



INTRODUCTION TO PROGRAM INTEGRITY DMC-ODS



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OBJECTIVES



- Understand the importance of Program Integrity
- Define Fraud, Waste and Abuse ("FWA")
- Identify Federal/State Agencies that combat FWA
- Identify Applicable FWA Laws
- Understand reporting suspected FWA to the County
- Explain the County's requirement for Paid Services Verification and monitoring process
- Resources related to Program Integrity

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PROGRAM INTEGRITY DEFINED



The goal of Program Integrity is to create a culture of providing better health outcomes while avoiding over or underutilization of services.

This requires effective program management and ongoing program monitoring.



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EFFECTIVE PI 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

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ACCURATE ELIGIBILITY DETERMINATION  

- Drug Medi-Cal eligibility is verified at intake, when a client becomes Medi-Cal eligible, and monthly for the duration of services
 - Current process sufficient?
 - Other considerations?
 - Verifying identity
 - Check each client's Medi-Cal eligibility monthly

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MEDICAL NECESSITY:  

Under the DMC-ODS Medical Necessity is defined as:

- All clients must have at least one DSM-5 SUD Diagnosis
 - Except Tobacco-Related Disorders and non-substance related disorders, like gambling
- Adults 18 and over – Must meet the ASAM Criteria of medical necessity for the level of care
- Youth/Young adults (12-20 – Must meet the ASAM adolescent treatment criteria)
 - Eligible for Early Periodic Screening, Diagnostic, and Treatment (EPSDT) to receive all appropriate and medically necessary services to ameliorate health condition
- See SUDPOH Section A
- What processes are in place to verify accuracy of the DSM diagnosis and use of ASAM criteria?

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FRAUD  



Drug Medi-Cal FRAUD involves

- Making false statements or misrepresentation of material facts
- Obtaining some benefit or payment for which no entitlement would otherwise exist
- May be committed for the person's own benefit or for the benefit of another party
- The act must be performed knowingly, willfully and intentionally.

Example: Purposely billing for services that were never given.

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FRAUD  



FRAUD

Other examples of fraud:

- Billing DMC for appointments a client didn't keep (i.e. intentionally billing for "no shows")
- Falsifying a diagnosis so a client will meet medical necessity
- Knowingly billing for services at a level of complexity higher than services provided
- Falsifying records to claim for a higher level of service

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FRAUD  



FRAUD

Defrauding Drug Medi-Cal is illegal:

- May lead to penalties, fines, and imprisonment
- Risks exclusion from participating in all Federal health care programs
- Risk losing professional licenses

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WASTE  



WASTE:

- Spending that can be eliminated without reducing the quality of care
- Generally refers to over/inappropriate utilization of services
- Misuse of resources

Example: Poor or inefficient billing methods cause unnecessary costs

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ABUSE  

ABUSE includes:

- Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Drug Medi-Cal program
- Reimbursement for services that are not medically necessary
- Fail to meet professionally recognized standards for health care and health care coding.
- Example: Providing services at a higher level of care than medically necessary

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DMC-ODS BENEFIT "PHASES"  

Eligibility → Coverage → Payment

- Fraud, Waste, and Abuse can happen in every phase
- Acts of Commission
- Acts of Omission

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ACTIVITIES CAUSING IMPROPER PAYMENTS  

Types of improper payments:


MISTAKES	RESULT IN ERRORS: SUCH AS INCORRECT CODING
INEFFICIENCIES	RESULT IN WASTE: SUCH AS ORDERING EXCESSIVE DIAGNOSTIC TESTS
BENDING THE RULES	RESULTS IN ABUSE: SUCH AS IMPROPER BILLING PRACTICES (LIKE UP CODING)
INTENTIONAL DECEPTIONS	RESULT IN FRAUD: SUCH AS BILLING FOR SERVICES OR SUPPLIES THAT WERE NOT PROVIDED

Image source: "Medicare Fraud & Abuse: Prevent, Detect, Report", CMS Medicare Learning Network 13

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THE COST OF "FWA"  

- In 2019, The Office of Inspector General (OIG), US Department of Health and Human Services:
 - Recovered nearly \$2 billion in criminal and civil recoveries
 - Over 1200 individual or entities were excluded from federally funded health programs
 - Resulted in over 1500 convictions
- The Centers for Medicare & Medicaid Services (CMS) estimates that Improper Payment Rates and Payments totaled over \$100 billion in 2019.



