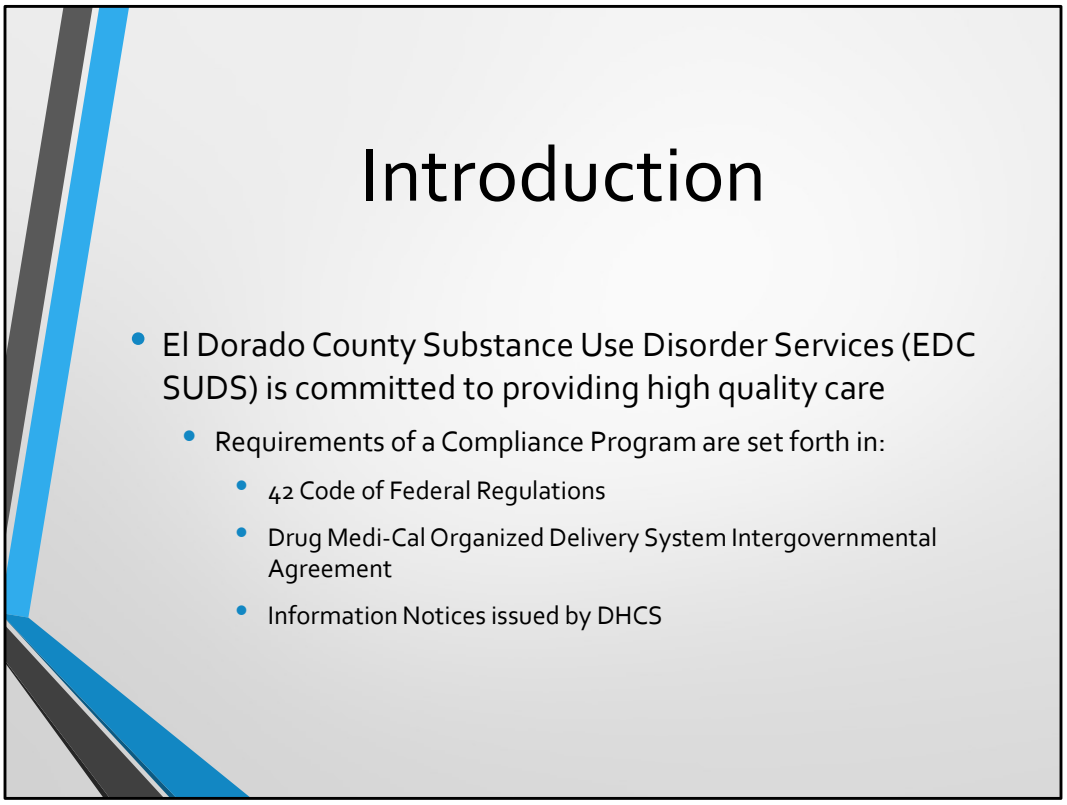
Hello everyone. Thanks for coming. We will be sending a sign in sheet form link to everyone who is here and you will need to complete the sign in sheet form to receive credit for attending with Certificates of Attendance.

This presentation will be taped and posted to the EDC SUDS webpage under trainings and the PPT will be sent out later this week.

(Start recording)

Welcome to another El Dorado County Substance Use Disorder Services DMC-ODS Quality Assurance Training Series presentation. Today we will be discussing Compliance-Raising awareness of requirements and activities



