COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 4, POLICY 024

FRAUD, WASTE AND ABUSE

POLICY NUMBER:	*5-4-024*
SYSTEM OF CARE:	BEHAVIORAL HEALTH
FINALIZED DATE:	02.05.2021
EFFECTIVE:	03-01-2020
SUPERSEDES # :	Supersedes Policy #'s: PP 405 Reporting Suspected Fraudulent Activity (11-30-12) PP 1117 Fraud, Waste and Abuse (10-24-08) PP 1117-A Federal False Claims Requirements (3-6-08) PP 1117-B California False Claims Act Requirements (3-6-08)

A. PURPOSE: To establish a uniform Fraud, Waste and Abuse policy, to detect and prevent fraud, waste and abuse (C.F.R. 42 § 455.1(a)(1) and C.F.R. 42 § 438.608) for Yolo County Health and Human Services Agency (HHSA) Behavioral Health (BH) workforce members and Network Provider workforce members, consistent with state and federal requirements.

B. FORMS REQUIRED: N/A

C. DEFINITIONS:

1. **Fraud:** An intentional deception or misrepresentation that an individual knows or should know to be false that 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.

2. **Waste:** Overutilization or underutilization 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 systems controls or bad decisions. Waste is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

3. **Abuse:** 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.

4. **False Claim:** A false claim occurs when an individual or entity knowingly submits a claim for reimbursement, or false documentation for a claim, to a State or Federal payer source for a service or product despite the quality or quantity of that service or product not fulfilling the requirements associated with those goods or services. A partial list of potential behavioral health - related false claims includes the following:

    a. **Double billing:** Submitting more than one claim for the same service;
    b. **Lacking a case note:** An authorized service for an eligible client provided by an appropriately licensed staff member but lacking a proper case note that documents the service and establishes medical necessity;
    c. **Case note lacking a signature and/or date:** Same as # 2 but lacks the clinician's signature and/or date;
    d. **Out of scope practice:** An authorized service for an eligible client with all appropriate documentation being completed but performed by a staff member lacking the necessary training or registration/certification/license/waiver;
    e. **Expired license or registration:** Any clinical service that requires a licensed or registered clinician but is provided by a person with an expired, suspended, or revoked license or registration;
    f. **Up-coding:** Using an inaccurate diagnosis or claiming an inaccurate procedure code that has a higher reimbursement rate than is appropriate for the client's condition or the service actually rendered;
    g. **Overcharging:** Claiming more minutes (or other applicable reimbursement criteria) than actually provided;
    h. **False claim:** Claiming for a service that was never provided. A false claim related legal case could be filed against an individual or entity by the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), other Federal or State agency.

5. **Auditing:** Consists of retrospectively testing the established monitoring systems to ensure they are functioning as prescribed.

6. **Monitoring:** Conducted in real-time and broad in scope to facilitate appropriate management action on an ongoing basis to document compliance with policies, procedures, laws or regulations.

7. **Workforce Members**: Active behavioral health employees of an organization, including permanent employees (Full time or Part time), extra help employees, interns, peer support workers, volunteers, contracted providers, and sub-contractor employees, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

8. **Office of Compliance**: Yolo County HHSA BH Compliance unit, including the Compliance Officer and the Compliance Committee.

D. POLICY: It is the policy of Yolo County HHSA BH and Network Provider(s) or subcontracted provider(s), where Yolo County HHSA BH has delegated responsibility for coverage of services and payment of claims, per contractual requirements, to implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse (FWA). FWA shall be reported no later than five (5) business days or within 24 hours depending on the egregiousness of the issue, to the Department of Health Care Services (DHCS) for the following:

1. Any potential FWA, including False Claims. (42 C.F.R.§438.608(a)(7); MHSUDS IN No. 19-034)
2. All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R.§438.608(a), (a)(2); MHSUDS IN No. 19-034), Ex. A, Att. 13; 42 C.F.R.§ 438.608(a)(4).)
3. Information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery system (DMC-ODS, including any termination of the Provider's agreement with Yolo County HHSA BH.

Additionally, Yolo County HHSA BH and Network Providers shall establish, implement, and maintain procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. Yolo County HHSA BH and Network Providers shall respond no later than five (5) business days or within 24 hours depending on the egregiousness of the issue, to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly (any suspected criminal acts shall be coordinated with law enforcement agencies) to reduce the potential for recurrence, and to ensure ongoing compliance. (42 C.F.R. §438.608(a)(1).) Yolo County HHSA BH will suspend payments to any Network Provider for which there is a credible allegation of fraud.

Written policies shall be implemented and maintained for all BH workforce members, and for any contractor or agent, that provides detailed information about the False Claims Act and any other federal and state laws, including information about rights of workforce members to be protected as whistleblowers. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(6).) All Yolo County HHSA BH and Network Provider workforce members, are required to adhere to all Yolo County HHSA BH policies and procedures, as well as all state and federal laws to ensure public resources are utilized appropriately.

E. PROCEDURE: To ensure successful implementation of compliance standards, to track compliance violations and to evidence Yolo County HHSA BH's commitment to compliance, Yolo County HHSA BH has developed the following procedures:

1. **Fraud, Waste and Abuse (FWA) Reporting:** The Compliance Officer or Office of Compliance, shall ensure effective lines of communication are available between the Office of Compliance Yolo County HHSA BH workforce members (MHP Contract, Ex. A, Att. 13; 42 C.F.R. §438.608(a)(1).)
    a. FWA can be reported:
        i. Anonymously to the 24-hour Compliance Hotline (800) 391-7400;

ii. Directly to the Office of Compliance, a Supervisor or Manager;
iii. Directly to the State Department of Health and Human Services at 1-800-822-6229;
iv. The Federal Government at the California Department of Justice, Attorney General's Office at (916) 210-6276 or 1-800-952-5225;
v. The U.S. Department of Health and Human Services, Office of the Inspector General hotline, which offers a confidential means for reporting vital information at 1-800-HHS-TIPS (1-800-447-8477).

