

# Compliance Program and Fraud, Waste, and Abuse Provider Annual Training

Updated March 2026

# What is compliance?

- Compliance is an organization's responsibility to act in accordance with applicable laws, regulations, policies, procedures, and other explicit standards.
- Compliance is important for many reasons, but most importantly, it ensures funds are used appropriately to provide quality services to your community.
- Organizations create or have a compliance program to implement compliance plans and institute internal controls.
- While the fundamental elements of a compliance program are generally the same, the specific components of a compliance program depend on the organization's size and needs.

# Your role in healthcare provider compliance

- When you drive compliance, you ensure that the business you conduct is within the boundaries of the law, and guide your practice in acting ethically, legally, and responsibly.
- When you make ethical decisions and commit to doing the right thing, you build trust with your patients, managed care organizations, stakeholders, and regulators.

## All of us must:

- Act fairly and honestly
- Act with integrity, transparency, and accountability
- Adhere to high ethical standards in all of your practices
- Comply with all applicable laws, regulations, State Medicaid and CMS requirements
- Report suspected violations
- Do the right thing!

# Provider responsibilities

As a healthcare provider, you are responsible for:

- **being a vital part of the effort to prevent, detect, and report** noncompliance, fraud, waste, and/or abuse identified;
- **complying with all applicable statutory, regulatory, Medicaid and Medicare healthcare program requirements**, including adopting and implementing an effective compliance program;
- **reporting any violations** of laws that you may be aware of; it is your obligation and duty to report; and
- **following your organization's Code of Conduct**, a tool that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

# 7 Elements of Effective Compliance Programs

# Effective compliance programs consist of 7 elements



Written Standards,  
Policies, and  
Procedures



Compliance  
Leadership and  
Oversight



Training and  
Education



Effective Lines of  
Communication



Enforcement of  
Disciplinary  
Standards



Risk Assessment,  
Auditing, and  
Monitoring



Responding to  
Detected Offenses and  
Developing Corrective  
Action Initiatives

# 7 elements of effective compliance programs



## 1. Written Policies, Procedures, and Standards of Conduct

- These articulate the organization's commitment to comply with all applicable Federal and State standards and **describe the compliance expectations** according to the Standards of Conduct.
- Entities should **assess how their operations may present risk** areas specific to them and design policies and procedures that address these risks.



## 2. Compliance Officer, Compliance Committee, and High-Level Oversight

- The organization must **designate a compliance officer and a compliance committee** accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.
- The organization's **senior management and governing body must be engaged** and exercise reasonable oversight of the organization's compliance program.



## 3. Effective Training and Education

- This covers the elements of the **compliance plan** as well as preventing, detecting, and reporting suspected or actual fraud, waste, and abuse.
- **Tailor training and education to the different employees** and their responsibilities and job functions.

## 7 elements of effective compliance programs *(cont'd.)*



### 4. Effective Lines of Communication

- Make effective lines of communication **accessible to all**.
- **Ensure confidentiality** and provide methods for anonymous and good-faith issues reporting at all organizational levels.
- Having “effective lines of communication” means that **several avenues to report compliance concerns** are available.



### 5. Well-Publicized Disciplinary Standards

- The organization **must enforce standards** through well-publicized disciplinary guidelines.



### 6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

- **Conduct routine monitoring and auditing** of the organization’s operations to evaluate compliance with Federal and State requirements as well as the overall effectiveness of the compliance program.



### 7. Procedures and System for Prompt Response to Compliance Issues

- The organization must use effective **measures to respond promptly to non-compliance**, undertake appropriate corrective action, and report to government agencies, as required.

# A provider's compliance responsibilities and awareness

As a provider, you should be aware of high-risk areas to ensure your part in maintaining compliance. This includes, but is not limited to:

<b>Beneficiary Notices</b>	<b>Ethics</b>
<b>Billing Practices</b>	<b>Formulary Administration</b>
<b>Conflicts of Interest</b>	<b>HIPAA</b>
<b>Monthly Exclusion Screening</b>	<b>Quality of Care</b>
<b>Documentation Requirements</b>	

# Non-compliance and impact

## What is non-compliance?

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Non-compliance is conduct that does not conform to regulations, laws, state, and/or federal healthcare program requirements, or to Meridian's ethical and business policies.

