Slide Number	Slide Heading	Slide Narration Text
1	Introduction to Program Integrity DMC-ODS	Welcome to the County of San Diego's program integrity webinar, provided by the County of San Diego Behavioral Health Services SUD Quality Management team. This is meant to be a resource for your program or legal entity as you create, review and/or improve existing policies and procedures regarding program integrity. The webinar takes approximately 30 minutes to complete.
2	Objectives	Our objectives for this session are: • 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 monitoring process • Provide resources related to Program Integrity
3	Program Integrity Defined	Let's start off with one definition of program integrity: 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.
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 first a few specific DMC-ODS considerations regarding numbers 1 and 3.
5	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. What is your current process and is the current process sufficient? There are 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 is your process for to assure each client's Medi-Cal eligibility is checked monthly? These are some examples of the types of questions a thorough Program Integrity or Compliance plan will address.

6	Medical Necessity	The definition of Medical Necessity in the Drug Medi-Cal Organized Delivery System is as follows: All clients must have at least one diagnosis from the DSM-5 for a Substance Use Disorder, excluding Tobacco-Related Disorders and non-substance related disorders (such as gambling). Adult Clients, defined as those 18 and over, must also meet the ASAM Criteria for medical necessity for the level of care. Youth and young adults, defined as those between the ages of 12 and 20, must meet the ASAM adolescent treatment criteria. These clients are also eligible for Early Periodic Screening, Diagnostic, and Treatment or EPSDT services that are medically necessary to ameliorate their health condition Please see SUDPOH section A for more information. 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 you 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	The statutory definition of Drug Medi-Cal FRAUD involves four components: 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. For example: Purposely billing for services that were never provided
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 (for example 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 or documented in the file -Knowingly falsifying records to claim for a service that reimburses higher than what was provided

9	Fraud	Drug Medi-Cal Fraud is illegal. Committing fraud exposes individuals or entities to potential criminal and civil liability, and may lead to penalties, fines, and imprisonment. Criminal and civil penalties 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. Finally, individuals and organizations risk losing their professional licenses when committing health care fraud.
10	Waste	Although not defined in statute, waste is generally understood as health care spending that can be eliminated without reducing the quality of care. Waste also refers to overutilization or inappropriate utilization of services, and misuse of resources. One example is poor or inefficient billing methods including 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.
11	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, or 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.
12	DMC-OD 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: eligibility, coverage, and payment. As previously mentioned, benefit eligibility is determined both initially and ongoing on a monthly basis. 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. Payment is the final phase of each month of service. Fraud, Waste, and Abuse can be in every phase of every program and will include acts of both commission (that is, done intentionally) and omission (that is, done due to carelessness).

13	Activities Causing Improper Payments	Program integrity encompasses a range of activities targeting various causes of improper payments. For example, mistakes result in errors – data entry errors can cause overbilling and therefore overpayment by Drug Medi-Cal. We've seen examples of these errors that have caused thousands of dollars of overpayment. For instance, providing a service for 15 minutes but accidentally entering 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 provided. (This is referred to as "Up coding") And intentional deceptions result in fraud –for example, billing for services that were not provided. So why is this so important?
14	The Cose of "FWA"	Fraud, waste and abuse create a terrible cost for the system. In 2019, the Office of Inspector General recovered nearly 2 billion dollars in criminal and civil recoveries. Over 1200 individuals or entities were excluded from federally funded health programs as a result of fraud, waste, and abuse, and resulted in over 1500 convictions. The Centers for Medicare and Medicaid Services estimate that improper payment rates and payments totaled over 100 billion dollars in 2019. Looking at program culture, as well as current management and monitoring practices in order make necessary changes to create the most efficient system of care possible, are part of the overall quality improvement process for services provided to clients with Substance Use Disorders.
15	Agencies Combating FWA	Combatting fraud, waste and abuse on the federal, state, and local levels involves many different agencies. These include: • The Office of Inspector General (OIG), US Department of Health and Human Services • Department of Justice • Centers for Medicare & Medicaid Services or CMS • Office of the State Attorney General • Department of Health Care Services (Audits and Investigations) • and 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 – this is discussed in more detail towards the end of the presentation.
16	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. 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) to influence Drug Medi-Cal clients to select an 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 may 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. Links to more information on these laws are provided in the resources at the end of the presentation.
17	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. 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.
18	Program Integrity Requirements (42 CFR Section 438.608)	42 CFR Section 438.608 outlines the minimum requirements for a program integrity or compliance plan to prevent fraud, waste and abuse. Program integrity starts with 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. The Compliance Officer, leadership, and employees should be trained on the Policies and Procedures related to Program Integrity. This should include effective lines of communication between the Compliance Officer and employees. 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. Ongoing monitoring is another necessary ingredient and will take place at both the program and County level. Any items of fraud, waste, and abuse should be responded to promptly and corrected, including any corrective actions or discipline. Finally, staff should receive ongoing trainings of all relevant Program Integrity Requirements in an agency.
19	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.
20	Internal Compliance Program	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 at the program. 7. Development of response and prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.
21	Internal Compliance Program	All Programs, regardless of size and scope, shall have processes in place to ensure 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 Agency policies and procedures. • Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.
22	Internal Program Compliance	• Staff will 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.
23	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 contact 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 concerns, or suspected incidents of fraud, waste, and/or abuse.
24	Reporting FWA	Additionally, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit via one of four ways: • By phone at 1-800-822-6222 • Via the online form. This link is active in the downloadable PowerPoint and Transcript, and is included in the SUDPOH • Email at fraud@dhcs.ca.gov • Or by mail to: Medi-Cal Fraud Complaint, Intake unit. Audits and Investigations. PO Box 997413, MS 2500. Sacramento, CA, 95899-7413
25	Paid Claims Verification	Verification of paid claims is an important means of monitoring for instances of fraud, waste and/or abuse. The County requires 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 provided to clients. We are not prescribing exact templates or ways to create this process, because we want you to have flexibility to develop what may be best based on your current workflow, but also meets the needs for monitoring for Fraud, Waste, and Abuse. 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.

		One simple example – random verification during specified time periods, comparing sign-in sheets to paid claims.
26	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. In 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 contains 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 how you must format your Program Integrity P&Ps. You can also search Google for samples, or ask other programs or legal entities to share theirs for ideas when creating your own.
27	Monitoring	The SUD QM team will conduct reviews annually at minimum. This monitoring will become part of our SUD QM chart review process or part of a separate site visit. Part of the monitoring will be asking to see the Legal Entity's Program Integrity Compliance Plan, discuss how your program is following the plan, and ask for evidence of implementation of your Paid Claims Verification. The SUD QM team is available for consultation or to answer questions. Don't hesitate to contact us at any time while you are reviewing or developing your own P and P's. As part of this monitoring process, encounters in SanWITS will be compared to documentation present in the chart to ensure all services claimed have associated documentation. Programs are expected to conduct their own regular Program Integrity activities and to maintain records for QM audit purposes. The SUD MIS team also provides tip sheets on SanWITS reports to be used as part of a program's internal Program Integrity process.
28	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.
29	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 detailing what has been discussed in this webinar.

30	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 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
31	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.