of material fact.
    c. Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.
- A request for payment that the person knows or has reason to know is in violation of an agreement between the person and the State of Arizona or AHCCCS.

REMEDIES

A person who violates one of the provisions above is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.