# Fraud, Waste & Abuse (FWA)

Valley Area Agency On Aging

Answers, Action & Advocacy for **All Things Senior**

# Federal and State Oversight Authorities

- The Office of the State OIG and Medicaid OIG
- The Office of Inspector General (OIG), U.S. Department of Health and Human Services
- Department of Justice
- Centers for Medicare & Medicaid Services (CMS)
- Office of the State Attorney General
- State Medicaid Agencies
- Medicaid Fraud Control Units

# Fraud


Fraud is the intentional act of deception, misrepresentation, or concealment in order to gain something of value. The intent to deceive is high despite knowing an act is illegal.

Examples:

- Knowingly billing for services not provided or received.
- Knowingly billing for services at a higher rate than is actually justified.
- Accepting bribes.
- Billing for equipment that was returned to the manufacturer.
- Altering invoices, certifying patients/ participants as homebound when they were not.

# Fraudulent Activities Specific to YOU

- Determining and/or falsifying records to enroll an applicant in services when you know the person is not eligible for services. This includes service authorizations.
- Conveying that an assessment has been completed when it has not.
- Intentionally documenting false information (i.e. aide logs, case notes, service authorizations).
- Documenting contact with participant(s), family member(s), healthcare professional(s) or vendor(s) that did not take place in order to continue services.
- Attempting to authorize unnecessary services to allow financial gain for a participant, aide, agency or family caregiver.
- Submitting timesheets or signing a blank timesheet that in home services i.e. CLS, personal care, homemaking, respite or any other services was completed and services were not complete.

# Waste


Waste is the over utilization of services (not caused by criminally negligent actions) and the misuse of resources. The intent to deceive is low.

Examples:

- Unnecessary use of supplies or services.
- Overuse, underuse and ineffective use of services.
- Inaccurate claim data submission resulting in unnecessary rebilling or claims.

# Wasteful Activities Specific to You

- Conveying you spent longer in an assessment to decrease workload or additional work requests.
- Staff is made aware services were not received via monthly call and fails to follow agency procedure that would prevent unnecessary provider billing (need to always cancel service authorizations).
- Using company equipment for personal use (without permission/ approval from supervisor).
- A worker/ aide sits down, watches television or uses their phone for social media instead of providing services scheduled (even if approved by participant).
- While completing an assessment or providing services you notice services such as meals on wheels, PERS or medication dispenser is not being used by participant and you do not address why and remove service when necessary.


# Abuse

Abuse is the excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Abuse refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss. The intent to deceive is in the middle.

Examples:

- Providing medically unnecessary services.
- Misrepresenting services resulting in unnecessary cost to Medicaid, improper payments to providers or overpayments.

# Abuse Activities Specific to YOU

- Bending the rules to benefit a participant or service worker that results in improper payment.
- Submitting timesheet for services you intend to provide in the future.
- Certifying a participant meets LOCD based on their verbal report when physical action indicate opposite i.e.

  -Participant states he/she is unable to transfer independently but this person answered the door walking by themselves.

  -Participant reports they do not take medications because they want to continue to use alcohol. No other evidence of deficiencies with planning, organizing or correction of daily routines is needed. This would not be an impaired person because this person is making an informed to choice to not take their medication.

  -Participant reports they have a stage 3 pressure sore and there is no corroborating evidence i.e. skilled care records, doctor's confirmation or treatment plan.

- Any actions you do or assist in that directly or indirectly result in unnecessary cost to Medicaid or Medicare.

# Who could be involved in FWA?

- In Illinois, a personal care attendant filled out time sheets and forged a beneficiary's signature stating he provided care to the beneficiary even though the attendant moved from the area and services were never provided. He billed a Medicaid waiver program for the services. He pleaded guilty to stealing from a health care program, was sentenced to 2 years of probation with 4 months' home confinement, and was ordered to pay $6,660.75 in restitution to the Medicaid program.
- Staff
- Participants
- Providers
- Community partners/ formal arranged providers

# Stop Fraud, Waste or Abuse

- Do not “go along” with the status quo. Speak up and speak out (even if you were “trained a certain way”). If it does not seem right, ask questions, look at policy or speak to your supervisor.

