AdvancedHealth
Bridging the Future of Healthcare

Fraud, Waste, and Abuse Training

For Board Members, Employees, Subcontractors, Providers, and Members

Revised 2026

Objectives

- Know the Difference Between Fraud, Waste, and Abuse.
- Understand When and How to Report Allegations of FWA.
- Understand Exclusions.
- Know Where to Find Advanced Health's FWA Policies and Procedures.
- Understand Whistleblower Protection.

What is FWA?

- **The key difference between fraud, waste, and abuse is the knowledge and intention of the individual(s).**
- **Fraud** means the intentional deception or misrepresentation that a person knows, or should know, to be false, or does not believe to be true, and makes knowing the deception could result some unauthorized benefit to themselves or some other person.
- Fraud may include:
  - Knowingly offering, soliciting, receiving, or paying kickbacks, bribes, rebates, or other remuneration to induce or reward referrals for services or items billed to federal health care programs.
  - Billing for services, supplies, appointments, or prescriptions that were not actually provided, filled, or did not exist.
  - Altering claim forms, medical records, or receipts to obtain a higher payment.
  - Use of another person's Medicaid ID Card or identity to get benefits.

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What is FWA?

- **Waste** means over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.
- Waste may include:
  - Scheduling unnecessary office visits.
  - Prescribing medications more often than clinically needed.
  - Dispensing or ordering more medication than is required to treat a specific condition.
  - Requesting an excessive number of laboratory tests.
- Waste in office use can include:
  - Unnecessary or redundant printing or copying.
  - Excess paper and supply consumption.
  - Overordering office materials.

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What is FWA?

- **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- Abuse may occur when an individual unknowingly:
  - Submits claims for services that are not medically necessary.
  - Bills for name brand medications when generic equivalents were provided.
  - Applies excessive charges for services or supplies.
  - Uses incorrect billing codes.
- Common coding mistakes include practices such as unbundling or upcoding, where a provider selects inaccurate or inflated billing codes for procedures or treatments in order to obtain higher reimbursement.

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Applicable State and Federal Laws

False Claims Act (FCA)

- Authorizes substantial civil penalties against anyone who knowingly submits, or causes another person to submit, a false or fraudulent claim to the federal government. The False Claims Act imposes penalties for submitting false claims, even without intent if there is reckless disregard.
- "Knowingly" can also include deliberate ignorance or willful blindness.
- A person may be liable for triple the government's damages, plus additional penalties.
- Civil monetary penalties may range from $5,000 to $11,000 for each false claim.
- Violations of the Criminal Health Care Fraud Statute can lead to fines of up to $250,000 and imprisonment for as long as 20 years. If the violation results in death, the sentence may be for any term of years or life.
- In addition to monetary penalties, individuals and organizations may be excluded from participation in government programs.

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Applicable State and Federal Laws

Anti-Kickback Statute (AKS)

- Prohibits offering or accepting anything of value in return for referrals or services covered by federal healthcare programs.
- This includes gifts or benefits such as free or reduced rent, hotel accommodations, costly meals, or other items of value given in exchange for referrals.
- Violations can result in fines of up to $250,000 and imprisonment for up to five years.
- This law also governs relationships with vendors, physicians, and others involved in federal healthcare. Any incentive or reward tied to a business arrangement may create a legal violation.
- This includes matters such as physician recruitment and interactions with pharmaceutical and medical device companies.

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Applicable State and Federal Laws

Stark Law (Physician Self-Referral)

- This law bars healthcare providers from referring patients for designated health services to an entity with which the physician or an immediate family member has a financial interest.
- Penalties can include fines of more than $15,000 for each service billed, along with other possible sanctions.
- Certain exceptions may apply. To review additional details, please see 42 U.S.C. Section 1395nn

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Reporting Fraud, Waste, and Abuse Is Required

- Employees are required to report any suspected fraud, waste, or abuse.
- If you believe misconduct may have occurred, raise the concern right away.
- Advanced Health offers a hotline and other methods to report suspected fraud, waste, and abuse, including anonymous submissions. See the next slide for details.
- Advanced Health is required to report all suspected cases of fraud, waste, and abuse to the Oregon Health Authority's Office of Program Integrity and other applicable agencies.

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Advanced Health Hotline

- Advanced Health provides several ways you can make a report.
  - Hotline Report Forms on its public website and internal intranet page (allows for anonymous reporting).
  - A secure drop box by the employee entrance (allows for anonymous reporting).
  - You may call the compliance hotline (541) 266-6500.
  - By email: CCO.Compliance@advancedhealth.com

- Any one of these methods can be used to make prompt, confidential reports of noncompliance and suspected fraud, waste, or abuse to the Compliance Department.
- Please note that when calling or emailing we keep your report confidential, however, as part of the investigation process applicable parties may be included to resolve the report.
- If you do not wish to disclose your name, use the Hotline Report Form or the secure drop box to report anonymously.

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Important Reporting Timeframes

- Advanced Health is required to report all suspected cases of fraud, waste, or abuse by employees, Participating Providers, Subcontractors, Members and any other third-party to the Oregon Health Authority's Office of Program Integrity and the Medicaid Fraud Control Unit promptly but not more than 7 days after we are made aware of the suspicious case.
- In addition, we are required to report all incidents that meet certain characteristics defined in our CCO Contract regardless of our own suspicions or lack thereof.
- Self-reporting of overpayments - 60 days from discovery.
- We are required to report overpayments identified during an audit to OHA promptly and no more than 7 days following discovery.
- We are required to adjust encounter claims within 30 days of discovering it is incorrect.