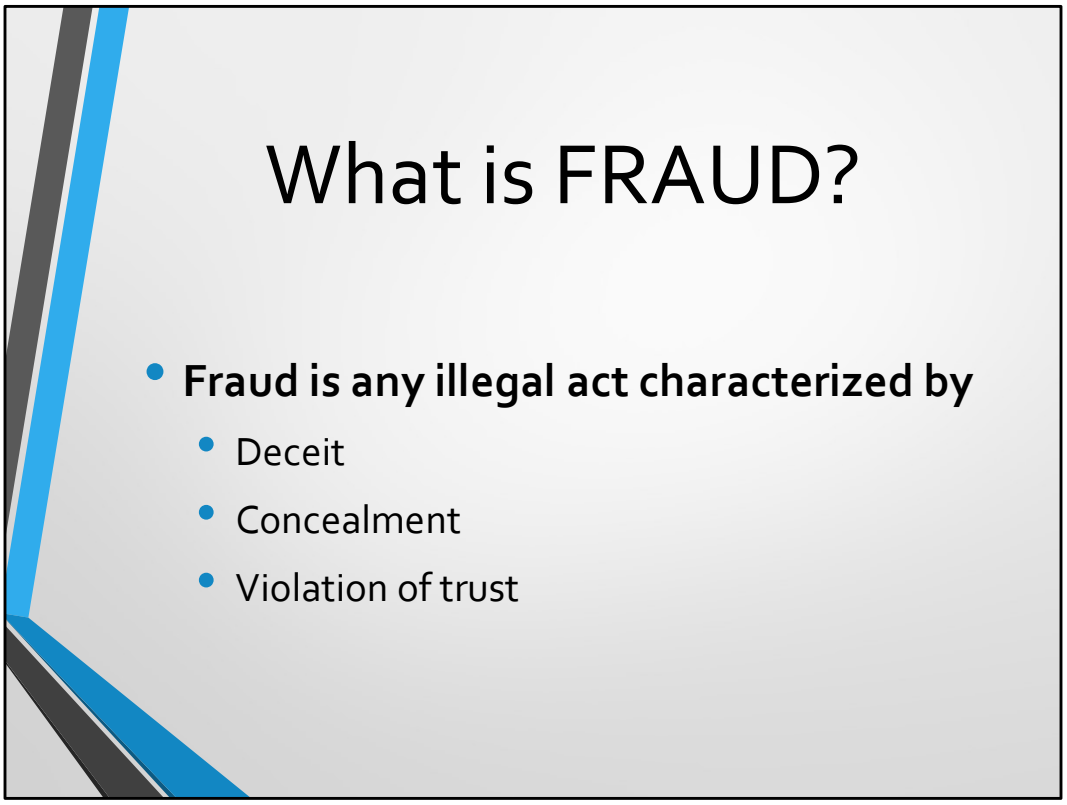
El Dorado County Substance Use Disorder Services (EDC SUDS) is committed to providing high quality care to clients and being of maximum service to the community. The services provided by the EDC SUDS DMC-ODS Provider Network are reimbursed in large part by federal and State funding sources. It is the policy of the EDC SUDS to comply with all applicable federal and State laws, regulations, and statutes, conditions of participation, and guidelines that govern reimbursement from all third-party payers.

Requirements of a Compliance Program are set forth in 42 Code of Federal Regulations Sections 455.1 and 438.608. Further requirements for Program Integrity, which includes the Compliance Program, are established pursuant to the Drug Medi-Cal Organized Delivery System Intergovernmental Agreement between the State of California Department of Health Care Services (DHCS) and El Dorado County HHSA, as well as through Information Notices issued by DHCS.

The Center for Medicare & Medicaid Services states:

Fraud, waste and abuse cost states billions of dollars every year, diverting funds that could otherwise be used for legitimate services. Not only do fraudulent and abusive practices increase the cost without adding value – they increase risk and potential harm to beneficiaries.

