Fraud, Waste and Abuse Training 2026

Fraud, Waste and Abuse

Introduction

- The Medicare and Medicaid programs are governed by statutes, regulations, and policies.
- Millions of healthcare dollars are improperly spent because of fraud, waste, and abuse (FWA).
- Inappropriate and unethical behaviors drive up the cost of healthcare, drain the Medicare Trust Fund, and burden taxpayers and the healthcare system
- Integrated is required to provide training to prevent, detect and correct FWA.
- This training will help you detect, correct and prevent FWA.
- You are part of the solution!

Fraud, Waste and Abuse

Introduction - Continued

- Integrated is committed to a culture of ethical business practices and compliance.
- Our success as an industry leader is based on realizing our Mission through policies and procedures supportive of Integrated's Values, which are **Innovation**, **Accountability**, **Compassion**, and **Trust.**
- The purpose of this training is to provide an overview of fraud, waste, and abuse and to engage employees in preventing, detecting and reporting FWA.
- Additional training and resources are available to address requirements that are specific to your area of responsibility.

Fraud, Waste and Abuse

Training Objectives

- Meet the regulatory requirement for training and education.
- Provide information on the scope of fraud, waste, and abuse.
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse.
- Provide information on how to report fraud, waste, and abuse.
- Provide information on laws pertaining to fraud, waste, and abuse.

Fraud, Waste and Abuse

What are Your Responsibilities

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse:

- **First**, you are required to comply with all applicable statutory and regulatory requirements.
- **Second**, you have a duty to the Medicare Program to report any violations of laws of which you become aware.
- **Third,** you have been entrusted with a responsibility to adhere to Integrated's Code of Conduct that outlines our commitment to standards of conduct and ethical behavior.

Fraud, Waste and Abuse – Additional Responsibilities

What Are Your Additional Responsibilities?

- To improve the healthcare system, IHCS, in collaboration with its Participating and Preferred Providers, has made a commitment in detecting, correcting, and preventing fraud, waste, and abuse.
  - Detecting and preventing FWA is the responsibility of everyone, including employees, members, providers and sub-contractors.
- Each of us plays a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.
- Fraud, Waste, and Abuse (FWA) affects everyone - including you.
- Become familiar with laws that pertain to FWA:
  - Stark Physician Self-Referral Law (42 U.S.C. § 1395nn)
  - Anti-Kickback Statute (42 U.S.C. § 1320a–7b(b))
  - False Claims Act (31 U.S.C. §§ 3729–3733)
  - Civil Monetary Penalties Law (42 U.S.C. § 1320a–7a)
  - HIPAA and HITECH regarding Protected Health Information

Fraud, Waste and Abuse

How Do I Prevent It?

- Make sure you are up to date with laws, regulations & policies.
- Take action to improve processes that are deficient or prone to error.
- Ensure data is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity and report it.
- Assist in promoting a culture of compliance.

Fraud, Waste and Abuse

What is It?

- **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.

- **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 the Medicare and Medicaid programs
  - 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

Understanding It

In order to detect fraud, waste and abuse, you need to know the law.

- **Criminal fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice 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

  - - 18 United States Code §1347

- This means intentionally submitting false information to the government or a government contractor in order to get money or a benefit.

Fraud, Waste and Abuse

Understanding It - continued

- **Waste**: overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- **Abuse**: includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Fraud, Waste and Abuse

The Differences

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge.

- **Fraud** requires the person to have an intent to obtain payment and the knowledge that their actions are wrong.
- **Waste and Abuse** may involve obtaining an improper payment but does not require the same intent and knowledge.

Fraud, Waste and Abuse

Reporting

- Report any FWA concerns to Integrated's Compliance Department through the compliance hotline or email which is available 24 hours a day.

- Do not be concerned about whether it is fraud, waste, or abuse. Compliance will investigate and make the proper determination.

- **24 Hour - Compliance Hotline** – 954-381-7954
- **Email** - Compliance@ihcscorp.com

- Insurance Administration Services (IAS)
  Fraud Referrals via Compliance@ihcscorp.com

Fraud, Waste and Abuse

Preventing and Reporting

How Else Do You Prevent FWA?

- Look for suspicious activity.
- Conduct yourself in an ethical manner.
- Ensure accurate and timely data and billing.
- Know FWA policies and procedures, standards of conduct, laws, regulations, and reference CMS' guidance.
- Verify all information received.