## The effects of non-compliance

### *Damage to the patient:*

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Hurdles to care

### *Damage to everyone:*

- Higher insurance copayments
- Higher premiums
- Lower benefits for individuals/employers
- Lower profits

# Fraud, Waste, & Abuse Overview

## Healthcare fraud, waste, and abuse (FWA)

A compliance program contains measures to prevent, detect, and correct FWA. **We all have a role to play in detecting FWA.** Be alert for suspicious activities and report anything you notice.

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Compliance programs are **designed to ensure that we meet all legal, regulatory, and business requirements**, both domestic and international. They reflect our commitment to reduce the potential for non-compliance with these requirements.

## Definitions | Fraud

**Fraud** is the intentional deception or misrepresentation an individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes “reckless disregard” of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

For the purposes of this training, fraud is intentionally submitting false information (including situations in which you should have known the information was false) to get money or a benefit.

### **The complete definition has three primary components**

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit

## Definitions | Waste

**Waste** includes practices that, directly or indirectly, result in unnecessary costs to federally funded programs, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources. Examples include:

- Prescribing more prescriptions than necessary
- Conducting excessive and/or unnecessary laboratory tests
- Scheduling and billing unnecessary office visits

## Definitions | Abuse

**Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to federally funded programs. Abuse involves paying for items or services when there is no legal entitlement to that payment, resulting in:

- Unnecessary costs to the healthcare system
- Improper payment
- Payment for services that fail to meet professionally recognized standards of care
- Services that are medically unnecessary

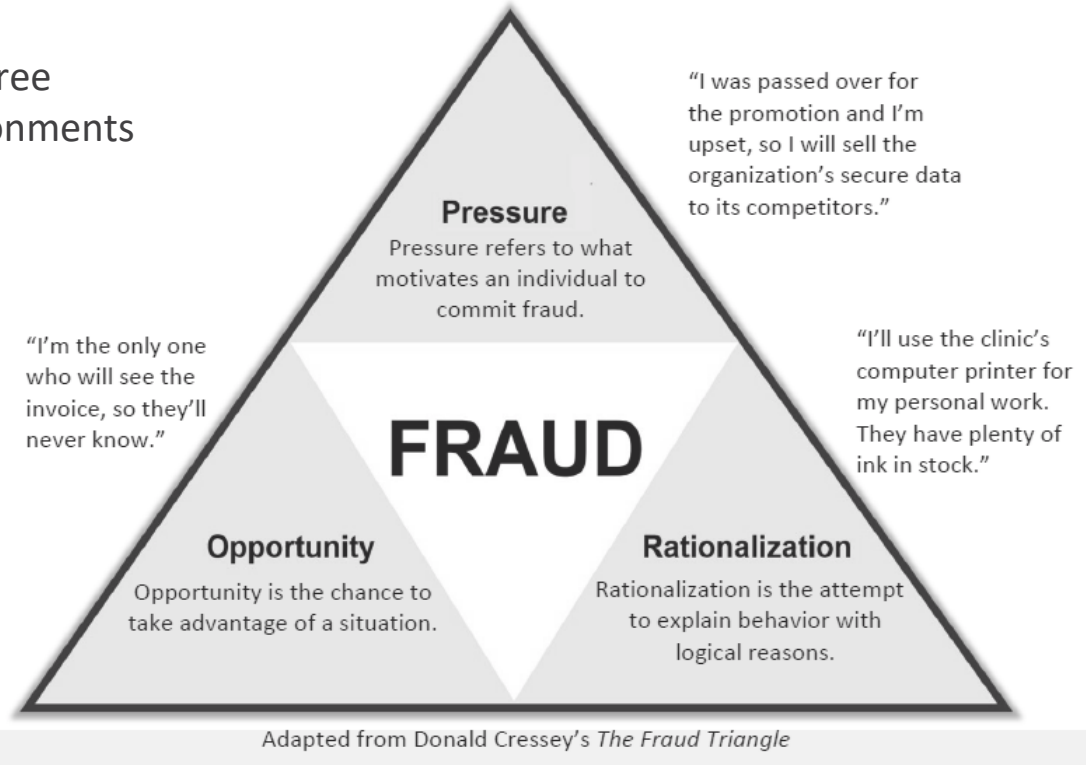
# The Fraud Triangle

The fraud triangle illustrates the three elements that are present in environments where fraud occurs.