Medicaid FWA Reporting Requirements

Office of Program Integrity
OHA Office of Program Integrity (OPI)
500 Summer St. NE, E36
Salem, OR 97301
Secure email: OPI.Referrals@oha.Oregon.gov
Hotline 1-888-FRAUD01 (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

To Report a Case of Fraud or Abuse by a Member
ODHS Fraud Investigation
PO Box 14150, Salem, OR 97309.
Hotline 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline.
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

Medicaid Fraud Unit
Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone 971-673-1880
Fax 971-673-1890
Secure email:
Medicaid.Fraud.Referral@doj.state.or.us

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Exclusions

- **Any individual or entity may be subject to exclusion.**
- **What are the different types of exclusions?**
  - Mandatory exclusions: The Office of Inspector General (OIG) must exclude an individual or entity for at least five years if they are convicted of certain offenses, such as program-related crimes, patient abuse, felony healthcare fraud, or felony drug-related offenses.
    - 42 U.S.C §1320a-7(a)
  - Permissive exclusions: The OIG may choose to exclude individuals or entities under 16 separate grounds, such as loss of a state professional license, failure to repay student loans, conviction of certain misdemeanors, or providing substandard care.
    - 42 U.S.C §1320a-7(b)

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Exclusions

- **What happens when someone is excluded?**
  - Federal health care programs will not pay for any items or services furnished, ordered, or prescribed by an excluded individual or entity.
  - The restriction also extends to the excluded person, anyone who employs, or contracts with that person, and any hospital, provider, or supplier where the excluded person performs services.
  - This applies even if someone else submits the claim and also covers administrative and management services provided by the excluded person.
- **How long do exclusions last?**
  - Some exclusions are set for a specific period, while others may be open-ended, including those based on licensing board actions.
  - Reinstatement does not happen automatically. Anyone who wants to participate again in Medicare, Medicaid, or other federal health care programs must apply for reinstatement and wait for formal approval from OIG.
- **Advanced Health uses the List of Excluded Individuals and Entities (LEIE) and System of Award Management (SAM) to verify exclusion status.**

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Exclusions and Prohibited Affiliations

- Advanced Health, its subcontractors, and downstream entities are not permitted to maintain relationships with individuals or entities that are excluded, suspended, debarred, or otherwise ineligible to participate in federal health care or procurement programs, or that have had a required license denied, revoked, or not renewed.
- Advanced Health works with subcontractors to handle employment relations, credentialing and recredentialing services, and provider network functions. During credentialing and recredentialing, and when onboarding new employees, exclusion verifications are completed. Ongoing monthly exclusion verification checks are also performed.
- Under the CCO contract, Advanced Health may not refer members to, or use in its provider network, any provider who has been terminated by OHA, excluded by CMS from Medicare, CHIP, or Medicaid participation, or otherwise subject to exclusion based on qualifying convictions.

Exclusions and Prohibited Affiliations

- Advanced Health, its subcontractors, and downstream entities must report to OHA when:
  - A provider has been convicted of a felony or misdemeanor involving Medicare, Medicaid, Title XIX, or related federal or state law violations, including a plea of nolo contendere.
  - They identify an excluded individual (provider or employee).
  - A provider's license or certification expires, is not renewed, or becomes subject to sanction or administrative action.
  - Any for-cause termination, exclusion, or license-related notice.
- Advanced Health and its subcontractors that process claims will not accept claims for services provided after the date of a provider's exclusion, conviction, or termination. In addition, if an exclusion is discovered at any point during a provider's or subcontractor's participation, the contract must be ended until the exclusion is resolved. If the exclusion can be cleared, the provider may reapply.

Policies and Procedures

- Policies and Procedures are available to staff in the Document Control system on SharePoint, and publicly on our website.
  - Advanced Health Compliance and FWA Prevention Handbook
  - Compliance Training and Reporting Policies and Procedures
  - Whistleblower Policy Statement

Advanced Health Compliance and FWA Prevention Handbook

- Publicly available on our website
  - Advancedhealth.com
- Overview of our FWA program including:
  - Standards of Conduct
  - Contact Information for Compliance Department, MFCU and OPI
  - How to Report Compliance Concerns Including Anonymous Reporting

Compliance Training, Reporting and Response Policies and Procedures

- Publicly available on our website
  - Advancedhealth.com
- More detail than FWA Handbook
  - Includes training, response, reporting and corrective action or disciplinary measures
  - Reporting requirements and timelines

Whistleblower Policy Statement

- Publicly available on our website
  - Advancedhealth.com
- Provides more detailed information about State and Federal FWA Laws
- Whistleblower laws prohibit discrimination, retaliation or harassment against anyone who reports, in good faith, a violation of the FCA.
  - "qui tam" suits

Fraud, waste, and abuse prevention is everyone's responsibility. If you have questions or concerns, please contact the Compliance Department.

CCO.Compliance@advancedhealth.com

Thank you for your time and attention.