PROCEDURE

Series:	**Operating Procedures**	**COA: N/A** **CFOP: N/A**
Procedure Name:	Fraud, Waste and Abuse Prevention, Reporting and Training (Anti-Fraud Plan)	
Procedure Number:	OP1168	
Review Date:	05/03/17 (2) 12/10/19	
Revision #/Date:	(1) (05/03/17)	
Effective Date:	07/11/14	
Applicable to:	Brevard Family Partnership Family of Agencies (BFP FOA) Staff	

PURPOSE:

The purpose of this policy is to establish the method used by Brevard Family Partnership (BFP) to ensure compliance in regards to the Sunshine Health Fraud and Abuse Compliance and Anti-Fraud Plan as it relates to clients enrolled in the Medicaid funded integrated health plan, as well as to ensure that BFP employees understand how to recognize Fraud and Abuse Compliance and report it to the appropriate parties. BFP will coordinate and follow the Sunshine Health Fraud and Compliance Plan and the Anti-Fraud Plan.

PROCEDURE:

References

Verification of Services Provided to Enrollees
Sunshine Health Quality Improvement and Compliance Committee
CBCIH Compliance Committee

Application

This procedure applies to CBCIH and BFP FOA Staff, and addresses care coordination activities that are provided on behalf of all CWSP plan enrollees.

Key Terms *Abuse* is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Florida 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 recipient practices that result in unnecessary cost to the Florida Medicaid program. (42 CFR 455.2).

Abuse may, directly or indirectly, result in unnecessary costs, improper payment, payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. The provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Child Welfare Specialty Plan Enrollee—a child who is Medicaid eligible and is enrolled in the Sunshine Health, Child Welfare Specialty Plan, or the Sunshine Health Managed Medical Assistance Plan (MMA), due to an active status in the child welfare system of care. This includes

children who have an open child welfare case, those who have been adopted from dependency and those who are receiving extended foster care or independent living services.

Contracted Service Provider means a private agency that has entered into a contract with the department or with a community-based care lead agency to provide supervision of and services to dependent children and children who are at risk of abuse, neglect, or abandonment.

*Conviction or Convicted (*42 CFR 455.2) means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

A credible allegation of fraud (42 CFR 455.2) may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

1. Fraud hotline complaints;
2. Claims data mining; or
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

*Exclusion (*42 CFR 455.2) means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud is defined as knowingly and intentionally executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program. It is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2).

Lead Agency means an "eligible lead community-based provider" as defined in Section 409.1671(1) (e), F.S. The functions of a community-based care lead agency include: (a) Organize and manage a network of service providers; (b) Provide case management for any children/families referred.

Medicaid means "Medicaid" as defined in Rule 59G-1.010, F.A.C. which includes eligibility based on income for most groups using Modified Adjusted Gross Income (MAGI).

Overpayment is defined per s. 409.913, F.S., as including any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Suspension (42 CFR 455.2) means items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

Standards

This procedure acknowledges that CBCIH and BFP will notify Sunshine Health of, potential fraud, abuse, and/or waste. CBCIH shall submit updated fraud, abuse, and waste procedures, which includes the anti-fraud plan, annually to Sunshine Health.

General Requirements:

I. Identification of Fraud, Waste, and Abuse and Internal Reporting

A. Initial identification of suspicious activity may be observed via various avenues, including but not limited to, the following:

1. Member and/or customer complaints;
2. Suspicions raised by CBCIH personnel and the BFP staff, including the Behavioral Health Care and Nurse Care Coordinator;
3. An external source (i.e., government agencies or other insurers);

B. CBCIH staff members are required to report identified suspected cases of fraud, waste or abuse within ten (10) days of receiving information suggesting potential fraud. Additionally, the QFAAR report is submitted to Sunshine Health within five (5) days following the end of each quarter.

C. BFP staff will report suspected fraud, waste and abuse directly to the CBCIH Compliance Manager. Information regarding Fraud, Waste and Abuse is posted on the CBCIH website (www.cbcih.com).