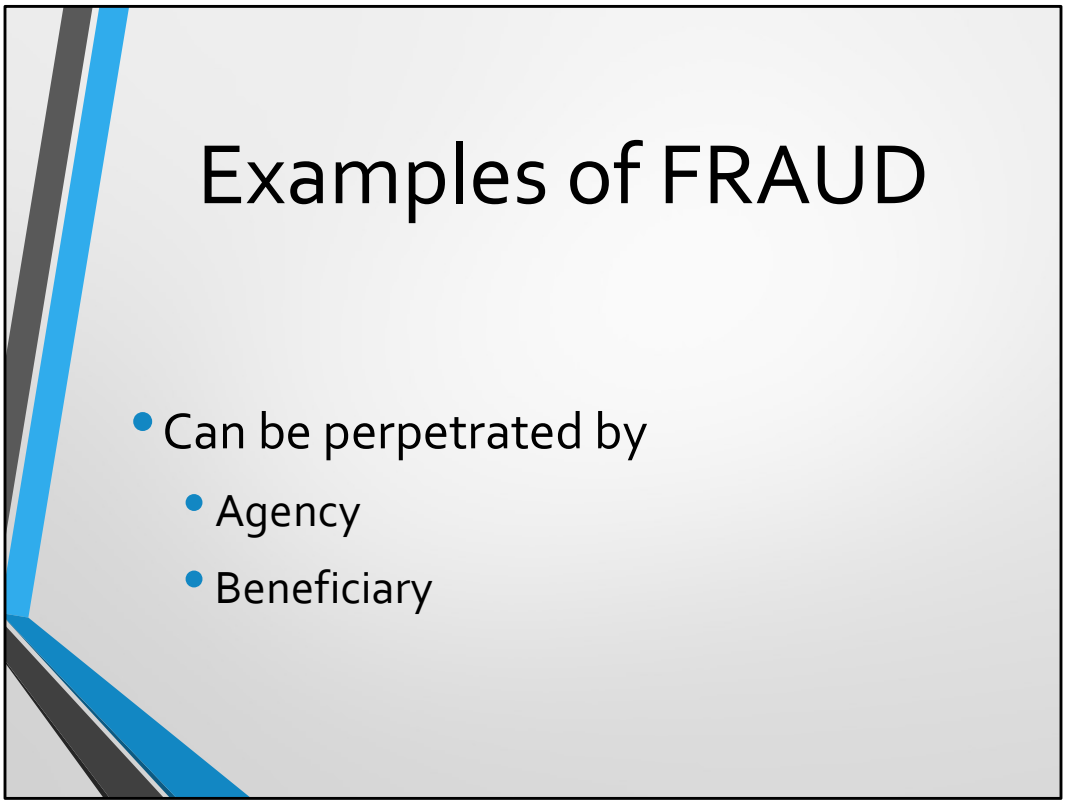
There are differences between Fraud, Waste, and Abuse. These differences are based upon intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and Abuse may involve obtaining an improper payment but does not require the same intent and knowledge.



The Center for Medicare & Medicaid Services defines fraud as:

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment for up to 10 years. It is also subject to criminal fines of up to $250,000

Simply put Fraud is any illegal act characterized by deceit, concealment, or violation of trust. Fraud is perpetrated by parties and organizations to obtain money, property, or services; to avoid payment or loss of services; or to secure personal or business advantage.



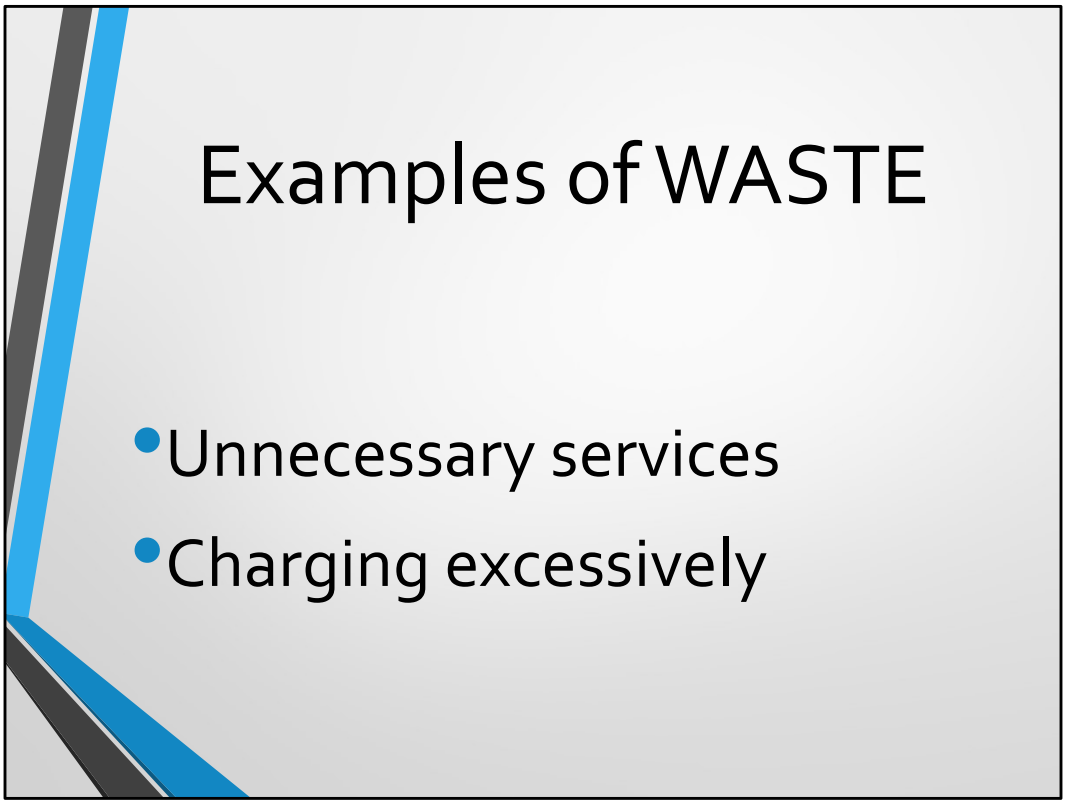
Agency examples:
Billing for services not performed
Billing duplicate times for one service
Falsifying a diagnosis
Billing for a more costly service than performed
Billing for a more costly service than performed
Knowingly collaborating with beneficiaries to file false claims for reimbursement
Knowingly billing for an ineligible beneficiary

