Program Integrity Webinar 1-23-18 Transcript

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1	Introduction to Program Integrity: DMC-ODS	Welcome. This is a brief introduction to program integrity, provided by the County of San Diego Behavioral Health Services SUD Quality Management team. It is meant to be a resource for your program or legal entity as you review existing policies and procedures regarding program integrity, or create new ones. The webinar takes approximately 30 minutes to complete.
2	Objectives	Our objectives for this session are to: • Understand the importance of Program Integrity • Define Fraud, Waste and Abuse (often abbreviated as "FWA") • Identify Federal and State Agencies that combat FWA • Identify Applicable FWA Laws • Understand the process for reporting suspected FWA to the County • Explain the County's requirement for Paid Services Verification and the monitoring process for that • Provide resources related to Program Integrity
3	Program Integrity Defined	Let's start off with one definition of program integrity: The goal of <u>Program Integrity</u> is to <u>create a culture</u> of providing better health outcomes while <u>avoiding over- or underutilization of services</u>. This requires <u>effective program management</u> and <u>ongoing program monitoring</u>.
4	Effective PI Will Ensure	Effective program integrity will ensure: 1. Accurate eligibility determination 2. Prospective and current providers meet state and federal participation requirements 3. Services provided to beneficiaries are medically necessary and appropriate 4. Provider payments are made in the correct amount and only for covered services We will talk more about all of these in this presentation, but a few specific DMC-ODS considerations regarding numbers 1 and 3 before moving too far ahead…
5	Accurate Eligibility Determination	Regarding accurate eligibility determination, Drug Medi-Cal eligibility currently is verified at intake, when a client becomes Medi-Cal eligible, and monthly for the duration of services The County is planning on incorporating functionality in SanWITS that will assist with eligibility determination; however, this will take some time. What process will you have prior to this functionality in SanWITS? Is your current process sufficient? Other considerations – how do you know a client is using their own Medi-Cal and not someone else's? What process is in place to verify identity? Once verified, what's your process for monthly verification? What monitoring activities are in place to assure each client's Medi-Cal eligibility is checked monthly? This is one example of the type of questions a thorough Program Integrity or Compliance plan will address.
6	Medical Necessity	Another area is medical necessity. The definition of Medical Necessity in the Drug Medi-Cal Organized Delivery System is as follows: Adult clients (ages 21 and older) must have at least one diagnosis from the current DSM for a Substance Use Disorder, excluding Tobacco-Related

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		Disorders and non-substance related disorders (like gambling). For Youth/Young Adults ages 12-20), EPSDT broadens the definition of medical necessity to include individuals who either meet DSM criteria specified for adults, or are assessed to be "at risk" for a substance use disorder. Additionally, all clients must meet the ASAM Criteria definition of medical necessity for services. Some considerations: what processes are in place to assure accuracy of DSM diagnosis? What processes are in place or in development to assure ASAM Criteria are used competently? These are a few more examples of the types of questions your program should be considering as your operationalize service provision in the DMC-ODS, and assuring your program integrity in the process. Now, let's look at three terms at the heart of program integrity – Fraud, Waste and Abuse.
7	Fraud	There are four components of the statutory definition of fraud: Drug Medi-Cal FRAUD involves 1. making false statements or misrepresentation of material facts 2. In order to obtain some benefit or payment for which no entitlement would otherwise exist. 3. The acts may be committed for the person's own benefit or for the benefit of another party. 4. In order to be considered fraud, the act must be performed knowingly, willfully and intentionally. <u>Example:</u> Purposely billing for services that were never given
8	Fraud	Anyone can commit health care fraud. Fraud schemes range from solo ventures to broad-based operations by an institution or group. Other examples of fraud include: Billing Drug Medi-Cal for appointments the client failed to keep (i.e. billing for "no shows") Falsifying a diagnosis so, on paper, client will meet "medical necessity." Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file Knowingly falsifying records in order to claim for a service higher than what was actually provided Drug Medi-Cal Fraud is **illegal**. Committing fraud exposes individuals or entities to potential criminal and civil liability, and may lead to imprisonment, fines, and penalties. Criminal and civil penalties for fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud risk exclusion from participating in all Federal health care programs and risk losing their professional licenses.
9	Waste	Waste is not defined in statute, but is generally understood to refer to as health care spending that can be eliminated without reducing the quality of care. Generally waste is understood to refer to overutilization or inappropriate utilization of services, and misuse of resources. One example is poor or inefficient billing methods, such as data entry errors. Without proper processes in place to monitor the integrity of data entry for billing, services can be over billed costing the Drug Medi-Cal system money in error.
10	Abuse	Abuse includes provider practices that are inconsistent with sound fiscal,

