Policy Name: FRAUD, WASTE, AND ABUSE COMPLIANCE REPORTING STANDARDS **Policy Number:** CP303

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PURPOSE

To outline and define the scope, responsibilities, and activities to prevent, detect, and report incidents of Fraud, Waste, and Abuse (FWA). To outline a culture within, and activities conducted by, Salish Behavioral Health Administrative Services Organization (SBH-ASO) to prevent, detect, and report instances of FWA.

POLICY

All SBH-ASO business shall be conducted in compliance with state and federal requirements and regulations (including the False Claims Act), applicable local laws and ordinances, and the ethical standards/practices of the industry.

DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Allegation of Fraud: An unproved assertion, especially relating to wrongdoing or misconduct on the part of the Individual. An Allegation of Fraud is an allegation, from any source, including but not limited to the following:

- Fraud hotline complaints;
- Claims data mining; and

- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Fraud: An intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Subrogation: for the purposes of this policy, means the right of any state of Washington government entity or local law enforcement to stand in the place of the SBH-ASO or Individual in the collection against a third party.

Waste: Practices that, directly or indirectly, result in unnecessary costs such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Fraud, Waste, and Abuse may include but not be limited to:

- Failure to identify, pursue, and document Third Party resources
- Intentional billing for services not performed or improper billing
- Duplicate billing
- Unnecessary or misrepresented services
- Billing individuals for SBH-ASO covered services
- Upcoding
- Unbundling
- Kickbacks
- Evidence of intentional false or altered documents
- Unlicensed or excluded professional or facility at time of service
- Falsification of health care provider credentials or no credentials
- Falsification of agency financial solvency
- Agency management knowledge of fraudulent activity
- Incentives that limit services or referral
- Evidence of irregularities following sanctions for same problem
- Embezzlement and theft

PROCEDURE

SBH-ASO Administration

1. SBH-ASO does not enter into contracts or other arrangements with subcontractors which, directly or indirectly, pay, offer to pay, or give anything of value, in return for the referral of individuals or business to SBH-ASO for services paid by any federal health care program.

2. SBH-ASO does not approve, cause claims, nor allow encounter data to be transmitted or submitted to any federal health care program:
   A. For services provided as a result of payments made in violation of (1.) above.
   B. For services that are not reasonable and necessary.
   C. For services which cannot be supported by the documentation in the clinical and/or medical record.

3. SBH-ASO does not falsify or misrepresent facts concerning the delivery of services or payment of claims in connection with any federal health care program.

4. SBH-ASO does not provide incentives to providers to reduce or limit medically necessary behavioral health services to individuals.

5. SBH-ASO conducts all business with subcontractors at arm's length and pursuant to written contract that will stand up to legal scrutiny with frequent and various monitoring mechanisms.

6. No SBH-ASO staff or person associated with SBH-ASO prevents or delays the communication of information, or records related to, violation of the SBH-ASO Compliance and Program Integrity Plan (the Plan) to the SBH-ASO Compliance Officer (CO).

SBH-ASO Fraud Waste and Abuse Program and the Role of the Compliance Officer

1. The CO duties include the following with respect to FWA:
   - To oversee and monitor the overall compliance activities of the SBH-ASO, including co-facilitating the QACC, whose agenda reviews FWA agenda items.
   - Continue to develop the Plan and monitoring activities with the QACC that have SBH-ASO-wide application to the provider entities.
   - To assist the Boards and staff in establishing methods to reduce SBH-ASO vulnerability to FWA.
   - To receive, and investigate when appropriate, reports of possible fraud and abuse violations, per HCA BH-ASO contract.
   - To develop corrective action plans, in coordination with the SBH-ASO Leadership Team, for the SBH-ASO and providers to correct violations and prevent future incidents of noncompliance.
   - To develop policies and programs and educational activities that encourage employees, contractors, and Boards to report suspected FWA violations without fear of retaliation.

2. The SBH-ASO Compliance Officer (CO) is responsible for overseeing the SBH-ASO Compliance and Program Integrity Plan (the Plan) and coordinating monitoring activities in conjunction with the SBH-ASO Leadership Team.

3. The SBH-ASO Compliance Officer provides reports to the SBH-ASO Quality Assurance and Compliance Committee (QACC). The CO provides reports to the SBH-ASO Executive Board at least annually.

