

CENTERS FOR MEDICARE & MEDICAID SERVICES CONTINUING EDUCATION (CMSCE)

06-08-2016 HEALTH CARE FRAUD: Protect Yourself & Your Practice

Continuing Education (CE) Activity Information & Instructions *(Live Activity # IP-06082016)*

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Continuing Education Credit Information

Continuing Education Credit

Accreditation Council for Continuing Medical Education (ACCME)

The Centers for Medicare & Medicaid Services (CMS) designates this **live activity** for a maximum of **6 AMA PRA Category 1 Credit™**. Physicians should only claim credit commensurate with the extent of their participation in the activity. Credit for this course expires at midnight on **June 27, 2016**.

International Association for Continuing Education and Training (IACET)

The Centers for Medicare & Medicaid Services (CMS) is authorized by IACET to offer **.6 Continuing Education Unit (CEU)** for this activity. CEU will be awarded to participants who meet all criteria for successful completion of this educational activity. CEU credit for this course expires at midnight on **June 27, 2016**.

Accreditation Statements

[Please click here for accreditation statements.](#)

Instructions for Continuing Education Credit

The Medicare Learning Network® (MLN) recently upgraded its Learning Management and Product Ordering System (LM/POS).

If you were already registered in the former MLN Learning Management System (LMS), you do not need to create a new login or password for the LM/POS. However, the appearance of the system and instructions for registering, logging-in, accessing courses, and obtaining certificate information have all changed.

For more information on the new LM/POS, please visit <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LMS-Upgrade.pdf>.

Learning Management and Product Ordering System (LM/POS) Instructions

In order to receive continuing education credit for this live activity, you must pass the session post-assessment and complete the evaluation. The continuing education post-assessments and evaluations are being administered through the Medicare Learning Network®.

The post-assessment will be available on the Medicare Learning Network® (MLN) Learning Management and Product Ordering System (LMS/POS). Participants will need to login or register to access the post-assessment.

Registering To Take a Post-Assessment

If you have previously taken Medicare Learning Network® (MLN) web-based training courses, you may use the login ID and password you created for those courses. If you are a new user, you will need to register.

To register (if you do NOT have an account):

1. Go to the LM/POS Homepage <https://learner.mlnlms.com>;
2. Click on “Create Account;” and
3. Enter information for all the required fields (with the red asterisks) and click “Create.”

***NOTE:** When you get to the ‘Organization’ field, click on Select. From the ‘Select Organizations’ screen, leave the ‘Find Organization’ field blank and click Search. Select ‘CMS-MLN Learners Domain - Organization’ and click Save.

Please add MLN@cms.hhs.gov to your address book to prevent MLN communication from going into your spam folder.

To login (if you already have an account):

1. Go to the LM/POS Homepage <https://learner.mlnlms.com>; and
2. Enter your login ID and password and click on “Log In.”

Finding the Post-Assessment:

1. Go to the LM/POS Homepage <https://learner.mlnlms.com>;
2. Enter your login ID and password and click on “Log In;”
3. Click on “Training Catalog” in the menu beneath the MLN logo;
4. Enter “**06-08-2016 HEALTH CARE FRAUD: Protect Yourself & Your Practice**” in the “search for” box and click “search;”
5. Click on the title;
6. Click “Enroll;”
7. Click “Access Item;”
8. Scroll down on the page and click on the link titled “Post-Assessment;”
9. Click “Open Item;”
10. A new window will open. Click “Post-Assessment” in this new window for it to display;
11. Complete the assessment and click “close;”
12. Click the grey and white “x” in the upper right-hand corner to close the window; and
13. Click “OK” when prompted about closing the window.

Accessing Your Transcript and Certificate

[Please click here for instructions for accessing your transcript and certificate.](#)

For questions regarding continuing education credit contact CMSCE@cms.hhs.gov via email.

