


<b>Governing Body:</b>  <b>MARION COUNTY COMMUNITY AND PROVIDER SERVICES (CAPS)</b>	<b>Function:</b> <b>INTEGRATED DELIVERY SYSTEM (IDS) HANDBOOK</b>	
<b>Subject:</b> <b>Fraud and Abuse</b>	<b>Prepared By:</b> <b>CAPS</b>	<b>Original Date: 01/01/2009</b>

**PURPOSE AND SIGNIFICANCE:**

Acting as the Local Mental Health Authority (LMHA), CAPS is committed to complying with all applicable Federal and State standards to guard against fraud and abuse. As an IDS Provider, agencies are required to establish administrative and management arrangements, internal controls, policies and procedures, and a mandatory compliance plan that is designed to prevent, detect, and guard against fraud and abuse as they relate to OHP Members.

**PROCESS AND/OR PROCEDURE:**

This document identifies the responsibilities of CAPS and its IDS Providers with respect to the prevention and detection of Fraud and Abuse related to the Oregon Health Plan (OHP). CAPS must fully comply with federal and state laws and rules that relate to the prevention and detection of fraud and abuse. IDS Providers must also fully comply with these federal and state laws. CAPS will review this document annually and revise as necessary.

CAPS and its Providers shall follow the applicable sections of this policy to the extent that it applies to the MH services that they manage under delegation from MVBCN and/or provide to MVBCN OHP Members.

IDS Providers are subject to the following laws and rules that relate to fraud and abuse involving Medicaid funds:

1. Federal False Claims Act (31 USC 3729-3733): This law provides for penalties and triple damages for anyone who knowingly submits or causes the submission of false or fraudulent claims for government funds, such as Medicaid funds. Under this law’s quid tam provisions, an individual with evidence of fraud, also known as a “whistleblower”, is authorized to file a case in federal court and sue, on behalf of the government, the Persons or entities engaged in the fraud and to share in any money that the government may recover.
2. Federal administrative remedies for false claims and statements (31 USC 3801-3812): Known as the Program Fraud Civil Remedies Act, under this law, anyone who makes, presents or submits (or causes to be made, presented or submitted) a claim to the federal government, such as for Medicaid funds, that the person knows or has reason to know is false, fictitious or fraudulent, or that omits a material fact, is subject to a penalty of up to \$5,000 per claim, plus an assessment of up to twice the amount of each false or fraudulent claim. The United States Inspector General investigates violations of this law. Enforcement can begin with a hearing before an administrative law judge. The government can recover penalties by a lawsuit or through an administrative offset against “clean” claims.

3. Federal Regulation 42 CFR Subpart A 455.12 – 455.106 Medicaid Agency Fraud Detection and Investigation Program, which defines the responsibilities of the state agency
4. Oregon laws pertaining to civil or criminal penalties for false claims and statements:
  - a. ORS 411.670 to 411.690 (submitting wrongful claim or payment prohibited; liability of person wrongfully receiving payment; amount of recovery);
  - b. ORS 646.505 to 646.656 (unlawful trade practices);
  - c. ORS chapter 162 (crimes related to perjury, false swearing and unsworn falsification);
  - d. ORS chapter 164 (crimes related to theft);
  - e. ORS chapter 165 (crimes involving fraud or deception), including but not limited to ORS 165.080 (falsification of business records) and ORS 165.690 to 165.698 (false claims for health care payments);
  - f. ORS 166.715 to 166.735 (racketeering – civil or criminal);
  - g. ORS 659A.200 to 659A.224 (whistleblowing);
  - h. ORS 659A.230 to 659A.233 (whistleblowing);
  - i. OAR 410-120-1395 to 410-120-1510 (DMAP program integrity, sanctions, fraud and abuse); and
  - j. Common law claims founded in fraud, including Fraud, Money Paid by Mistake and Money Paid by False Pretenses.
5. MVBCN, CAPS, and Participating Provider may be subject to other fraud and abuse laws not identified above.