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		business, or medical practices, and result in an unnecessary cost to the Drug Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care and health care coding. One example of abuse would be providing services at a higher level of care to a client who does not meet medical necessity for that level. For example, admitting a client to a residential program who does not meet the ASAM Criteria risk ratings for that level of care.
11	DMC-ODS Benefit "Phases"	Let's put fraud, waste and abuse into context. Imagine that each client goes through certain "phases" of utilizing their Drug Medi-Cal benefit while receiving services at your program. The phases can be thought of eligibility, coverage and payment. As previously mentioned, benefit eligibility is determined both initially and ongoing. Services are part of a Drug Medi-Cal Organized Delivery system "benefit package" that constitutes the client's coverage, with medical necessity requirements defined for each modality. And obviously payment is the final phase of each month of service. Fraud, Waste, and Abuse can be in <u>every</u> phase of <u>every</u> program and will include acts of both commission (that is, done intentionally) and omission (that is, done due to carelessness).
12	Activities Causing Improper Payments	Moving into the Drug Medi-Cal Organized Delivery system offers an opportunity to examine all your legal entity and/or program processes to decrease instances of improper payment. Program integrity encompasses a range of activities targeting various causes of improper payments. This slide represents examples along the spectrum of causes of improper payments. For example, mistakes result in errors – data entry errors can cause overbilling and therefore overpayment by Drug Medi-Cal. In Quality Management, we've seen examples of this that have caused thousands of dollars of overpayment, like when someone provided a service for 15 minutes but accidentally entered it as 15 hours. Process inefficiencies can result in waste – an example from medical practices is ordering excessive diagnostic tests. "Bending the rules" results in abuse – for example, when someone claims to a higher paying service from the one that was actually provided. (This is referred to as "Up coding") And intentional deceptions result in fraud – as we mentioned previously, for example, billing for services that were not provided. So why is this so important?
13	The Cost of "FWA"	Fraud, waste and abuse create a terrible cost for the system. This slide reflects information from the Centers for Medicare & Medicaid Services (CMS) for the percentage of loss related to fraud, waste and abuse in 2013. Remember, we said at the beginning of this presentation: The goal of <u>Program Integrity</u> is to <u>create a culture</u> of providing better health outcomes while <u>avoiding over- or underutilization of services</u>, which requires <u>effective program management</u> and <u>ongoing program monitoring</u>. Our move into the Drug Medi-Cal Organized Delivery system offers an opportunity to look at our program culture, as well as current management and monitoring practices in order make necessary changes to create the most efficient system of care possible. These efforts are part of the overall quality improvement process for services provided to clients with