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AGENCIES COMBATTING FWA  

- 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

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LAWS & REGULATIONS RELATED TO "FWA"




- Federal False Claims Act
- Anti-Kickback Statute
- Beneficiary Inducement Law
- Exclusion & Debarment Statute
- Whistleblower Protection Act



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LAWS & REGULATIONS RELATED TO "FWA"



Other Relevant Federal FWA Laws


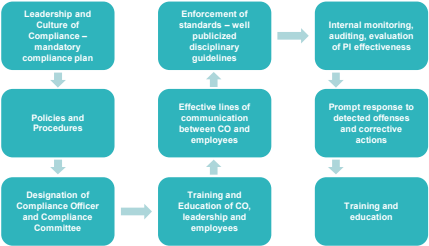
- Physician Self-Referral Prohibition (Stark Law)
- Civil Monetary Penalties Law (CMPL)
- Health Insurance Portability and Accountability Act (HIPAA)



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PROGRAM INTEGRITY REQUIREMENTS (42 CFR SECTION 438.608)

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INTERNAL COMPLIANCE PROGRAM  

- Recommended that programs have an internal program integrity/compliance program commensurate with the size and scope of their agency.
- Contractors with more than \$250,000 in annual agreements with the County must have a compliance program that meets the following:
 1. Development of a code of conduct and compliance standards
 2. Assignment of a compliance officer who oversees/monitors compliance program
 3. A communication plan which allows workforce members to express complaints/concerns without fear of retribution

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INTERNAL COMPLIANCE PROGRAM  

- Contractors with more than \$250,000 in annual agreements with the County must have a compliance program that meets the following:
 4. Create and implement 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 at the program
 7. Development of response and prevention mechanisms to respond to, investigate and implement corrective action regarding compliance issues

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INTERNAL COMPLIANCE PROGRAM  

Regardless of size/scope, all programs have processes in place to ensure, at a minimum:

1. Staff have proper credentials, experience, and expertise to provide client services
2. Staff shall document client encounters in accordance with funding source requirements and Health and Human Services Agency (HHSA) policies/procedures
3. Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures


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INTERNAL COMPLIANCE PROGRAM  



Regardless of size/scope, all programs have processes in place to ensure, at a minimum:

- Staff promptly elevate concerns regarding possible deficiencies or errors in the quality of care, client services, or client billing
- Staff shall act promptly to correct problems if errors in claims or billings are discovered



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REPORTING FWA  

- Any concerns about ethical, legal, and billing issues (or of suspected incidents of FWA) should be reported immediately to: the HHSA Agency Compliance Office (ACO):
 - By phone at 619-338-2807, or
 - By email at Compliance.HHSA@sdcounty.ca.gov
 - or contact the HHSA Compliance Hotline at 866-549-0004
- Additionally, contact your program COR immediately and the SUD QM team at QIMatters.HHSA@sdcounty.ca.gov

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PAID CLAIMS VERIFICATION  

"Paid claims verification" – Each program must develop Policy & Procedure to verify whether services reimbursed by Drug Medi-Cal were actually provided to clients.

- Flexibility in developing your own process
- Can current processes (i.e. sign-in sheets) be leveraged to create your paid claims verification process
- Keep it simple (i.e. random verification)
 - i.e. random verification during specified time periods

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RESOURCES  

- Office of Inspector General – US Department of Health and Human Services
Website <https://oig.hhs.gov/>
- US Department of Justice Health Care Fraud Unit Website
<https://www.justice.gov/criminal-fraud/health-care-fraud-unit>
- Centers for Medicare & Medicaid Services Provider Compliance Website
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>
- State of California Department of Justice Medi-Cal Fraud Website
<https://oag.ca.gov/bmfea/medical>
- DHCS Audits & Investigations Website
<http://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx>

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RESOURCES  


- Brief Video on the False Claims Act:
<https://www.youtube.com/watch?v=BbZ78QTLztQ&feature=youtu.be>
- False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law, Exclusion Statute: <https://oig.hhs.gov/compliance/physician-education/01laws.asp>
- CMS Resource Guide: Laws Against Health Care Fraud
<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-laws-resourceguide.pdf>
- Beneficiary Inducement Law OIG Bulletin
<https://oig.hhs.gov/fraud/docs/alertsandbulletins/sabgiftsandinducements.pdf>
- County of San Diego HHSA Exclusion and Debarment Verification info
http://www.sandiegocounty.gov/content/sdc/hhsa/programs/sd/agency_contract_support/exclusion_and_debarment_verification.html
- OIG Whistleblower Protection Information <https://oig.hhs.gov/fraud/whistleblower/>

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WE'RE HERE TO HELP  

QIMatters.HHSA@sdcounty.ca.gov



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