## What can my organization do to prevent fraud?

Your organization can establish a compliance program to proactively avoid the vulnerabilities in The Fraud Triangle.

Additionally, your organization can identify issues early and, as part of your compliance program, build robust internal controls to prevent them.



# What are some examples of healthcare fraud?

Note the examples of fraud that can happen with healthcare providers.

Submitting false claims, such as claims for services that were not provided

Inflating costs reported on cost reports

Diverting prescription drugs

Offering or receiving kickbacks for patient referrals

Providing medically unnecessary care

# Healthcare Fraud Enforcement and Other Standards: Overview of Certain Federal Laws

# False Claims Act

**The False Claims Act (FCA) ([31 U.S.C. § § 3729-3733](#)) allows the federal government to recover damages and penalties from entities that knowingly submit, or knowingly cause to be submitted, false or fraudulent claims to the federal government, including to Medicare or Medicaid.**

Basically, the FCA protects the government from being overcharged, mischarged, or sold shoddy goods or services. The FCA defines "knowingly" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information.

The FCA prohibits filing a claim for an item or service that was not actually provided as claimed. Every time you submit a claim, you are, essentially, certifying that all the criteria for payment for that item or service on that claim have been met.

The Affordable Care Act (ACA) also expanded the range of health plan business subject to the FCA, and compliance must now be a significant concern in “non-government” lines of business (e.g., commercial insurance). Under Section 1313 of the ACA, payments made by, through, or in connection with an Exchange are subject to the FCA if the payments include any federal funds.

## False Claims Act (cont'd.)

Depending on the circumstances, some **examples of potential False Claims Act violations** in the healthcare fraud context include:

- Upcoding
- Billing for unnecessary services
- Billing for services or items that were not provided
- Billing for services performed by an excluded individual



**Failure to return overpayments** may lead to liability under the False Claims Act. Under section 1128J(d) of the Social Security Act, persons who have received an overpayment from a federal health care program must report and return the overpayment within 60 days of the date the overpayment was identified. Failure to do so may make the overpayment a false claim.



**Violation of the False Claims Act may lead to exclusion from federal health care programs**, along with criminal fines, imprisonment, and civil legal action for penalties and damages.

# Federal Anti-Kickback Statute

The Federal Anti-Kickback Statute (AKS) ([42 U.S.C. § 1320a-7b\(b\)](#)) is a criminal law that prohibits the knowing and willful exchange, offer to exchange, solicitation, or receipt of anything of value in an effort to influence, induce, or reward the referral of Federal health care program business, including the referral for Medicare, Medicaid, or IHS items and services, and arranging for or recommending such items and services.

It is important to understand that submitting a claim to Medicare, Medicaid, or another federal health care program that was the result of a kickback scheme, in addition to violating the criminal AKS, can also lead to liability under the False Claims Act.

## Examples of improper kickback relationships include:

- A diagnostic lab offers a nurse practitioner \$100 for each Medicare referral.
- An oncologist takes family vacations paid for by a pharmaceutical company in exchange for prescribing the company's drug in lieu of alternatives.
- A medical equipment company and a physician agree that the physician can establish a rent-free office in a space owned by the medical equipment company if the physician refers Medicaid patients to the company.

# Stark Law

The Prohibition on Certain Physician Referrals ([42 U.S.C. § 1395nn](#)) is frequently referred to as the “Stark Law,” after Peter Stark, the former member of Congress credited for the law’s enactment. **The Stark Law prohibits physicians from referring Medicare and Medicaid patients for “designated health services” (e.g., inpatient and outpatient hospital services, home health care services, clinical laboratory services, physical therapy, speech therapy, etc.) to entities with which the physician or an immediate family member has a financial relationship (ownership, investment, or compensation).**

- Additionally, the entities are prohibited from presenting or causing to be presented claims to Medicare or Medicaid (or billing another individual, entity, or third-party payer) for those referred services.
- For example, under the Stark Law, a general physician is prohibited from referring a patient to a physical therapy office that is owned by his wife unless an exception applies.
- As another example, a physician who is an employee of a hospital, and refers patients to that hospital, may not be paid above fair market value by the hospital.