Individuals employed by MVBCN, an LMHA or Participating Provider who come forward with evidence of fraud and abuse involving Medicaid funds have the following legal protections:

1. Federal False Claims Act (31 USC 3729-3733): Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the Act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.
2. Oregon Whistleblower Law (ORS 659A.200-224): In brief, it is an unlawful employment practice for any public employer to:
  - a. Prohibit any employee from disclosing, or take or threaten to take disciplinary action against an employee for the disclosure of, any information that the employee reasonably believes is evidence of:
    - i. A violation of any federal or state law, rule or regulation by the state, agency or political subdivision; or
    - ii. Mismanagement, gross waste of funds or abuse of authority or substantial and specific danger to public health and safety resulting from action of the state, agency or political subdivision; or
    - iii. The fact that a person receiving services, benefits or assistance from the state or agency or subdivision, is subject to a felony or misdemeanor warrant for arrest.

- b. Require any employee to give notice prior to making any disclosure or engaging in discussion described in Section II (A)(2)(a)(i-iii).
  - c. Discourage, restrain, dissuade, coerce, prevent or otherwise interfere with disclosure or discussions described in Section II (A)(2)(a)(i-iii).
3. Oregon law pertaining to an employee initiating or aiding in a legal proceeding (ORS 659A.230-233): In brief, it is an unlawful employment practice for an employer to discharge, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported criminal activity by any person, has in good faith caused a complainant's information or complaint to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.
  4. Individuals may have other legal protections not identified above.

At a minimum, IDS Providers must include the following within their program to prevent and detect fraud and abuse:

1. Credentialing of employed and sub-contracted Providers in accordance with MVBCN's credentialing policy. Elements of MVBCN's credentialing policy relating to fraud and abuse include:
  - a. Provider self-disclosure of adverse actions relating to Medicaid and Medicare provider status, and suspected or verified fraud and/or abuse involving Medicaid funds;
  - b. Criminal background checks; and
  - c. Exclusion of persons described in Subsection D below.
2. Requiring employees and contractors to disclose any conflict of interest relating to the provision of and payment for OHP services.
3. Disciplinary guidelines for employees and sub-contracted Providers whose actions constitute fraud or abuse.
4. Formal Complaint and Appeal procedures for OHP Members and OHP Member Representatives.
5. Periodic auditing of a random sample of Provider clinical records and the corresponding billing and claims payment data.
6. Procedures to promptly repay Medicaid funds paid in error to the appropriate LMHA in MVBCN's Service Area, and to correct the corresponding billing data.
7. Appropriate controls on employee and contractor access to clinical records, billing and accounting records, service authorization records, appointment schedules, eligibility data, and related resources that may be used to facilitate fraud or abuse.

Lastly, IDS Providers must train all employees and contractors on the MVBCN's policy, *Prevention and Detection of Fraud and Abuse*. In addition, the Provider must include, at a minimum, the following within the training and an employee handbook:

1. Articulation of the organization's commitment to guard against fraud and abuse.
2. Articulation of the organization's obligation to adhere to MVBCN's policy.
3. Description of federal and state laws relating to personal liability for knowingly engaging in actions that may constitute fraud or abuse.
4. Discussion of an employee's rights as a "whistleblower" to be protected from retaliation by his/her employer for coming forward with information about fraud or abuse.

5. Description of the organization’s program to prevent and detect fraud and abuse, including discussion of disciplinary guidelines for actions that constitute fraud or abuse.
6. Procedures to report fraud or abuse to the LMHA and/or MVBCN.
7. DHS and other health oversight entities are not limited in their authority to pursue legal redress for fraud and abuse to the full extent of the law.

To assist providers in ensuring that their program to prevent and detect fraud and abuse is comprehensive, a table outlining agency requirements and practices is below.