Beneficiary examples:
Sharing a Medi-Cal identification (ID) card with someone else so they can obtain services
Accepting payment from a provider for referring other beneficiaries for services
Altering or duplicating a Medi-Cal ID card and using it or selling it for someone else to use
Providing incorrect information to qualify for Medi-Cal

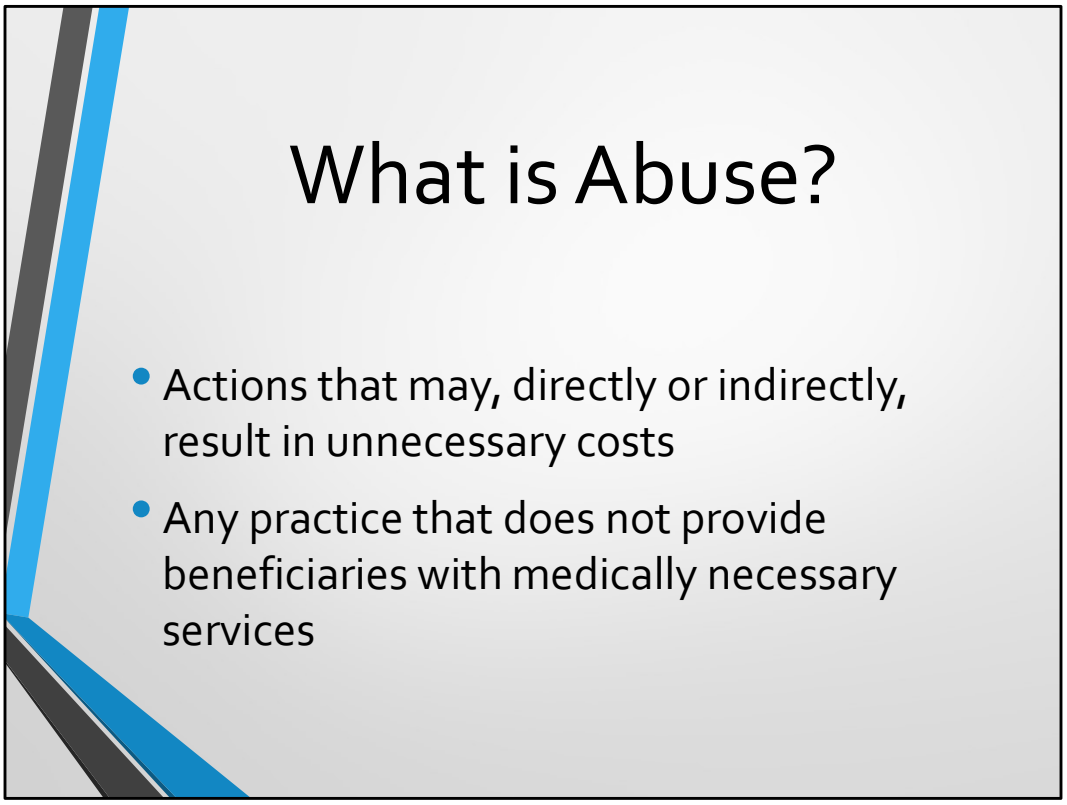
The Center for Medicare & Medicaid Services defines waste as:

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

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities. Waste relates to mismanagement, inappropriate actions, and inadequate oversight.