# Civil Monetary Penalties Law

The Civil Monetary Penalty Law (CMPL) ([42 U.S.C. § 1320a-7a](#)) protects the government from a variety of improper conduct, including the submission of false claims related to HHS grant programs, federal contracts, or federal healthcare programs.

The Office of Inspector General (OIG) has the authority to seek penalties and exclusion from federal healthcare programs against an individual or entity based on a wide variety of prohibited conduct related to federal healthcare programs, HHS grants, and HHS contracts. The amount of civil monetary penalties imposed by the government depends on the conduct but can be up to \$20,000 per claim for the submission of false claims. In addition, the government may seek to recover up to three times the amount of damages or losses to the program.

## Violations include, but are not limited to:

- Submitting false claims
- Violating Medicare assignment provisions or the physician agreement
- Providing false or misleading information expected to influence a decision to discharge a patient
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency condition or in labor
- Making false statements on applications or contracts to participate in a federal health care program

## Exclusion provisions

The **OIG can exclude providers from federal health care programs** if the provider has committed certain acts, such as fraud or patient abuse.

- **OIG has authority ([42 U.S.C. § 1320a-7](#)) to exclude an individual or entity from participation as a provider or supplier in federal healthcare programs, including Medicare, Medicaid, and IHS, among others.**
- **The effect of an OIG exclusion is that no federal healthcare program payment may be made for any items or services furnished (1) by an excluded person or (2) at the medical direction or on the prescription of an excluded person.**
  - The exclusion and the payment prohibition continue to apply to an individual even if he or she changes from one health care profession to another while excluded.
  - This payment prohibition applies to all methods of federal healthcare program payment, whether from itemized claims, cost reports, fee schedules, capitated payments, a prospective payment system, other bundled payment, or other payment system—and applies even if the payment is made to a State agency or a person that is not excluded.

# Exclusion provisions *(cont'd.)*

There are two general types of exclusions

## Mandatory Exclusions

- Exclusions that **OIG *must* impose**
- Conduct that would result in a mandatory exclusion includes criminal convictions relating to Medicare or Medicaid fraud, patient abuse or neglect, and felony convictions related to controlled substances.

## Permissive Exclusions

- Exclusions that **OIG, in its discretion, *may* impose**
- Conduct that could result in a permissive exclusion includes misdemeanor offenses related to health care fraud, misdemeanor offenses related to controlled substances, loss of professional license in certain circumstances, and defaulting on student loans.

## The effects of exclusion

- The effect of exclusion is that **no payment shall be made by Medicare, Medicaid, IHS, or any other federal healthcare program** for services furnished, ordered, or prescribed by a person or entity who is excluded.
- This **prohibition on payment applies even when the excluded person would only indirectly receive payment**, for example, when a hospital bills Medicare for services provided by an excluded nurse.

## Criminal Health Care Fraud Statute

- The Criminal Health Care Fraud Statute is primarily found in 18 U.S. Code § 1347, which makes it a crime to knowingly and willfully execute a scheme to defraud a healthcare benefit program.
- This statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for healthcare benefits, items, or services to either:
  - Defraud any healthcare benefit program
  - 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 healthcare benefit program

**Conviction under the statute doesn't require proof that the violator knew the law or had specific intent to violate it.**

## Example of an identified liability



\*Note that the federal government is aware of the difference between a fraudulent claim and an innocent, erroneous claim. Even though billing errors do not rise to the level of fraud, providers should return payments received for claims submitted in error.

# Legal consequence awareness

Healthcare FWA is on the rise. Anti-fraud and abuse laws protect insurers, their employees and members, as well as public health benefit programs and taxpayer dollars.



## Legal Consequences

There are legal consequences for committing fraud, waste and abuse. The actual consequence depends on the violation. The following are potential penalties:

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- Civil Monetary Penalties
  - Criminal Conviction/Fines
  - Civil Prosecution
  - Imprisonment
  - Loss of Provider License
  - Exclusion from Federal Healthcare Programs

# Preventing fraud, waste, and abuse

## What are my responsibilities?

You play an important role in preventing, detecting, and reporting potential FWA.