To report suspected fraud, waste, abuse, or neglect in the Child Welfare Specialty Plan, please use one of the following avenues:

1. **Potential Fraud, Waste or Abuse may be reported** to the CBCIH Compliance Manager via the Integrate® Notify Application
2. **Potential Fraud, Waste or Abuse may be reported** by calling the CBCIH's Compliance Officer:

CBCIH Compliance Officer:
Paige Blinderman
1-321-441-2060
compliance@cbcih.com

- Once the report is submitted to CBCIH, additional reporting of suspected fraud, waste, abuse, or neglect in the Medicaid Child Welfare Specialty Plan may be done via one of the following avenues:

  Sunshine Health Corporate Compliance: 1-866-685-8664
  Sunshine Health Compliance Officer: 1-866-796-0530
  Sunshine Compliance email: compliancefl@centene.com
  AHCA Consumer Complaint Hotline: 1-888-419-3456
  Florida Attorney General's Office: 1-866-966-7226
  Florida Medicaid Program Integrity Office: 1-850-412-4600
  Reports to the Sunshine Health Corporate Compliance Hotline may be made 24 hours a day/7 days a week and is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

- AHCA Consumer Complaint Hotline

  Reports can also be made to the Departments' Consumer Complaint Hotline tollfree at 1-888-419-3456 or by completing a Medicaid Fraud and Abuse Complaint Form, which is available online at:
  https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

- Florida Attorney General's Office: 1-866-966-7226
- Florida Medicaid Program Integrity Office: 1-850-412-4600
- Department of Financial Services – Complaint Form

D. Approved training material has been developed and distributed to CBCIH staff and BFP for annual review. BFP will ensure staff complete all required trainings annually. CBCIH and BFP may utilize either of the following links to complete the training:

1. Training may be completed via the CBCIH website: http://www.cbcih.net/#!training/c10b0

Upon completion of the training, the trainee must indicate (via the FWA Attestation) that the training material has been reviewed and that the training has been completed. The FWA Attestation can be completed online at: http://www.cbcih.net/#!forms/c20ko; or the trainee may utilize the certificate contained at the end of either of the presentations. This Attestation of training completion should be maintained for review during contract monitoring visits by CBCIH and/or Sunshine Health. CBCIH submits FWA training information to Sunshine Health in accordance with the reporting requirements, detailed within Exhibit IV of the Vendor Agreement.

II. Reporting of Disclosures Regarding 42 CFR 1002.3, and 42 CFR 1001.1, 42 CFR 455.104, 105 & 106 to the Departments and Other External Regulatory Agencies.

A. CBCIH shall notify Sunshine Health, who in turn shall notify the Departments and the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG), within ten (10) business days after discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.

1. In accordance with 42 CFR 455.106, Sunshine Health (with assistance of CBCIH) shall disclose to HHS-OIG, with a copy to the Departments within ten (10) business days after discovery, the identity of any person who:

a) Has ownership or control interest in CBCIH or Sunshine Health, or is an agent or managing employee of either; and

b) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

B. Disclosures Obtained from Sunshine Health's Network Providers & Subcontractors: The Credentialing staff contact the Local Compliance Officer to provide all reportable disclosure information described below and in Table 1 that is obtained during the credentialing and re-credentialing process. The Local Compliance Officer notifies the Departments and the HHSOIG as outlined in this policy.

1. The provider credentialing and re-credentialing process includes a review of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE), the U.S. General Services Administration's (GSA) web-based Excluded Parties List System (EPLS) and other applicable federal & state exclusion lists. Excluded individuals/entities are not

allowed to join Sunshine Health's Florida Medicaid Provider Network. Sunshine Health (assisted by CBCIH) reports information regarding excluded providers, managing employees, or subcontractors to the HHS-OIG and the Departments.

2. Sunshine Health (assisted by CBCIH) shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in this section.

a) Sunshine Health (assisted by CBCIH) notifies the Departments and HHS-OIG within ten (10) business days when any action is taken to limit the ability of an individual or entity to participate in Sunshine Health's Florida Medicaid Provider Network, regardless of what such an action is called. This includes, but is not limited to, convictions, exclusions, revocations, and suspension actions, settlement agreements, and situations where an individual or entity voluntarily withdraws from the Network to avoid a formal sanction. The notification requirement also includes credentialing applications that are denied because of CBCIH's or Sunshine Health's concerns about provider fraud, program integrity, or quality.

b) Sunshine Health (assisted by CBCIH) notifies the Departments and HHS-OIG within ten (10) business days when Sunshine Health terminates a provider's contract for reasons related to CBCIH's or Sunshine Health's concerns about fraud, program integrity, or quality.

c) Sunshine Health (assisted by CBCIH) notifies the Departments and HHS-OIG within ten (10) business days when Sunshine Health dis-enrolls or de-credentials a provider, or a provider is denied initial entry into Sunshine Health's Provider Network for reasons related to CBCIH's or Sunshine Health's concerns about fraud, program integrity, or quality.