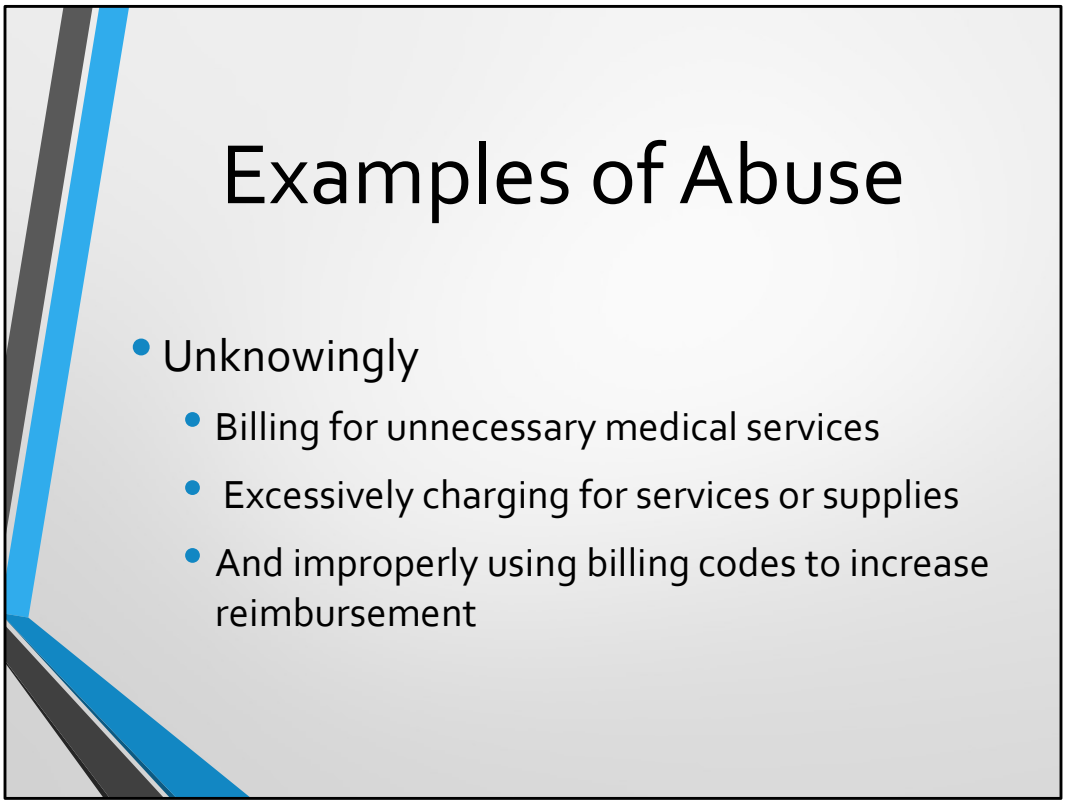
Recommending or invoicing for unnecessary services
Charging excessively for services



The Center for Medicare & Medicaid Services defines abuse as:

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Program. Abuse includes any practice that does not provide beneficiaries with medically necessary services or meet professionally recognized standards of care.

Abuse involves payment for items or services when there is no legal entitlement to that payment even when the provider has unknowingly and/or unintentionally misrepresented facts to obtain payment.



Unknowingly billing for unnecessary medical services

Unknowingly excessively charging for services or supplies

Unknowingly and improperly using billing codes to increase reimbursement

To detect FWA, you need to know the law.

There are several laws that govern fraud, waste and abuse.

Civil False Claims Act (FCA)-The False Claim Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system.

Health Care Fraud Statute-States, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both.”

To detect FWA, you need to know the law.

There are several laws that govern fraud, waste and abuse.

Civil Monetary Penalties (CMP) Law-The Office of Inspector General (OIG) may impose civil penalties for several reasons Providing services or items while excluded, Failing to grant OIG timely access to records ,Knowing of an overpayment and failing to report and return an overpayment , Making false claims and Paying to influence referrals

California Insurance Frauds Prevention Act-The California Insurance Fraud Prevention Act (CA IFPA) is a state antifraud statute that, while modeled on the FCA, stands on its own because it targets fraud on commercial insurance. The IFPA has become a primary vehicle in California for addressing alleged healthcare fraud.

Effective communication is the key to a successful Compliance Program, including providing the EDC SUDS DMC-ODS Provider Network and the public with open lines of communication for reporting suspected fraudulent activity, as well as to provide access to compliance information when needed.