SBH-ASO Fraud, Waste, and Abuse Monitoring

1. The SBH-ASO detects and prevents FWA through the following activities:
    a. SBH-ASO Annual Monitoring Reviews with each subcontractor
        i. The SBH-ASO audit tool includes a Program Integrity section that reviews various Compliance and Program Integrity activities conducted by a subcontractor.
        ii. The SBH-ASO verifies the Third-Party Resources pursued. The SBH-ASO inquires and verifies the provider agency process for pursuing other billing sources.
        iii. As part of the SBH-ASO Annual Monitoring Review, SBH-ASO staff verify the newly hired subcontractor staff have been screened through the Exclusion Websites, as evidenced in personnel files of new hires. Staff verify the screening through a website verification printout located in the personnel file.
    b. Internal monitoring and auditing for FWA includes reviewing SBH-ASO financial statements by the State Auditor's Office, multiple feedback loops through various SBH-ASO committees, and individual sources to receive timely and confidential information. Examples of specific internal monitoring activities may include, but are not limited to:
        i. SBH-ASO Leadership review of all invoices prior to payment
        ii. Contracted agencies' annual independent financial audits
        iii. SBH-ASO profiling of provider data
        iv. Ombuds reporting at QACC, and other in-network committees
        v. SBH-ASO Grievance, Appeal, and Adverse Authorization Determination Quarterly Reports
        vi. SBH-ASO Utilization Management Monthly Tracking Reports

Developing Effective Lines of Communication

1. An open line of communication between the CO and staff or others associated with the SBH-ASO is critical to the successful implementation and operation of the Plan.

- All staff and persons associated with the SBH-ASO have a duty to report all incidents of abuse and fraudulent activities, suspected or otherwise, to the CO or to the HCA Office of Medicaid Eligibility and Policy (OMEP). The SBH-ASO trainings provide information to encourage staff and subcontractors to report suspected violations of the Plan without fear of retaliation.
- CO has direct access to the SBH-ASO Executive Board

2. As outlined in the SBH-ASO training curriculum and widely distributed information material, an Individual may use any of the following mechanisms to report incidents of suspected violation(s):

    1. In person, to the SBH-ASO CO, Ileea Clauson
    2. Calling the CO directly at (360) 337-4833 or (800) 525-5637, information can be left anonymously
    3. By faxing the CO at (360) 337-5721
    4. By e-mailing the CO at SalishCompliance@co.kitsap.wa.us
    5. By mailing a written concern to the CO:

        SBH-ASO Compliance Officer
        Salish Behavioral Health Administrative Services Organization
        614 Division St. MS-23
        Port Orchard, WA 98366

    6. Calling Office of Medicaid Eligibility and Policy (OMEP) at 360-725-0934 and leaving a detailed message
    7. Mailing a written complaint to:
        Health Care Authority
        Attn: OMEP
        P.O. Box 45534
        Olympia, WA 98504-5534
    8. Entering the complaint online at: https://wadshs.libera.com/Sys7CMSPortal-FCMS-WA/fraud/report.aspx
    9. Faxing the written complaint to Washington Apple Health Eligibility Fraud at 360-725-1158
    10. Emailing the compliant electronically WAHeligibilityfraud@hca.wa.gov
    11. In addition, any person may seek guidance with respect to the Plan or the procedures contained in this policy at any time by following the same reporting mechanisms outlined above.

REFERRING OF ALLEGATIONS OF POTENTIAL FRAUD AND INVOKING PROVIDER PAYMENT SUSPENSIONS

The SBH-ASO maintains policies and procedures for referring all identified allegations of potential Fraud to HCA and for provider payment suspensions. When HCA notifies the SBH-ASO that a credible Allegation of Fraud exists, the SBH-ASO shall follow the provisions for payment suspension contained in this Section.

When the SBH-ASO has concluded that an allegation of potential provider Fraud exists, the SBH-ASO shall make a Fraud referral to HCA within five (5) Business Days of the determination. The referral must be emailed to HCA at HotTips@hca.wa.gov. The SBH-ASO shall report using the WA Fraud Referral Form.

When HCA determines the SBH-ASO's referral of potential Fraud is a credible Allegation of Fraud, HCA shall notify the SBH-ASO's compliance officer, who will notify the SBH-ASO Administrator to:

- To suspend provider payments, in full, in part, or if a good cause exception exists to not suspend. Unless otherwise notified by HCA to suspend payment, the SBH-ASO shall not suspend payment of any provider(s) identified in the referral.
- Whether the HCA, or appropriate law enforcement agency, accepts or declines the referral.
    - If HCA, or appropriate law enforcement agency accepts the referral, the SBH-ASO must "stand-down" and follow the requirements in the Investigation subsection of this section.
    - If HCA, or appropriate law enforcement agency decline to investigate the potential Fraud referral, the SBH-ASO may proceed with its own investigation and comply with the reporting requirements in the Reporting section, below.

