COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 4, POLICY 016

BEHAVIORAL HEALTH COMPLIANCE REPORTING AND NOTIFICATION REQUIREMENTS

A. **PURPOSE:** Yolo County Health and Human Services Agency (HSSA) is committed to adherence to federal and state health care behavioral health program requirements, including program integrity requirements regarding the detection and prevention of fraud, waste, and abuse, and notification to the appropriate state and federal agencies when appropriate.

B. **FORMS REQUIRED/ATTACHMENTS: N/A**

C. **DEFINITIONS:**

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. "Disclosing entity" means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

3. "Waste" is overutilization of services, needless expenditure of funds or consumption of resources or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs caused by deficient practices, poor system controls or bad decisions. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

D. **POLICY:** In accordance with Federal regulations and DHCS requirements, this policy establishes procedures for reporting all overpayments identified or recovered, specifying the overpayments due to potential fraud, waste and abuse; and procedures for notification to the State when it receives information about changes in a beneficiary's eligibility, or changes in a network provider's eligibility, including termination of the provider agreement with HHSA.

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E. PROCEDURES:

To ensure successful implementation of the compliance standards, to track compliance violations, and to evidence the department's commitment to compliance, HHSA has developed the following documentation procedures:

1. Compliance Officer Responsibilities

   a. Provide education and information to HHSA staff regarding their duty to report and of available protections for reporting compliance issues.

   b. Work with Quality Management to maintain an auditing and monitoring plan that is reviewed and updated as needed. This plan includes, but is not limited to training, policy and procedure reviews, privacy and security audits, action plans, audits or program activities, claims review and other auditing and monitoring activities to detect, deter and correct fraud, waste and abuse.

   c. Upon receipt of a report or reasonable indications of suspected non-compliance, the Compliance Officer will investigate the allegations to determine whether a violation of applicable law or the requirements of the Compliance Program has occurred. If so, a corrective action plan will be developed to correct and mitigate the compliance issue. This includes prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, waste and abuse.

      i. The Compliance Officer may initiate an investigation of an alleged compliance violation based on information from one of several sources:

         - Employee reports via the Compliance Officer, the 24-Hour Hotline (1-800-391- 7440), or a supervisor.
         - Monitoring of Medi-Cal claims by the Compliance Officer or Compliance or billing staff
         - Routine audits and self-assessments
         - Monitoring activities that may detect such warning indicators as the number and/or types of claim rejections, challenges to medical necessity, and/or high volumes of unusual charge or payment adjustment transactions
         - State chart disallowances
         - Other sources of information that may become available

      ii. If an investigation yields valid evidence of non-compliance, the Compliance Officer, in coordination with the Compliance Committee, will develop a plan of correction to address the violation. As determined by the type of violation, the corrective action may include:

         - Development of internal changes in policies, procedures, and/or the Compliance Program;
         - Re-training of staff;
         - Internal discipline of staff;
         - The prompt return of any overpayments (HHSA Fiscal staff will process overpayments within 60 calendar days of the overpayment being identified and quantified);

- HHSA will suspend payments to any provider for which DHCS or HHSA determines there is a credible allegation of fraud.
- Reporting the incident to DHCS and any other appropriate state or federal agency;
- Referral to law enforcement authorities if appropriate; and/or
- Other corrective actions as deemed necessary.

iii. Reporting of any suspected Medi-Cal Fraud may be submitted to:

Department of Health Care Services
Medi-Cal Fraud Complaint – Intake Unit
Audits and Investigation
PO Box 997413. MS 2500
Sacramento, CA 95899-7413

Hotline Toll-Free Number: (800) 822-6222
Department of Health Care Service Phone Toll-Free: 800-722-0432
Email: fraud@dhcs.ca.gov

iv. HHSA will report to DHCS within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services.

v. HHSA will report annually to the State on their recoveries of overpayments during the annual cost reporting process.

d. HHSA will provide prompt notification to the State when it receives information about changes in a beneficiary's eligibility or changes in a network provider's eligibility.

i. If HHSA behavioral health programs become aware of changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including changes in the beneficiary's residence or the death of the beneficiary, the HHSA behavioral health program will contact the HHSA Welfare Division within 3 business days to immediately make the correction in the Medi-Cal Eligibility Data System (MEDS).

ii. If HHSA becomes aware of changes in a network provider's circumstances that may affect the provider's eligibility to participate in the Medi-Cal SMHS program, including the termination of the provider agreement, HHSA will immediately discontinue the provider's certification to participate in the SMHS program and transmit the change to the appropriate entity within DHCS. If any overpayments were made to the provider, HHSA will promptly return any overpayments as soon as practicable. If fraud, waste or abuse is suspected HHSA will utilize the procedures described above.

2. Manager/Supervisory Responsibilities

a. Create a working environment of honesty and integrity within each manager/supervisor's span of control.

i. Provide employees with clear direction about work expectations and internal controls
ii. Actively discourage manipulation of clients, vendors or others for advantage.

b. Reduce opportunities for fraud, waste and abuse by implementing strong internal controls that detect and deter dishonest behavior.

c. Ensure that employees are aware of the options available for reporting fraud, waste and abuse and other compliance issues.

d. Establish an environment free from intimidation and retaliation to encourage open communication.

   i. Ensure that employees, contractors or other workforce members who report issues are not subject to intimidation, harassment, or other forms of retaliation for reporting issues in good faith.
   ii. Immediately address any and all forms of retaliation by co-workers.
   iii. Actively discourage conduct that could be perceived as retaliatory.

3. Individual Responsibilities

   a. Perform duties in a way that promotes the public trust and ensures proper expenditures and use of County assets and property.

   b. Employees, contractors, volunteers and other designated individuals have a duty to report actual or suspected violations of law, regulations or policy including fraud, waste and abuse to appropriate authorities.

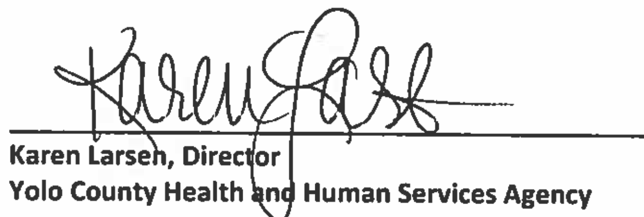
      i. Awareness of Federal False Claims Requirements including Qui Tam provisions
      ii. Awareness of California False Claims Act Requirements

   c. Cooperate with investigation of compliance issues.

F. REFERENCES:

1. Title 42, Code of Federal Regulations (CFR), Sections 438.608(a)(2), (3) and (4).
2. Yolo County's MHP Contract with the DHCS, Program Integrity Requirements
3. DHCS Program Oversight and Compliance Annual Review Protocol for Specialty Mental Health Services and Other Funded Services, Section H, Program Integrity

Approved by:



5/8/18

Karen Larsen, Director
Yolo County Health and Human Services Agency

Date