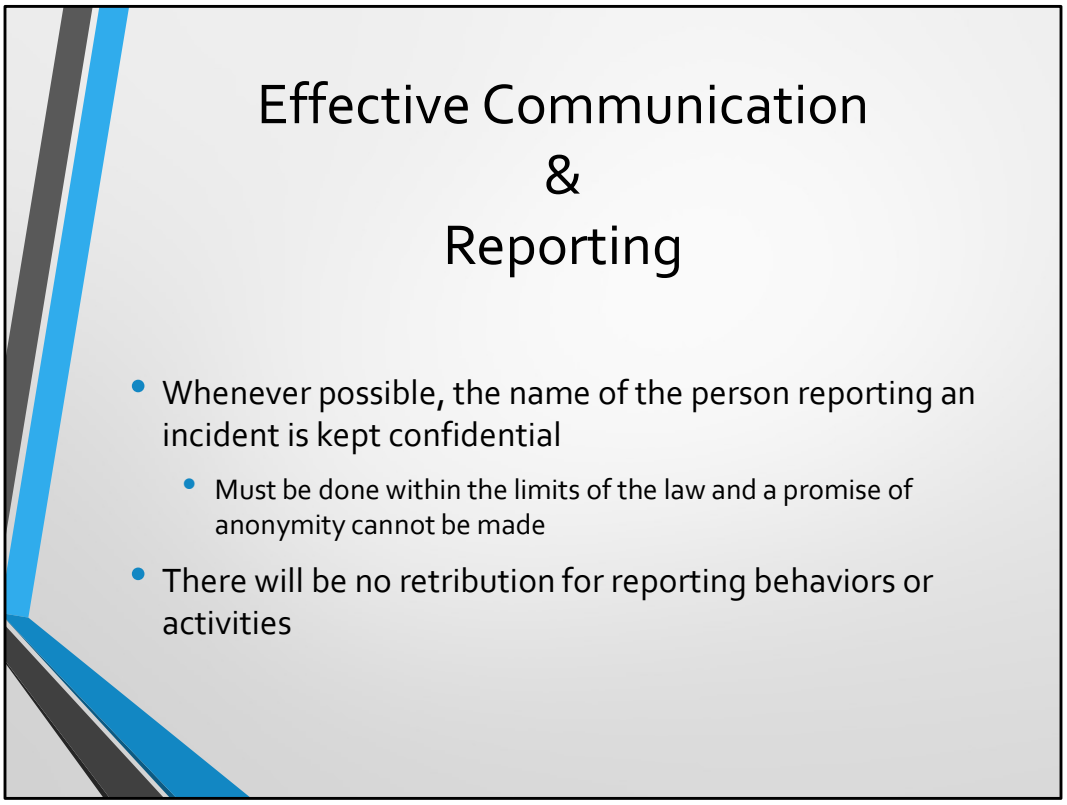
The Compliance Officer maintains an “open door” policy and may be contacted directly by any of the EDC SUDS DMC-ODS Provider Network or member of the public to report any violations or suspected violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices including, but not limited to, the following:
Incidents of fraud, waste, and abuse
Criminal activity (fraud, kickback, embezzlement, theft, etc.)
Conflict of interest issues
Code of Ethics and Expectation Standards violations; and
Activities that may violate the ethical and legal standards and practices of the Compliance Program.

To promote meaningful and open communication, the Compliance Program includes the following:

The requirement that the EDC SUDS DMC-ODS Provider Network workforce members report behavior that a reasonable person would, in good faith, believe to be suspected fraudulent activity.

A confidential process for reporting suspected fraudulent activity.

A standard that a failure to report suspected fraudulent activity is a violation of the Compliance Program.



To promote meaningful and open communication, the Compliance Program includes the following:

Whenever possible, the name of the person reporting an incident is kept confidential. Keeping the reporter's name confidential must be done within the limits of the law and a promise of anonymity cannot be made. There may be certain occasions when a person's identity may become known or may need to be revealed to aid the investigation or corrective action process. In such instances, there will be no retribution for reporting behaviors or activities that a reasonable person acting in good faith would have believed to be inaccurate or fraudulent

The phone number and the email address for reporting fraud, waste or abuse is shown on this slide.

The Compliance Hotline is accessible 24 hours a day, 365 days a year.