2. **Workforce Responsibilities:** All BH workforce members have a responsibility to follow the standards of conduct, as well as report any non-compliant behavior. The following responsibilities apply for preventing/detecting/correcting FWA:

a. **Individual Employee:**

i. Perform duties in an ethical and legal manner,
ii. Perform duties in a manner that promotes public interest and ensures appropriate use of time and resources, i.e., ensure proper expenditures and use of County assets and property.
iii. Report actual or suspected violations. Workforce members have a duty to report actual or suspected violations of law, regulations or policy including FWA to appropriate authorities.
iv. Be aware and understand California and Federal False Claims Requirements including Qui Tam provisions
v. Cooperate with investigation of compliance issues and/or preliminary research on compliance matters.

b. **Manager and/or Supervisor:**

i. Create an environment of honesty, integrity and accountability within your area of oversight. This includes providing clear direction on work expectations and internal controls, appropriate conduct and ethical standards, e.g., Actively discourage manipulation of clients, vendors or others for advantage.
ii. Reduce opportunities for FWA by implementing strong internal controls that detect and deter dishonest behavior;
iii. Ensure that employees are aware of the options available for reporting FWA and other compliance issues;
iv. Establish an environment free from intimidation and retaliation to encourage open communication. This includes:
    1. 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.
    2. Immediately address any and all forms of retaliation by co-workers.
    3. Actively discourage conduct that could be perceived as retaliatory.

3. **Network Provider Responsibilities:** Network Providers are responsible for maintaining a compliance program within their agency and developing internal reporting mechanisms per contractual terms.
    a. If Network Providers identify an issue or receive notification of a complaint concerning an incident of potential or actual FWA, in addition to notifying DHCS and/or relevant boards or authorities (e.g., National Provider Databank, Board of Behavioral Sciences etc.), the Network Provider shall notify the Yolo County Compliance Officer (HHSA.BHCompliance@yolocounty.org). The Network Provider shall conduct an internal investigation to determine the validity of the issue/complaint, develop and implement corrective action, if needed, and shall provide routine updates to Yolo County's Compliance Officer.
    b. If a Network Provider has identified an overpayment, Yolo County HHSA BH shall be notified immediately and the overpayment shall be returned within county, local, state or federal guidelines.

4. **Office of Compliance Responsibilities:** Yolo County HHSA BH Compliance Officer, or Office of Compliance shall be responsible for ensuring Yolo County HHSA BH workforce members and Network Providers adhere to applicable County, State and Federal regulations and requirements. This includes:
    a. Implementing guidelines pertaining to billing and coding standards, conflicts of interest, licensing and credentialing requirements, Code of Conduct, and ethical standards as set forth by the appropriate board(s).
    b. Conducting investigations in response to complaints and other reports, to prevent/detect/correct FWA. If Yolo County HHSA BH identifies an issue or receives notification of a complaint concerning an incident of potential or actual FWA, in addition to notifying DHCS no later than five (5) business days or within 24 hours depending on the egregiousness of the issue, and/or relevant boards or authorities (e.g., National Provider Databank, Board of Behavioral Sciences etc.), Yolo County HHSA BH shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed. (MHP Contract, Ex. A, Att.
    c. Implement and maintain arrangements or procedures that include provision for the suspension of payments to a Network Provider for which there is a credible allegation of fraud. (MHP Contract, Ex. A, Att. 13; 42 C.F.R. § 438.608(a)(8).)
    d. Implement, when applicable, any administrative, civil, and/or criminal remedies available under Federal and State laws prohibiting false claims, including but not limited to:
        i. Requiring repayment of falsely claimed amounts;
        ii. Require the payment of substantial financial penalties in addition to the repayment for the actual amount received per Civil remedies;
        iii. Require the repayment of funds received based on the false claim, plus substantial financial penalty fees, plus convicted individuals could receive prison sentences, per Criminal remedies;
        iv. Individuals or entities convicted of certain civil or criminal violations may be excluded from receiving any payment for

services or products from all federally funded health care programs for a specific term.

v. In addition to administrative, civil and/or criminal penalties, Yolo County HHSA BH and Network Providers may initiate personnel corrective action for individual employees -- up-to and including termination.

F. REFERENCES:

- California Government Code Section 12650-12656 (California False Claims Act)
- Department of Health Care Services All Plan Letter 17-003
- Title 42 of the Code of Federal Regulations (CFR), Section 438.608
- Title 42 of the Code of Federal Regulations (CFR), Section 455.1(a)(1)
- Mental Health and Substance Use Disorder Information Notice (MHSUD) No. 19-034
- Department of Health Care Services Intergovernmental Agreement for Substance Use Disorders
- United States Code, Section 3729-3733 (Federal False Claims Act)
- United States Code, Section 1320a-7
- United States Code, Section 1320a-7b(b)
- 42 United States Code, Section 1395nn.
- MHP Contract

Approved by:

Karen Larsen, Director **02/26/2021**
Yolo County Health and Human Services Agency **Date**