Health Plan of San Joaquin

Mountain Valley Health Plan

<table>
<tr><td colspan="2">POLICY AND PROCEDURE</td></tr>
<tr><td colspan="2">TITLE:
Fraud, Waste and Abuse</td></tr>
<tr><td>DEPARTMENT POLICY OWNER:
Compliance</td><td>POLICY #:
CMP05</td></tr>
<tr><td colspan="2">IMPACTED DEPARTMENT(S):
Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined</td></tr>
<tr><td>1) ☒All Departments
2) ☐Behavioral Health (BH)
3) ☐Benefits Administration (BA)
4) ☐Care Management (CM)
5) ☐Claims (CLMS)
6) ☐Community Marketplace & Member Engagement (MAR)
7) ☐Compliance (CMP/HPA)
8) ☐Configuration (CFG)
9) ☐Provider Contracting (CONT)
10) ☐Cultural & Linguistics (CL)
11) ☐Customer Service (CS)</td><td>12) ☐Facilities (FAC)
13) ☐Finance (FIN)
14) ☐Human Resources (HR)
15) ☐Information Technology / Core Systems (IT)
16) ☐Pharmacy (PH)
17) ☐Provider Networks (PRO)
18) ☐QI Health Equity (GRV/HE/HEQ/PHM/QM)
19) ☐ Utilization Management (UM)</td></tr>
<tr><td>PRODUCT TYPE:
☒Medi-Cal</td><td>Supersedes Policy Number:
N/A</td></tr>
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I. PURPOSE

The purpose of this policy is to ensure that Health Plan of San Joaquin and Mountain Valley Health Plan (“Health Plan”) complies with all laws governing its operations, conducts business according to legal and ethical standards, prevents fraud, waste, and abuse (FWA) of the Health Plan’s organizational assets, and aligns with Section 6032 of the Deficit Reduction Act of 2005 to decrease financial loss resulting from false claims.

II. POLICY

A. Protection of Assets:

1. The Health Plan prohibits FWA of its assets. This prohibition includes attempts and conspiracies to conduct such activity, as well as the aiding, abetting, or concealing of such attempts and

conspiracies. The Health Plan promotes behavior that avoids FWA and promotes organizational accountability.

B. Fraud Prevention Officer:
   1. Chief Compliance Officer (CCO) serves as the Fraud Prevention Officer and is responsible for developing, implementing, and ensuring compliance with the Health Plan's Fraud Prevention Program. The CCO reports directly to the Chief Executive Officer (CEO) and the Commission.

C. Electronic Individual Case Reporting to DHCS:
   1. Upon discovering or being notified of suspected instances of FWA, whether reported by the Health Plan itself, its subcontractors, downstream subcontractors, or network providers, the Health Plan submits a preliminary report to DHCS within ten (10) working days.
   2. Upon completion of its investigation, the Health Plan submits to DHCS a comprehensive report detailing its findings, actions taken, and all pertinent documentation supporting these actions.

D. Electronic Roll-up Reporting to DHCS:
   1. The Health Plan provides DHCS with a quarterly report that details the status of all preliminary, active, and completed investigations related to FWA.
      a. This report is submitted within ten (10) working days following the close of each calendar quarter.
      b. The Health Plan provides updates and available documentation upon request from DHCS.
   2. When overpayments are identified due to suspected FWA, the Health Plan submits a report to DHCS within 10 working days of identifying or recovering these overpayments. [1]
   3. As part of its annual report to DHCS, the Health Plan reports all recoveries of overpayments, incorporating in the Rate Development Template (RDT), as outlined in *CLMS14–Overpayment of Services: Recovery*.[2]

E. Confidentiality of Investigations:

1 APL 23-011 - *Treatment of Recoveries Made by The Managed Care Health Plan of Overpayments To Providers*
2 42 CFR 438.608(d)(3)

1. The Health Plan makes every reasonable effort to maintain respect, confidentiality, and privacy throughout the investigation and resolution of reported incidents. Information related to investigations is shared only on a need-to-know basis and may be subject to attorney-client privilege.
2. The Health Plan treats all information shared by DHCS, other State and Federal agencies, and other Medi-Cal managed care plans regarding FWA as confidential until formal criminal proceedings become public. The Health Plan only uses this information for conducting investigations into potential FWA activities and other program integrity efforts. If the Health Plan needs to share this confidential information with a subcontractor, downstream subcontractor, or network provider, these Third-Party entities should also acknowledge the confidentiality.