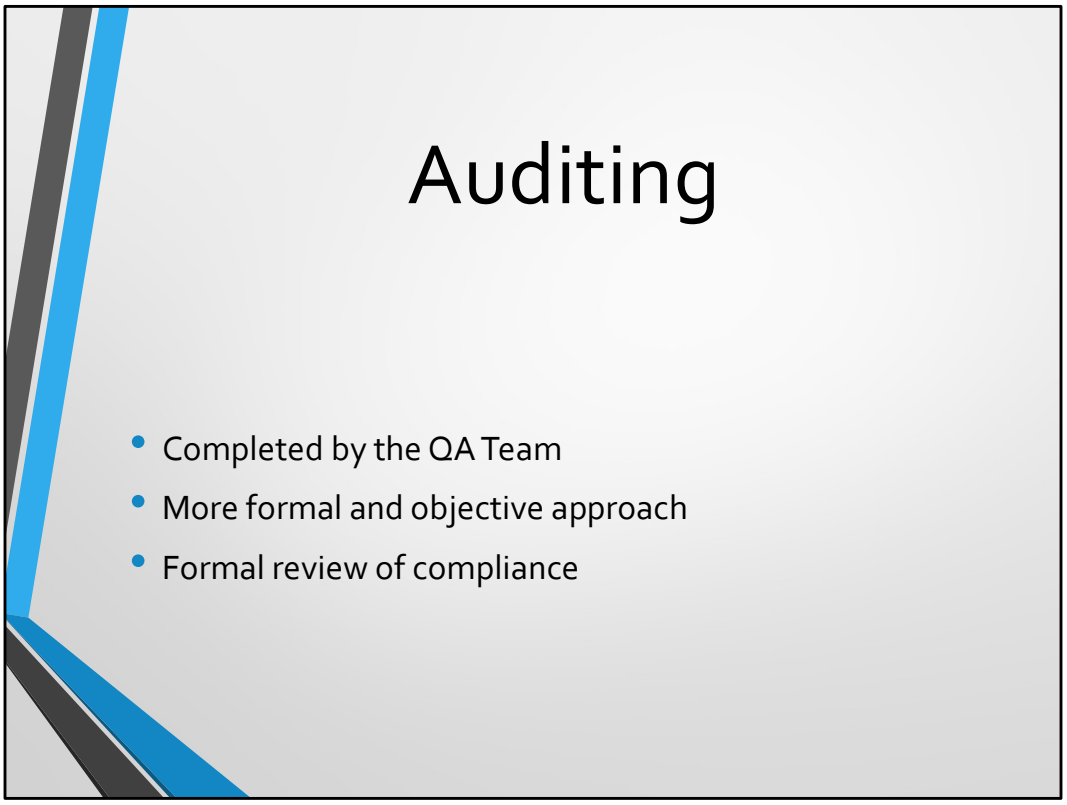
Messages left on the Compliance Hotline will be referred to the Compliance Officer and investigated.

Follow-up calls may be scheduled; however, information regarding the investigation and status of any action taken relating to the report may not be available to the caller.

The Compliance Program includes monitoring and auditing systems designed to detect areas of improvement, training needs, best practices, and ethical or legal violations.

Monitoring is an on-going process to ensure processes are working as intended. It consists of checking and measuring that can be performed on a regular schedule or on an ad hoc basis. Monitoring includes reviews conducted during the normal course of operations to ensure corrective actions are being implemented and maintained; or, when no specific problem has been identified to confirm ongoing compliance.

Internal monitoring is most frequently performed by Supervisors and Managers, who have responsibility for reviewing staff performance and compliance with program requirements. Supervisors and Managers are responsible for running reports from their EHR on a regular schedule, reviewing the reports, working with staff to address any performance or compliance issues, and reporting any potential fraud, waste, abuse or other suspected fraudulent activity to the Compliance Office. Any inconsistencies, suspected violations or questionable conduct is to be reported, investigated, and if necessary and appropriate, corrected.



Auditing is completed by the QA Team and is a more formal and objective approach to evaluate and improve the effectiveness of the EDC DMC-ODS's processes and to ensure oversight of delegated activities. An audit is a formal review of compliance using a particular set of standards as base measures performed by someone with no vested interest in the outcomes.

Audits may relate to program operations, chart documentation, or other special topics, and may include but is not limited to site visits, interviews with personnel, review of written materials and documentation and data analysis. EDC DMC-ODS may perform internal audits as well as audits of its contracted providers.