d) Sunshine Health (assisted by CBCIH) notifies the Departments and HHS-OIG within ten (10) business days after Sunshine Health's discovery, when a provider as well as other parties associated with the provider including subcontractors, agents, managing employees and individuals or entities with an ownership or controlling interests and relationships (pursuant to 42 CFR 1001.1001(a)(1), 42 CFR 1002.3, 42 CFR 455.104, 105 & 106) with the provider have disclosed information, or if primary source verification finds adverse actions regarding a criminal conviction related to Medicare, Medicaid, and Titles XX and XXI during the credentialing or recredentialing process.

e) Sunshine Health (assisted by CBCIH) notifies the Departments and HHS-OIG within ten (10) business days after Sunshine Health's discovery, the identity of any person who:

1. Has ownership or control interest in Sunshine Health's Network Provider, or subcontractor, or is an agent or managing employee of CBCIH or Sunshine Health's Network Provider or subcontractor; and
2. Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any Procedures & Practices Manual 6 |

Page program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;

f) In addition to the provider requirement to disclose the information outlined in Table 1 below during the credentialing and re-credentialing process and to ensure ongoing compliance after the credentialing and re-credentialing review process, providers are also required to provide updated information regarding the information outlined in Table 1 annually. Sunshine Health (assisted by CBCIH) will report to the Departments the names of providers that failed to provide the information during the annual update submission process. Furthermore, providers are also required to disclose any update in the provider's initial disclosure within ten (10) business days from when the provider becomes aware of the changes to the information.

g) Sunshine Health (assisted by CBCIH) supplies updated disclosure information and adverse information obtained through the disclosure process including any adverse action taken, to the Departments and HHS-OIG as soon as possible (but no later than) ten (10) business days after receipt of any of the disclosures listed in Table 1 from any provider or subcontractor.

h) Upon receipt of a request from the Departments or HHS-OIG, Sunshine Health (assisted by CBCIH) will provide the information disclosed by providers pursuant to 42 CFR 1002.3, and 42 CFR 1001.1, 42 CFR 455.104, 105 & 106.

C. The local Compliance officer refers the case to the appropriate Department listed in Table 2 (in consultation with the CBCIH Vice President of Integrated Health and under guidance from Sunshine Health's Corporate Compliance/Legal Department) with the required supporting documentation within the timeframes outlined in this policy. The Local Compliance Officer notifies the Departments and the HHS-OIG as outlined below.

1. Via email to: floridaexclusions@oig.hhs.gov and copy MPI via email to: mpifo@ahca.myflorida.com. Document information examples include but are not limited to court records such as indictments, plea agreements, judgments, and conviction/sentencing documents.

2. In lieu of an email notification, a hard copy notification is acceptable to the DHHS OIG at:

Attention: Florida Exclusions Office of the Inspector General Office of Investigations 7175 Security Boulevard, Suite 210 Baltimore, MD 21244

With a copy to MPI at:

3. Attention: Florida Exclusions Office of the Inspector General Medicaid Program Integrity 2727 Mahan Drive, M.S. #6 Tallahassee, FL 32308-5403

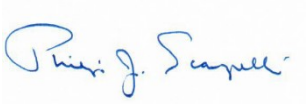
III. Penalties for Non-Compliance with the Anti-Fraud Plan Reporting Requirements Pursuant to Fla. Stat. § 409.91212

A. If CBCIH fails to meet contractual requirements set forth by Sunshine Health, who then in turn fails to timely submit to the Departments, a final, acceptable Anti-Fraud Plan; fails to timely submit its annual report; fails to implement its Anti-Fraud Plan or investigative unit, if applicable, or otherwise refuses to comply with this policy, the Departments shall impose:
1. An administrative fine of $ 2,000 per calendar day for failure to submit an acceptable Anti-Fraud Plan or report until the agency deems CBCIH or Sunshine Health to be in compliance;
2. An administrative fine of not more than $ 10,000 for failure by CBCIH or Sunshine Health to implement an Anti-Fraud Plan or investigative unit, as applicable; or
3. The administrative fines pursuant to paragraphs 1 and 2 above.

B. If Sunshine Health (including through CBCIH) fails to report all suspected or confirmed instances of provider or recipient fraud or abuse within fifteen [15] calendar days after detection to the Office of Medicaid Program Integrity within AHCA, penalties include:

1. Failure to timely report shall result in an administrative fine of $ 1,000 per calendar day after the 15th day of detection.
2. Failure to timely report may result in additional administrative, civil or criminal penalties

BY DIRECTION OF THE CHIEF EXECUTIVE OFFICER:



PHILIP J. SCARPELLI
Chief Executive Officer
Brevard Family Partnership Family of Agencies

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