REQUIREMENT	CURRENT PRACTICE, IF APPLICABLE
<p>1 A. Credentialing  Provider self-disclosure of adverse actions relating to Medicaid/Medicare provider status, suspected or verified fraud or abuse related to Medicaid funds</p> <p>B. Criminal Background Checks  Exclusion of persons currently excluded from participating in procurement and/or non-procurement activities under the Federal Acquisition Regulation or Executive Order No. 12549 (p.7, III.D.1)  Exclusion of persons currently excluded from participation in Medicaid programs under Section 1128 or 1129A under the Social Security Act (p.7, III.D.2)  Providers shall not refer OHP Members to the above excluded individuals, nor accept billings for services; or, knowingly have a person described above as a director, officer, partner, or owner of more than 5% of entity's equity; or, have an employment, consulting, or other agreement with a person described above for the provision of items and services that are significant (p.7, III.D.3)</p>	<p>Employees must complete MVBCN Adverse Actions Self Report  Provider must complete DHHS OIG inquiry prior to hire</p> <p>Provider must complete prior to hire  Provider must query Federal <i>Excluded Parties List System</i> at <a href="http://www.epls.gov">www.epls.gov</a></p> <p>Provider must complete DHHS OIG inquiry prior to hire</p> <p>The agency shall not refer OHP Members to such Providers and shall not accept billings for Services to OHP Members submitted by such Providers.</p>
<p>2 Conflict of Interest  Require employees and contractors to disclose any conflict of interest relating to the provision of and payment for OHP services.</p>	<p>IDS Provider must identify areas of conflicts of interest prior to hire and at throughout employment  Required by MHO contract (p. 129, #19)</p>
<p>3 Disciplinary Guidelines  Establish disciplinary guidelines for employees and sub-contractored Providers whose actions constitute fraud and abuse.</p>	<p>Agency must establish well-publicized disciplinary guidelines for employees and sub-contractors whose actions constitute fraud and abuse. The agency may have these already established within their policies and procedures. The agency can utilize the Marion County disciplinary guidelines for their staff, however these must be publicized with staff.</p>

REQUIREMENT	CURRENT PRACTICE, IF APPLICABLE
<p>4</p> <p>Complaints and Appeals</p> <p>Formal Complaint and Appeal procedures for OHP Members and OHP Member Representatives</p>	<p>BCN Delegated Activity</p>
<p>5</p> <p>Auditing</p> <p>Periodic auditing of a random sample of Provider clinical records and the corresponding billing and claims payment data.</p>	<p>CAPS conducts biannual reviews of clinical records and corresponding billing/claims records. Next review scheduled for July 2009.</p> <p>The agency is required to conduct regular internal reviews of clinical records and the corresponding billing/claims records.</p>
<p>6</p> <p>Repayment</p> <p>Procedures to promptly repay Medicaid funds paid in error to the appropriate LMHA in MVBCN's Service Area, and to correct the corresponding billing data.</p>	<p>(1) If the CAPS biannual chart reviews determine repayment is necessary, the Provider will receive a written request for the overpayment of funds. Provider will submit their repayment to MCHD via PH Tech, who adjusts the encounter data before sending to MCHD for deposit.</p> <p>(2) If the agency determines they have received an overpayment, the agency is required to refund the overpaid funds. To refund monies, the agency submits repayment to MCHD via PH Tech, who adjusts the encounter data before sending to MCHD for deposit.</p> <p>(3) If PH Tech determines that a Provider has been overpaid, a written refund request will be sent. To refund monies, the agency submits repayment to MCHD via PH Tech, who adjusts the encounter data before sending to MCHD for deposit.</p>
<p>7</p> <p>Controls</p> <p>Appropriate controls on employee and contractor access to clinical records, billing and accounting records, service authorization records, appointment schedules, eligibility data, and related resources that may be used to facilitate fraud or abuse.</p>	<p>Agencies are responsible for controlling access to clinical records, billing and accounting records, service authorization records, appointment schedules, and related resources. Eligibility data requires role-based authorization access via MVIPA CIM.</p>
<p>8</p> <p>Training</p> <p>Providers shall train its employees and contractors regarding MVBCN's policy to prevent and detect fraud and abuse. Training will include the 7 points outlined in the MVBCN policy, <i>Prevention and Detection of Fraud and Abuse</i>.</p>	<p>Agencies are required to train employees of the MVBCN's policy. To fulfill this requirement, the agency may utilize the CAPS/MVBCN's PowerPoint training tool, but must maintain documentation that all staff have been trained.</p>