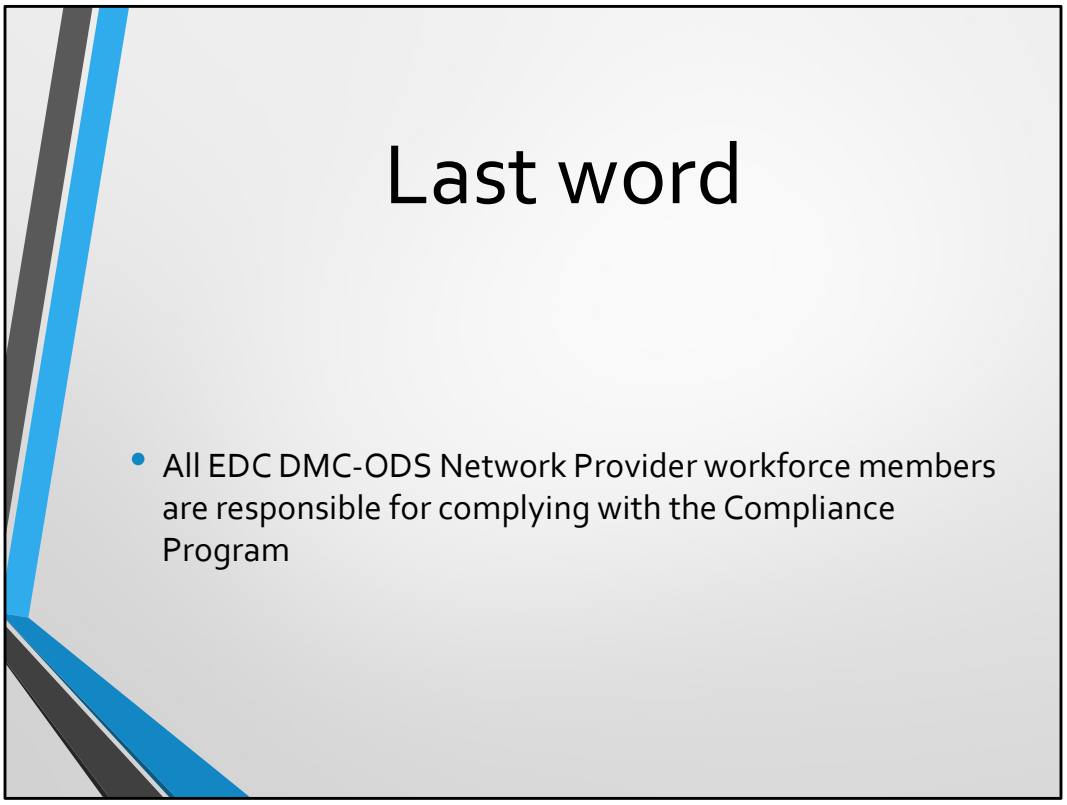
Audit irregularities are reported to the Compliance Officer.

When appropriate, the Compliance Officer informs the appropriate agency (e.g., DHCS or law enforcement) of reportable findings, such as fraud, waste, or abuse.

The Compliance Office has the authority to investigate any reported or otherwise identified potential compliance issue and will either conduct the investigation and/or refer the issue to a more appropriate area within or outside EDC DMC-ODS, including but not limited to a Compliance Committee Co-Chair, County and/or State Fraud Units, County Counsel, HHSA Personnel, County Human Resources, auditors, or health care consultants with the needed expertise.
Investigations are to be conducted promptly, objectively, thoroughly, confidentially, and within the limits of the law.

This Compliance Plan requires investigation of all reported or identified potential violations. When potential violations are reported or detected, the Compliance Officer, or designee, will perform the investigation, and determines whether:

A flaw in the Compliance Program failed to anticipate the problem;
Adequate training was provided on the issue;
Evidence exists that indicates the violation may be potential misconduct; and/or
There are any other contributing or mitigating factors to consider.



All EDC DMC-ODS Network Provider workforce members are responsible for complying with the Compliance Program. Failure to do so will be responded to fairly, firmly, consistently and in proportion to the real or potential risk of harm to the EDC DMC-ODS .

For EDC employees-Any required disciplinary action is initiated by the appropriate management personnel, not by the Compliance Program. Most small, unintentional and short term infractions are met with education and training whenever possible. When employees must be disciplined, each situation is evaluated on a case-by-case basis following the County's Personnel Rules and procedures.

Violations by individual service contractors are handled according to the terms of their contract with the County.


Questions

I want to thank every one for attending today.

Please fell free to contact Shaun or myself for any questions you may have.