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		Substance Use Disorders.
14	Agencies Combatting FWA	Combatting fraud, waste and abuse on the federal, state, and local levels involves a number of different agencies. As you can see from this slide there are multiple players including: • The Office of Inspector General (OIG), US Department of Health and Human Services • Department of Justice • Centers for Medicare & Medicaid Services (CMS) • Office of the State Attorney General • Department of Health Care Services (Audits and Investigations) • The Office of the State OIG and Medicaid OIG Locally, the County will be receiving reports of FWA and monitoring compliance with Program Integrity plans – we'll talk about that in more detail towards the end of the presentation.
15	Laws & Regulations Related to "FWA"	Because of the importance of program integrity and the costs associated with fraud, waste and abuse, there are numerous laws and regulations in place. Links to more information on these laws are provided in the resources, so we'll just touch on each briefly. The federal False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including Drug Medi-Cal. It spells out the details of civil penalties for fraud, and consequences, such as exclusion from participation in any federal health care program for non-compliance. We've mentioned several examples of fraud in the previous slides The Anti-Kickback Statute is a federal law that prohibits persons from directly or indirectly offering, providing or receiving kickbacks in exchange for goods or services covered by Medicare, Medicaid, and other federally funded health care programs (like Drug Medi-Cal). Violations of this law are punishable by criminal sanctions including imprisonment and civil monetary penalties. The Beneficiary Inducement Law prohibits individuals or programs from offering remuneration (such as money or gifts) as a way to influence Drug Medi-Cal clients to select that individual or program as their provider. The federal Exclusion Statute excludes individuals or entities from participating in the Medicare or Medicaid program for a minimum of 3 to 5 years, depending on the offense, up to possible lifetime exclusions. Programs man not employ or contract with an excluded or debarred individual or entity. The Whistleblower Protection Act is a federal law that encourages individuals to come forward and report misconduct involving false claims. The whistleblower may be awarded a portion of false claim funds recovered by the government, in addition to protections against employer retaliation.
16	Laws & Regulations Related to "FWA"	Other Relevant Federal Fraud, Waste and Abuse Laws include: The Physician Self-Referral Prohibition (also known as the Stark Law) which prohibits physicians from referring Medicaid & Medicare clients for services to an entity in which the physician or physician's immediate family has a financial relationship (unless an exception applies). Violations are punishable by a civil penalty, denial of payment, and refunds for certain past claims. The Civil Monetary Penalties Law is a federal law covering an array of fraudulent and abusive activities and is similar to the False Claims Act.

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		The Health Insurance Portability and Accountability Act (HIPPA) established the Health Care Fraud and Abuse Control Program under the US Attorney General and the Office of the Inspector General, with a goal to coordinate federal, state and local efforts in combatting fraud, waste and abuse.
17	Program Integrity Requirements (42 CFR Section 438.608)	Another important law is 42 CFR. Section 438.608 of 42 CFR specifically outlines the minimum requirements for a program integrity or compliance plan as a way to prevent fraud, waste and abuse. First, Program integrity requires leadership. Effective leadership develops a culture of compliance with written policies and procedures. Each legal entity should have Policies and Procedures that articulate the program's standards and commitment to comply with all applicable Federal and State requirements. At the legal entity level, designation of a compliance officer and compliance committee is also part of a comprehensive Program Integrity plan. Program leadership should make the disciplinary process for acts of fraud, waste and abuse well known in the program, and follow-up with enforcement of all Program Integrity standards promptly. Part of this done through effective communication – between the compliance officer, program leadership, and employees. It is also accomplished, in part, through ongoing trainings of all staff in an agency. Ongoing monitoring is key is another necessary ingredient and will take place at both the program and County level.
18	Internal Compliance Program	What does all of this mean to you specifically, as part of the County of San Diego Drug Medi-Cal Organized Delivery System? It is recommended that Contracted Programs have an internal compliance program commensurate with the size and scope of their agency. Further, contractors with more than $250,000 annually in agreements with the County must have a Compliance Program that meets the 42 CFR guidelines discussed on the previous slide. These include: 1. Development of a Code of Conduct and Compliance Standards. 2. Assignment of a Compliance Officer, who oversees and monitors implementation of the compliance program. 3. Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise complaints and concerns about compliance issues without fear of retribution.
19	Internal Compliance Program	The internal compliance program should also address 4. Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures. 5. Development and monitoring of Auditing Systems to detect and prevent compliance issues 6. Creation of Discipline Processes to enforce the program. 7. Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.
20	Internal Compliance Program	All Programs, regardless of size and scope, shall have processes in place to ensure at the least the following standards: • Staff shall have proper credentials, experience, and expertise to provide client services. • Staff shall document client encounters in accordance with funding source requirements and County of San Diego Health and Human Services policies and procedures. • Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.