Hardware/Software Requirements

[Please click here for hardware and software requirements.](#)

CMS Privacy Policy

[Please click here for CMS' Privacy Policy.](#)

Help

For assistance with questions regarding the post-assessment, your certificate, the Medicare Learning Network® (MLN) Learning Management and Product Ordering System (LM/POS), or continuing education in general, please contact CMSCE at CMSCE@cms.hhs.gov via email.



Activity Information

Activity Description

The Department of Health and Human Services (HHS) has made reducing fraud, waste, and abuse a top priority for HHS and the Centers for Medicare & Medicaid Services (CMS). The goal of this symposium is to educate and raise the awareness of our providers by making available information and resources regarding CMS' Program initiatives in the prevention, detection, and reduction of fraud, waste, and abuse (FWA).

Target Audience

This activity is designed for health care professionals.

Learning Objective

By the end of this presentation, learners should be able to:

- Recognize key program integrity provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA);
- Define Open Payments;
- Define medical identity theft;
- Recognize methods to prevent theft in the medical practice;
- Identify common audit findings in the Medicaid Managed Care Program;
- Identify top Part C and Part D Schemes;
- Identify Centers for Medicare & Medicaid Services (CMS) compliance programs;
- Identify different organizations responsible for auditing CMS programs;
- Recognize top issues identified by CMS audit contractors; and
- Recognize ways that law enforcement and the medical community are working together.

Participation

Register for and participate in the in-person activity. After the activity concludes, access and complete the post-assessment and evaluation per the instructions in this document.

Speaker Bios & Disclosures (alphabetical by last name)

All planners and developers of this activity have signed a disclosure statement indicating any relevant financial interests. This activity was developed without commercial support.

Shantanu Agrawal, MD, is a Board-Certified Emergency Medicine Physician and Fellow of the American Academy of Emergency Medicine. He is currently serving as an appointee for the Obama Administration as Deputy Administrator for Program Integrity and Director of the Center for Program Integrity (CPI) at the Centers for Medicare & Medicaid Services (CMS). His focus is to improve healthcare affordability and value in Medicare, Medicaid, and Affordable Care Act (ACA) Marketplace. Prior to this role, Dr. Agrawal served as Chief Medical Officer of the Center for Program Integrity, where he helped to launch new initiatives in data transparency and analytics, utilization management, assessment of novel payment models, and a major public-private partnership between CMS and private payers.

Prior to joining CMS, Dr. Agrawal was a management consultant at McKinsey & Company, serving senior management of hospitals, health systems, and biotech and pharmaceutical companies on projects to improve the quality and efficiency of healthcare delivery. Dr. Agrawal has also worked for a full-risk, capitated delivery system as the head of clinical innovation and efficiency. He has

published articles in the Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM), Annals of Emergency Medicine, Politics & Policy, among others, and has given national presentations on health care policy and the cost of care.

Dr. Agrawal completed his undergraduate education at Brown University, medical education at Cornell University Medical College, and clinical training at the Hospital of the University of Pennsylvania. He also has a Master's degree in Social and Political Sciences from Cambridge University. Dr. Agrawal has continued to work clinically both in academic and community settings and holds an academic position in Washington, DC.

Dr. Agrawal has nothing to disclose.

Elizabeth Brady, MBA, has been employed by the Centers for Medicare & Medicaid Services (CMS) since February 2011, as a Health Insurance Specialist in the Center for Program Integrity's (CPI's) Investigations and Audit Group in the Division of Plan Oversight and Accountability. From June 2007 through February 2011, she was employed by General Dynamics Information Technology, as a Manager providing anti-healthcare fraud consulting services to health payers. Prior to that position, Ms. Brady was employed by a Medicare Program Safeguard Contractor and a number of Medicare Carriers and Intermediaries.

Ms. Brady is a Certified Fraud Examiner (CFE) and an Accredited Healthcare Fraud Investigator (AHFI) with many years of experience in the detection, prevention, and investigation of healthcare fraud. Ms. Brady has presented fraud, waste, and abuse (FWA) topics on numerous occasions throughout her career.

Ms. Brady earned a Master of Business Administration degree in Health Care Administration at Adelphi Univeristy.

Ms. Brady has nothing to disclose.