- You must **comply with all applicable statutory, regulatory, and other requirements**, including adopting and using an effective compliance program.
- You have a duty to **report any compliance concerns** and suspected or actual violations.
- You have a duty to **follow your organization's code of conduct** that describes your and your organization's commitment to standards of conduct and ethical rules of behavior.

# How do I prevent fraud, waste, and abuse?

**Look** Look for suspicious activity

**Conduct** Conduct yourself in an ethical manner

**Ensure** Ensure accurate and timely data and billing

**Ensure** Ensure coordination with other payers

**Know** Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance

**Verify** Verify all information you receive

# Reporting FWA

**With your help, we can increase the detection and prevention of fraud, waste, and abuse** to improve the quality, safety, and value of Health and Human Services (HHS) programs. If you suspect fraud, waste, or abuse, you may report the information that suggests dishonest or illegal activities involving HHS programs.

- One method of reporting fraud, waste, or abuse is to contact the **OIG Hotline**.  
OIG protects certain current and former HHS employees; HHS employment applicants; and HHS contractors, subcontractors, personal services contractors, grantees, and subgrantees who disclose information to OIG through mechanisms such as the OIG hotline.
- Another method of reporting is to self-disclose if you suspect the law or program requirements have been violated. **OIG's Health Care Fraud Self-Disclosure Program** provides a framework for disclosing, coordinating, evaluating, and resolving potential violations of law.

**Contact your Compliance Officer for specific guidance on reporting FWA in your organization.**


# Reporting FWA | Where to report

## Meridian Health Plan of Illinois (Centene Special Investigations Unit)

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 24/7 Confidential FWA Hotline: **1-866-685-8664**

 [special\\_investigations\\_unit@centene.com](mailto:special_investigations_unit@centene.com)

 Centene Special Investigations  
7700 Forsyth Blvd, Suite 519  
Clayton, MO 63105-1807

## Illinois Department of Healthcare and Family Services (HFS)

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 **1-844-ILFRAUD** (1-844-453-7283)


 HFS Office of Inspector General  
**Provider Fraud Complaint Portal**  
([hfs.illinois.gov/oig/report\\_fraud](https://hfs.illinois.gov/oig/report_fraud))


## Federal Reporting (Medicare): U.S. Department of Health and Human Services Office of Inspector General (OIG)

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 **1-800-HHS-TIPS** (1-800-447-8477)

 **HHS-OIG Online Complaints**  
([tips.oig.hhs.gov](https://tips.oig.hhs.gov))

 Fax: 1-800-223-8164

 U.S. Department of Health and Human  
Services - Office of Inspector General  
ATTN: OIG Hotline Operations  
P.O. Box 23489  
Washington, DC 20026

# Resources

## Illinois

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- The **Illinois Department of Healthcare and Family Services (HFS) Office of Inspector General website** provides details on how to report suspected fraud and provider self-disclosure instructions. The website also offers a searchable list of [providers with active sanctions](#).
- The **Illinois Attorney General's Medicaid Fraud Control Unit (MFCU)** allows individuals to report suspected fraud, patient abuse, or neglect.
- **Illinois Department of Human Services (IDHS) Home Services Program (HSP) Fraud Unit**

## Federal

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- **OIG [Hotline Operations website](#)**: Accepts tips from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs
- **OIG [Compliance Resources](#)**: Includes the [General Compliance Program Guidance reference guide](#) and educational materials such as compliance toolkits, videos, podcasts, and advisory opinions.
- **OIG [HEAT Provider Compliance Training](#)**
- **OIG [Fraud Information website](#)**: Includes information such as OIG's Consumer Alerts; criminal, civil, or administrative legal actions; a tips and complaints hotline; and a list of fugitives wanted for health care fraud, abuse, or child support obligations.
- **OIG: [General Questions Regarding Certain Fraud and Abuse Authorities](#)**
- **CMS: [Medicaid Integrity Program – Educational Resources](#)**
- **CMS: [“Laws Against Health Care Fraud” Fact Sheet](#)**
- **CMS: [Combatting Medicare Parts C & D Fraud, Waste, and Abuse Training](#)**

# Disclaimer

This course was prepared as a service and is not intended to grant rights or impose obligations.

The information provided is only intended to be a general summary. It is not legal advice nor a substitute for independent review of the applicable laws, statutes, or regulations.

We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents and consult independent legal counsel.



# Thank you