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21	Internal Compliance Program	Also, all programs shall have processes for • Staff to promptly elevate concerns regarding possible deficiencies or errors in the quality of care, client services, or client billing. • And for Staff to act promptly to correct problems if errors in claims or billings are discovered.
22	Reporting FWA	Concerns about ethical, legal, and billing issues, (or of suspected incidents of fraud, waste and/or abuse) should be reported directly to the HHSA Agency and Compliance Office (abbreviated ACO) by phone at 619-338-2807, or by email at Compliance.HHSA@sdcounty.ca.gov. Or you may report to the Compliance Hotline at 866-549-0004 Additionally, contact your program COR immediately, as well as the SUD QM team at qimatters.hhsa@sdcounty.ca.gov to report any of these same concerns, or suspected incidents of fraud, waste, and/or abuse.
23	Paid Claims Verification	Verification of paid claims is an important means of monitoring for instances of fraud, waste and/or abuse. The County is requiring that each program develop a P & P on Paid Claims Verification – which is how your program will verify whether services reimbursed by Drug Medi-Cal were actually provided to clients. We are not prescribing exact templates or ways to create this, because we want you to have flexibility to develop your own process, which may be based on your current workflow. For example, you have current processes with sign-in sheets – can these be leveraged to create your paid claims verification process? It doesn't have to be complex, you can keep it simple. Think in terms of what works best in your workflow, but also meets the needs for monitoring for FWA. One simple example – random verification during specified time periods, comparing sign-in sheets to paid claims.
24	Sample	Here is a sample Program Integrity/ Compliance Plan that includes a process for paid service verification. The full version of this form (which includes a sample of the client signature form referenced in this P&P) is located on the Optum website next to the link for this webinar. You can see from this example the program states what their Program Integrity Policies and Procedures are, where they are located for staff access, and how they are reviewed during staff meetings. This sample states a plan for training, and details their plan for paid service verification. This is just a sample and not meant to be all inclusive, or a prescription for how you must format your Program Integrity P&Ps. You can also search Google for samples, or ask other programs/legal entities to share theirs for ideas when creating your own.
25	Monitoring	Here is a sample Program Integrity/ Compliance Plan that includes a process for paid service verification. The full version of this form (which includes a sample of the client signature form referenced in this P&P) is located on the Optum website next to the link for this webinar. You can see from this example the program states what their Program Integrity Policies and Procedures are, where they are located for staff access, and how they are reviewed during staff meetings. This sample states a plan for training, and details their plan for paid service verification. This is just a sample and not meant to be all inclusive, or a prescription for how you must format your Program Integrity P&Ps. You can also search

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		Google for samples, or ask other programs/legal entities to share theirs for ideas when creating your own.
26	Monitoring	After DMC-ODS implementation, the SUD QM team will run reports regularly on random samples of clients, comparing billing entered to supporting documentation in the system (such as ASAM risk ratings/levels of care determinations). This will help to identify any potential issues (such as data entry errors, any obvious discrepancies between LOC documentation and services provided, etc.) so that the SUD QM team will be able to provide ongoing technical assistance to programs. We will also provide tip sheets for programs to run regular SanWITS reports to help with their own internal monitoring processes.
27	Resources	Some resources that may be helpful are listed on the following slides: For training assistance on the False Claims Act, reach out to the HHSA Agency and Compliance Office by phone at 619-338-2807, or by email at Compliance.HHSA@sdcounty.ca.gov
28	Resources	These are the website addresses of some of the major organizations (both federal and state) with oversight of fraud, waste and abuse prevention. Most have helpful articles and information on what has been discussed in this webinar.
29	Resources	Finally, here are some educational materials you may find helpful: The brief video on the False Claims act (by the Office of the Inspector General) is only a little over 4 minutes long and may be a good starting point for review. The other resources are printed educational materials and/or websites you may find helpful
30	We're Here to Help	Thank you for participating in this webinar. We are here to help – please feel free to email us at any time with questions or to request consultation. Our email is QIMatters.HHSA@sdcounty.ca.gov. Someone will generally return emails within one business day. Thanks again.