Upon receipt of payment suspension notification from HCA, the SBH-ASO shall send notice of the decision to suspend program payments to the provider within five (5) calendar days of HCA's notification to suspend payment, unless an appropriate law enforcement agency requests a temporary withhold of notice.

The notice of payment suspension must include or address all of the following:

- State that payments are being suspended in accordance with this provision;
- Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;
- State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that it is no longer in place;
- Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and
- Where applicable and appropriate, inform the provider of any Appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the SBH-ASO.

All suspension of payment actions under this Section will be temporary and will not

continue after either of the following:

- The SBH-ASO is notified by HCA or appropriate law enforcement agency that there is insufficient evidence of Fraud by the provider; or
- The SBH-ASO is notified by HCA or appropriate law enforcement agency that the legal proceedings related to the provider's alleged Fraud are completed.

The SBH-ASO will document in writing the termination of a payment suspension and issue a notice of the termination to the provider and send a copy to HCA at ProgramIntegrity@hca.wa.gov.

HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible Allegation of Fraud if any of the following are applicable:

- A law enforcement agency has specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies are available to the SBH-ASO, after HCA approves the remedies as more effective or timely to protect Medicaid funds.
- HCA determines, based upon the submission of written evidence by the SBH-ASO, individual or entity that is the subject of the payment suspension, there is no longer a credible Allegation of Fraud and that the suspension should be removed. HCA shall review evidence submitted by the SBH-ASO or provider. The SBH-ASO may include a recommendation to HCA. HCA shall direct the SBH-ASO to continue, reduce, or remove the payment suspension within thirty (30) calendar days of having received the evidence.
- Individual’s access to items or services would be jeopardized by a payment suspension because of either of the following:
    - An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
    - The individual or entity serves a large number of Individuals within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.
- A law enforcement agency declines to certify that a matter continues to be under investigation.
- HCA determines that payment suspension is not in the best interests of the Medicaid program.

The SBH-ASO shall maintain for a minimum of ten (10) years from the date of issuance all materials documenting:

- Details of payment suspensions that were imposed in whole or in part; and
- Each instance when a payment suspension was not imposed or was discontinued for good cause.

If the SBH-ASO fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible Allegation of Fraud without good cause, and HCA

directed the SBH-ASO to suspend payments, HCA may impose sanctions in accordance with the Sanctions Subsection of the HCA BH-ASO Contract.

If any government entity, either from restitutions, recoveries, penalties, or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and the SBH-ASO and any involved subcontractor have no claim to any portion of this recovery.

Furthermore, the SBH-ASO is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the SBH-ASO or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.

Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

REPORTING

All Program Integrity reporting to HCA shall be in accordance with the Notices provisions of the General Terms and Conditions of the BH-ASO contract with HCA unless otherwise specified herein.

The SBH-ASO shall submit to HCA a report of any recoveries made or overpayments identified by the SBH-ASO during the course of their claims review/analysis. The report will be submitted to HCA at ProgramIntegrity@hca.wa.gov.

The SBH-ASO is responsible for investigating Individual Fraud, waste, and abuse. If the SBH-ASO suspects Client/member/Enrollee Fraud:

- The SBH-ASO shall notify and submit all associated information of any alleged or investigated cases in which the SBH-ASO believes there is a serious likelihood of Fraud by an Individual to the HCA Office of Medicaid Eligibility and Policy (OMEP) by any of the following:
    - Sending an email to WAHeligibilityfraud@hca.wa.gov;
    - Calling OMEP at 360-725-0934 and leaving a detailed message;
    - Mailing a written referral to:
      Health Care Authority
      Attn: OMEP
      P.O. Box 45534

Olympia, WA 98504-5534
- Faxing the written complaint to Washington Apple Health Eligibility Fraud at 360-725-1158.

The SBH-ASO will notify and submit all associated information of any alleged or investigated cases in which the SBH-ASO believes there is a serious likelihood of provider Fraud by an individual or group using the WA Fraud Referral Form within five (5) Business Days from the date of determining an allegation of potential Fraud exists.

The SBH-ASO shall submit to HCA on occurrence a list of terminations report including Providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related Program Integrity termination. The Salish BH-ASO shall send the report electronically to HCA at ProgramIntegrity@hca.wa.gov with subject "Program Integrity list of Terminations Report." The report must include all of the following:

1. Individual Provider/entitys' name;
2. Individual Provider/entity's NPI number;
3. Source of termination;
4. Nature of the termination; and
5. Legal action against the individual/entity.