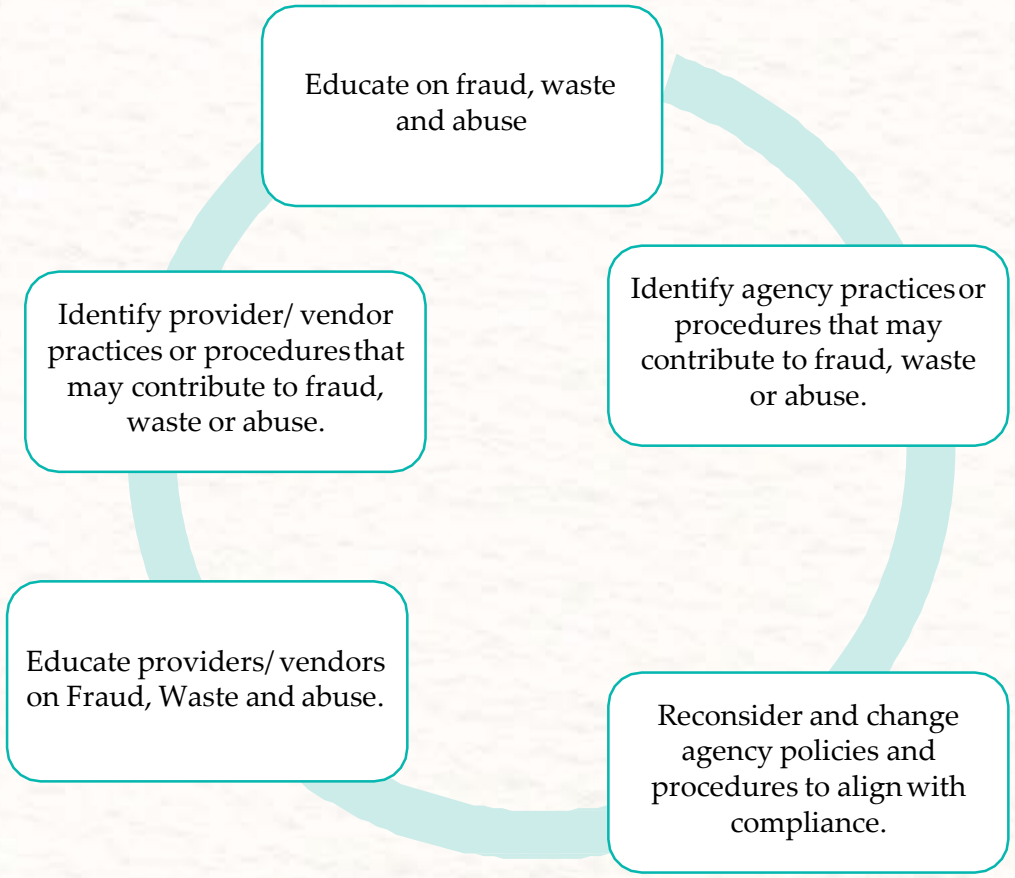
Remember under the False Claims Act:

- Any individual or organization that knowingly submits a claim he or she knows (or should know) is false and knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid or approved under any federally funded health care program, is subject to civil penalties. It also includes those cases in which any individual or organization obtains money to which they may not be entitled, and then uses false records or statements to retain the money, and instances where a provider retains overpayments.
- Under the federal FCA, a person, provider, or entity is liable for up to triple damages and penalties between $5,500 and $11,000 for each false claim it knowingly submits or causes to be submitted to a federal program.
- In addition to civil penalties, individuals and entities also can be excluded from participating in any federal health care program for non-compliance.

# Exclusion Lists

- The U.S. Department of Health and Human Services (HHS), through the Office of Inspector General (HHS-OIG), can exclude individuals and entities from participating in federally funded health care programs. The HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE) online at http://exclusions.oig.hhs.gov/. According to the HHS-OIG, the "basis for exclusion" includes:
- Convictions for program-related fraud and patient abuse;
- Licensing board actions; and
- Default on Health Education Assistance Loans.
- In addition, the U.S. General Services Administration's (GSA) web-based Excluded Parties List System (EPLS) at https://www.epls.gov/ is used to identify individuals and entities excluded from receiving federal contracts, certain subcontracts, and certain types of federal financial and non-financial assistance and benefits.

# How VAAA will Fight FWA




- Educate staff on Fraud, Waste and Abuse;
- Conduct activities to identify potential opportunities for improvement;
- Revise or create policies and procedures that maintain compliance;
- Create provider training;
- Require providers to revise or create procedures to maintain compliance;

# Reporting Suspected Cases of FWA

VAAA will not retaliate against an employee for reporting or assisting in a False Claims Act action. VAAA will not retaliate against any of its providers or contractors for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. All reports of Fraud, Waste, and Abuse may be made anonymously.

**Email**

**fwa@valleyaaa.org**

**Agency Tip line**

**810-249-6549**