Remember, Reporting FWA…

- Everyone must report suspected instances of FWA without fear of retaliation for making a good faith effort in reporting.
- Report any potential FWA concerns to your compliance department, or designee.
- Your compliance department, or designee, should investigate and make the proper determination.

Any confirmed instances of Fraud, Waste, or Abuse should be reported to IHCS's Enterprise Chief Compliance Officer upon confirmation of the non-compliance.

Fraud, Waste and Abuse

Recognizing Indicators

- In addition to knowing what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

- The following slides present issues that may be potential fraud, waste or abuse. They provide areas to keep an eye on, depending on whether the role is a sponsor, pharmacy, or other entity involved in the Medicare Part C and/or D programs.

Key Indicators

Potential Beneficiary Issues

- Does the prescription look altered or possibly forged?
- Have numerous identical prescriptions been filled for this beneficiary, possibly from different doctors?
- Is the person receiving the service/picking up the prescription the actual beneficiary (identity theft)?
- Is the prescription appropriate based on beneficiary's other prescriptions?
- Does the beneficiary's medical history support the services being requested?

Key Indicators

Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?
- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the Sponsor for services not provided?

Key Indicators

Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or “Dispense As Written”)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?
- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

Key Indicators

Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?
- Does the manufacturer promote off-label drug usage?
- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

Key Indicators

Potential Sponsor Issues

- Does the sponsor offer cash inducements for beneficiaries to join the plan?
- Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

Fraud, Waste and Abuse

Reporting and Correcting

- Employees are required to report suspected instances of fraud, waste, and abuse. Reporting can be done anonymously. There will be no retaliation for making a good faith effort in reporting suspected fraud, waste or abuse.
- Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with requirements.
- When issues have been identified, a plan to correct the issue needs to be developed. Consult Compliance to find out the process for the corrective action plan development. The actual plan is going to vary, depending on the specific circumstances.
- Serious non-compliance or FWA will be reported to the Centers for Medicare & Medicaid Services (CMS) and the National Benefit Integrity Medicare Drug Integrity Contractor (NBI Medic) by IHCS' Compliance Department.

Laws You Need To Know

- The Social Security Act is the foundation for the Medicare and Medicaid programs and governs how these programs are to be administered.
- In addition, overviews are provided on the following:
  - False Claims Act
  - Anti-Kickback Statute
  - Stark Statute (Physician Self-Referral Law)
  - Exclusion
  - HIPAA

False Claims Act

The **False Claims Act** prohibits:

- Presenting a false claim for payment or approval
- Making or using a false record or statement in support of a false claim
- Conspiring to violate the False Claims Act
- Falsely certifying the type/amount of property to be used by the government
- Certifying receipt of property without knowing if it is true
- Buying property from an unauthorized government officer
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the government

  - 31 United States Code § 3729-3733

False Claims Act

- **Damages and Penalties:**

  The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

- **Criminal Fraud Penalties:**

  If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

Stark Law

- The **Stark Law** prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

  - 42 United States Code §1395nn

- Medicare claims tainted by an arrangement that does not comply with Stark are not payable. There is up to a $15,000 fine for each service provided. There is up to a $100,000 fine for entering into an arrangement or scheme.

Exclusion

No federal healthcare program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the **Office of Inspector General.**

- 42 U.S.C. §1395(e)(1)
- 42 C.F.R. §1001.1901

Non-Retaliation

- The Whistleblower Protection Act of 1989 is a federal law that protects whistleblowers who report misconduct as it relates to fraud, waste, and abuse.
- **Whistleblowers**
  - A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- **Protected**
  - Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- An employer, employee, agency or independent contractor shall not dismiss, discipline, or take any other adverse personnel action against an employee for disclosing information pursuant to the provisions of FWA.
- An employer, employee, agency or independent contractor shall not take any adverse action that affects the rights or interests of a person in retaliation for the person's disclosure of information under FWA

FWA and HIPAA

Are They Related?

The Health Insurance Portability and Accountability Act created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry

- HIPAA outlines safeguards to prevent unauthorized access to protected health care information.
- As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Consequences of Committing

Fraud, Waste and Abuse

The following are potential penalties; the actual consequence depends on the violation:

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs

Congratulations

Congratulations! You have completed the 2026 Fraud, Waste and Abuse Training

The following is a summary of the key points from this training:

- Employees are required to comply with all requirements to prevent, detect, and report FWA.
- Any concerns should be reported to the Integrated Compliance Department at 954-381-7954.
- There will be no retaliation for making a good faith effort in reporting suspected FWA.
- Additional training and resources are available to address requirements that are specific to your area of responsibility.