Zabeen Chong, MS, has been employed by the Centers for Medicare & Medicaid Services (CMS) since 2002 and has extensive background in Medicare and Medicaid enrollment operations. Prior to her current position, she served as the Director of the Website Project Management Group at CMS, where she led the redesign and implementation of new technologies on www.medicare.gov and www.cms.gov as well as other web-based initiatives critical to advancing the Agency's mission and operations.

Ms. Chong has been the director of Provider Enrollment Operations Group (PEOG) since 2010 and is responsible for oversight and operations of the policy and systems related to Medicare and Medicaid enrollment. Her responsibilities include management of the Provider Enrollment Chain, and Ownership System (PECOS) and the National Plan & Provider Enumeration System (NPPES) systems. She is also responsible for initiatives to streamline the Medicare and Medicaid provider enrollment process including: establishing stakeholder focus groups, implementing enhancements to the PECOS system, and developing solutions that will better suit the diverse needs of the stakeholder community including providers, States, and other Federal agencies. Ms. Chong's additional responsibilities include development of provider enrollment operating policy and procedures for the processing of Medicare enrollment applications and enumeration of provider applicants and identification of vulnerabilities and implementation of processes directed at preventing fraud and abuse in Medicare and Medicaid provider enrollment.

Ms. Chong earned a Master's Degree in Information Systems at Johns Hopkins University.

Ms. Chong has nothing to disclose.

Susan Crowe, JD, has been with Humana since November, 2011. During her time with Humana, she has served in both legal and compliance capacities. Ms. Crowe became Humana's Medicare Compliance Officer in June, 2014. Prior to joining Humana, she practiced health care law at the firm of Stites & Harbison, as a member of the firm's Health Law Practice Group. After leaving private practice, she served as Associate General Counsel for KentuckyOne Health, a regional health care organization with over 70 health care facilities in and around Louisville, Kentucky.

Ms. Crowe earned her Doctor of Law degree at the University of Kentucky in 2005. Throughout her professional career she has participated in the development and implementation of training materials on various health law related topics, including fraud, waste, and abuse laws and Medicare program requirements.

Ms. Crowe has disclosed that she is an employee and stock shareholder of Humana.

Jessica Dresner, MEd, has been Director of the Missouri Medicaid Audit and Compliance Unit (MMAC) since 2013. She began her career with the Missouri Department of Social Services in 2011. Prior to that, she had a career in law enforcement.

As MMAC Director, Ms. Dresner oversees enrollment, audits and investigations, and sanctions for approximately 55,000 Fee-for-Service (FFS) Medicaid providers, continually seeking to educate them regarding services and billing as an integral part of the process. Missouri is a partial managed care state. Ms. Dresner is actively working with the Missouri State Medicaid Agency to develop "best practices" in managed care oversight.

Ms. Dresner earned a Master of Education degree in Education and Counseling Psychology at Stephens College. She has presented training courses and done public speaking as a certified instructor for approximately 30 years.

Ms. Dresner has nothing to disclose.

Daniel J. Duvall, MD, is the Chief Medical Officer for the Center for Program Integrity (CPI) and an emergency medicine physician. He is responsible for advising the Center on the clinical implications of healthcare fraud as it relates to Medicare, Medicaid, and the Exchange. Prior to joining CPI, Dr. Duvall was a Medical Officer in the Centers for Medicare & Medicaid Services' (CMS') Medicare Hospital Policy area. He has also spent a number of years working for a Blue Cross plan in their Medicare, Medicaid, and commercial operations, where his focus was on claims processing, automation, and process improvement. Dr. Duvall has practiced in both large academic and small rural settings, including the North Slope, New Zealand, and Saudi Arabia.

As CPI's Chief Medical Officer, Dr. Duvall regularly speaks on healthcare fraud, waste, and abuse (FWA), both to industry groups and healthcare professionals, as well as to those charged with combatting that fraud.

Dr. Duvall earned a Doctor of Medicine degree at Georgetown University School of Medicine.

Dr. Duvall has nothing to disclose.

Scott Dyer, MBA, MS, has been employed by the Defense Criminal Investigative Service (DCIS) in Wichita as a Special Agent, since January 2004. Prior to that, he worked for the Department of Justice in the Office of Inspector General's Fraud Detection Office, in Washington, DC. Prior to working with the OIG, he was an Officer and Special Agent working for the US Air Force's Office of Special Investigations in Charleston, SC and Dayton, OH. Special Agent Dyer has been a fraud investigator for various federal agencies for 19 years, and over those years he has presented numerous investigations at fraud symposiums and training seminars to a variety of audiences.

Special Agent Dyer has a Bachelor's of Science Degree in Management from the US Air Force Academy, a Master's Degree in Business Administration from Webster University, and a Master's of Science degree in Criminal Justice with an emphasis on White Collar Crime from the University of Alabama-Birmingham.

Special Agent Dyer has nothing to disclose.

Ross Heflin, MBA, is currently the Vice President of Operations and Program Director for AdvanceMed, a CMS Zone Program Integrity Contractor (ZPIC) for Zone 2. He has worked in the Medicare and Medicaid fraud and abuse industry for 21 years in numerous roles such as Investigations Manager, Program Director, and Fraud Specialist. During his career he has worked for four Centers for Medicare & Medicaid Services (CMS) contractors, each charged with investigating fraud and abuse allegations to protect Federal health program dollars. Mr. Heflin has worked on investigations in all high risk areas of fraud and abuse activity. He served as a Benefit Integrity Manger for six years for CIGNA and AdvanceMed, Director of Benefit Integrity at AdvanceMed, and Program Director for five years with TrustSolutions. Additionally, Mr. Heflin served as the National Durable Medical Equipment (DME) Medicare Fraud Specialist for all 50 states for 7 years. During this time, he led regional and national fraud training conferences for Federal and State Law Enforcement on behalf of CMS, while also delivering over 250 presentations to various health care industry organizations, hospitals, home health agencies, physician groups, and assisted living/nursing home associations.

Mr. Heflin earned a Master of Business Administration degree in Business Management at Belmont University's Massey Business School.

Mr. Heflin has nothing to disclose.

Stefani Hepford, JD, has served as an Assistant Attorney General in the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office since 2008. As senior prosecutor, her case load is focused on a wide range of issues, such as home health care, nursing, pill mills, durable medical equipment, Medicaid billing agencies, and abuse of elders and disabled adults. Ms. also Hepford was serves as a Special Assistant United States Attorney. In this role, she prosecutes complex cases of Federal health care fraud and related crimes in the United States District Court for the District of Kansas.

Prior to joining the Attorney General's Office, Ms. Hepford was in private practice in Kansas City, focusing on real estate issues and litigation. She is a member of the Women Attorney's Association of Topeka and the Attorney General's Senior Consumer Protection Advisory Council.

Ms. Hepford has presented to a wide variety of audiences across Kansas on the topics of health care fraud, identity theft, and prosecution of crimes against vulnerable adults. Her article, "Getting Better with Age: Statutory Changes to Protect our Elders" was published in the March 2015 issue of the Kansas Bar Journal.

Ms. Hepford earned a Doctor of Law degree at the University of Kansas School of Law.

Ms. Hepford has nothing to disclose.

Christa Jewsbury, JD, joined Humana in 2012, as Manager of the Internal Audit Department's Fraud & Investigations Team. She developed and led an internal consortium of all investigative teams throughout Humana to implement consistent policies and standards, as well as ensure effective communication and collaboration between the investigative teams. Ms. Jewsbury was named Director of Humana's Special Investigations Unit (SIU) in early 2014. She actively participates in and represents Humana in the Healthcare Fraud Prevention Partnership (HFPP), the National Health Care Anti-Fraud Association (NHCAA), and other fraud associations and taskforces.

Prior to joining Humana, Ms. Jewsbury served as a Deputy Attorney General with the Indiana Medicaid Fraud Control Unit (MFCU) and with a private law firm litigating corporate regulatory matters. While at the Indiana MFCU, Ms. Jewsbury litigated Medicaid fraud, provider licensing, and patient abuse cases in tandem with the Office of the United States Attorney (U.S. Attorney's office) and local prosecutors. She also coordinated healthcare fraud investigations with Federal and State agencies, including the United States Department of Health and Human Services' Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), and local law enforcement.

Ms. Jewsbury frequently provides training to fraud investigators throughout the country at conferences hosted by national fraud and healthcare fraud associations. She also developed training curriculum for Humana's investigative teams, including her SIU department.

Ms. Jewsbury earned a Doctor of Law degree in health law at the University of Indiana, Bloomington and maintains credentials as a Certified Fraud Examiner (CFE) and an Accredited Healthcare Fraud Investigator (AHFI).

Ms. Jewsbury has disclosed that she is an employee and stock shareholder of Humana.

Kevin Larm has been employed as a Special Agent with United States Department of Health and Human Services (HHS) since 2008. He participated in an investigation that is being presented by the panel.

Special Agent Larm earned a Bachelor of Arts degree in Political Science at Rockhurst.

Special Agent Larm has nothing to disclose.

Kris Martin has been the Jurisdiction 5 (J5) Medicare Administrative Contractor (MAC) Program Manager since WPS was awarded the contract in 2007. Her responsibilities include ensuring compliance with the MAC Statement of Work, as well as general oversight for the J5 contract.

Ms. Martin has extensive experience in Medicare, having worked in the Fiscal Intermediary (FI) and MAC environments since 1992. She has held multiple supervisory, management, and project management positions in her tenure with Medicare. Ms. Martin has also been responsible for training, as well as working with complex beneficiary and provider issues. She has coordinated with the Federal Bureau of Investigation (FBI), Office of Inspector General (OIG), and Government Accountability Office (GAO) on various provider issues, and has assisted with investigations.

Ms. Martin earned a Bachelor of Arts degree in English at Iowa State University.

Ms. Martin has nothing to disclose.

Kory D. Patrick, MBA, has been employed as a Special Agent by the Federal Bureau of Investigation (FBI) since June 2005. During his tenure with the FBI, Mr. Patrick has investigated computer intrusions targeting highly-sophisticated Advanced Persistent Threat (APT) actors, as well as financially and ideologically-motivated actors targeting critical infrastructure. He also coordinated international investigations targeting cyber criminals active in the cyber underground.

Special Agent Patrick is an FBI Adjunct Faculty member and a certified FBI instructor. Prior to the working with the FBI, Mr. Patrick was employed by a Technology Center providing continuing adult education on technology subjects. Mr. Patrick is a Certified Information Systems Security Professional (CISSP) and holds many other industry certifications.

Special Agent Patrick earned both a Master of Business Administration degree and a Bachelor's of Science degree in Management Information Systems at Oklahoma State University.

Special Agent Patrick has nothing to disclose.

Nanette Foster Reilly has been employed by the Centers for Medicare & Medicaid Services (CMS) since 1995. From 2008 to the present, she has been the Consortium Administrator for the Consortium for Financial Management and Fee-for-Service Operations (CFMFFSO). Prior to this position, Ms. Foster Reilly was the Associate Regional Administrator for the Kansas City Division of CFMFFSO and the Kansas City Division of Medicare Operations. She has also been detailed to CMS Central Office as the Acting Director of the Medicaid Integrity Group and Acting Group Director/Acting Deputy Director in the Center for Medicaid and Children's Health Insurance Program (CHIP) Services. She is also a graduate of the United States Department of Health and Human Services (HHS) Senior Executive Service Candidate Development Program.

Ms. Foster Reilly has expert knowledge of CMS' programs, initiatives and related program integrity activities. Throughout her 20+ years with CMS, she has developed and presented educational material to both internal and external audiences, through a variety of mechanisms, on CMS' programs and initiatives, including fraud and abuse.

Ms. Foster Reilly earned a Bachelor of Arts degree in Education and Speech at the University of Northern Iowa.

Ms. Foster Reilly has nothing to disclose.

Erin W. Skinner, JD, joined the Centers for Medicare & Medicaid Services' (CMS'), Center for Program Integrity (CPI) Data Sharing and Partnership Group (DSPG), which helps detect fraud by improving data sharing among government and private insurance programs, in July 2015. Before joining DSPG, she worked in the Center for Medicare (CM), Chronic Care Policy Group (CCPG), Division of Technical Payment Policy (DTPP) with the Physician Self-Referral Disclosure Protocol (SRDP). Ms. Skinner joined CMS and the Center for Medicare's (CM's) Medicare Parts C & D Oversight and Enforcement Group (MOEG) (f/k/a Program Compliance and Oversight Group or PCOG) in 2010 and worked in Medicare Part C & D compliance and enforcement. In 2014, she transitioned to the Office of Hearings and Inquiries (OHI), Marketplace Appeals Groups (MAG), where she adjudicated marketplace eligibility appeals and served as a policy analyst.

Ms. Skinner earned a Doctor of Law degree with honors at the University of Baltimore and has developed education materials on open payments in various formats, such as printed materials and slide presentations.

Ms. Skinner has nothing to disclose.

Abbie Toney, JD, MBA, is a Compliance Lead for Aetna. She has worked in Aetna's Medicare Compliance department as a subject matter expert on fraud, waste, and abuse (FWA) and first tier, downstream, and related entity oversight since 2013.

Ms. Toney earned both a Doctor of Law degree and a Master of Business Administration degree at Drake University. She also earned a Bachelor's Degree in Business Administration at Carnegie Mellon University. She has conducted teleconferences and provided one on one training to provider organizations, and other external parties, on the Medicare compliance program requirements.

Ms. Toney has disclosed that she is an employee and stock shareholder of Aetna.

Tanya J. Treadway, JD, has been with the United States Attorney's Office in the District of Kansas since 1990. For the past 20 years, she has specialized in the prosecution of health care fraud. Ms. Treadway is a nationally-recognized expert in prosecuting federal health care crimes, and is a frequent speaker and educator on the topic of health care fraud.

Ms. Treadway earned a Doctor of Law degree at the University of Kansas School of Law.

Ms. Treadway has nothing to disclose.

Barret Wolters has been employed by Missouri Medicaid Audit and Compliance (MMAC) Services as the Investigations and Terminations Manager, since November 2015. From July 2014 through November 2015, Mr. Wolters served as the Investigations Supervisor for MMAC and from September 2012 through July 2014, he served as an Investigator II with MMAC. He was employed as a Police Officer with the Jefferson City Missouri Police Department, serving as a Detective for six years of his nearly 17 years of service with the department, from December 1995 through September 2012.

Mr. Wolters earned a Bachelor of Science degree in Criminal Justice with a Minor in Sociology at Lincoln University and is a Certified Program Integrity Professional (CPIP). He has conducted

presentations to Medicaid providers on fraud prevention and detecting Medicaid fraud, waste, and abuse.

Mr. Wolters has nothing to disclose.

Mary Woon joined HealthDataInsights (HDI) as Director of Provider Services in November, 2009 and was named as the Project Director for the Region D Recovery Auditor in February, 2011. As Project Director of the Region D Recovery Auditor, Ms. Woon is accountable for providing the work direction for Region D and responsible for ensuring compliance with the Recovery Auditor Statement of Work. She has over 35 years of operational and management experience in the health insurance industry, with over 15 years of that experience in Medicare and Recovery Auditor managerial positions.

Ms. Woon has acquired extensive experience in Provider outreach and education in her current position as Project Director of the Region D Recovery Auditor and in her prior positions as Manager of Outreach and Education for WPS, a Medicare Administrative Contractor (MAC), and Mutual of Omaha Medicare, a Fiscal Intermediary (FI). She has developed educational materials, including slide presentations and printed materials and delivered education by webinars, teleconferences, seminars, and partnerings with other Centers for Medicare & Medicaid Services (CMS) Contractors.

Ms. Woon has nothing to disclose.