F. Cooperation with Law Enforcement:

1. The Health Plan cooperates with the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), the United States Department of Justice (U.S. DOJ), and/or any other law enforcement organization in their investigations or prosecution, to include providing records and making staff available upon request.
2. The Health Plan requires its subcontractors and downstream subcontractors to conform to this policy and the Health Plan's commitment to fully cooperate with directives from stated law enforcement agencies. This includes enforcing compliance from effected providers, contractors, subcontractors, and downstream subcontractors and ensuring their cooperation with investigations and prosecution as outlined in the Health Plan's policy Corrective Action and Sanctions.
3. The Health Plan provides guidelines on how it complies with investigations or legal actions by DMFEA and/or the U.S. DOJ, including sharing these guidelines with subcontractors, downstream subcontractors, and network providers.

G. Federal False Claims Act (FCA) Requirements:

1. The Health Plan defines the False Claims Act as 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.

2. The Health Plan maintains this policy to serve as education of the workforce, subcontractors, downstream subcontractors, and network providers on the federal False Claims Act.
3. The Health Plan also requires its Workforce, subcontractors, downstream subcontractors, and network providers to participate or attest to completing training of FWA, including false claim act training, annually and within the first 30 of hire.
4. The Health Plan adopts the laws and regulations related to Whistleblowers. The Federal False Claims Act protects employees who report (Whistleblowers) a violation under the False Claims Act from discrimination, harassment, suspension, or termination of employment as a result of reporting possible fraud. Employees who report fraud and consequently suffer discrimination may be awarded:
   a. Two times their back pay plus interest
   b. Reinstatement of their position without loss of seniority
   c. Compensation for any costs or damage they incurred.
5. In compliance with HIPAA Federal and State regulations and the Health Plan's policy Whistleblowers and Workforce Crime Victims, the Health Plan's Workforce does not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against health plan members, physicians, employees or any other person or entity for reporting ethics issues or suspected violations of law and regulatory requirements, accreditation requirements, or exercising their rights under federal or state laws including protections under the False Claims Act for whistleblowers.

H. California False Claims Act:

1. The Health Plan complies with the CA FCA laws and regulations which is a civil action similar to the federal False Claims Act but is

more stringent than the Federal False Claims Act.

a. CA FCA permits the State Attorney General to bring a civil law enforcement action to recover treble damages and civil penalties against any person who knowingly makes or uses a false statement or document to either obtain money or property from the State or avoids paying or transmitting money or property to the State.
b. CA FCA also allows the "Whistleblower" to receive a higher percentage of the recoveries and to participate even when prosecuted by the Department of Justice (DOJ) or Office of Attorney General (OAG).
c. Under the CA civil FCA, each instance of an item or a service billed to Medicare or Medi-Cal counts as a claim and the penalties start at $10,000 a claim.

2. Criminal penalties, under CA FCA, for submitting false claims include imprisonment and criminal fines.

I. DHCS Recovery of Funds:
   1. The Health Plan understands that if funds are recovered by Office of Attorney General, DMFEA or the US DOJ as a result of prosecution of a subcontractor, downstream subcontractor, or network provider, under the California or Federal False Claims Act, that those funds belong exclusively to DHCS. The Health Plan waives any claim to those funds.

J. Notification of Settlement:
   1. Any settlement or resolution of a disputed matter involving FWA between the Health Plan and its subcontractors, downstream subcontractors, or network providers includes a written provision notifying them that DHCS, DMFEA, or the U.S. DOJ are not bound by the settlement and may take further action against the parties involved.

III. PROCEDURE

A. Method to Report
   1. In compliance with the Health Plan's Code of Conduct and Ethics, the Health Plan's Workforce is required to report suspected acts of

FWA immediately. Suspected acts of FWA should be reported to one or more of the following:

a. Through the Compliance Department Share Point Link titled, "Report an Incident."
b. To any member of the Health Plan's management team
c. To the Chief Compliance Officer or any staff member within the Compliance Department
d. To a Human Resource representative
e. Through the Anonymous Reporting Hotline

2. FWA Lead is an initial identification of an unsubstantiated allegation of a potentially fraudulent activity.

B. Identification and Sources:

1. As part of Health Plan's commitment to detecting FWA of its assets, it sources Leads from the following activities:

a. Proactive manual and software assisted data mining to identify aberrant billing patterns based on a set of pre-determined data selection criteria.
b. Concerns identified during an audit.
c. Anonymous reporting.
d. Health Plan's Workforce disclosure.
e. Other external reporting sources include, but not limited to; members, community members, Third-Party current and former employees.

2. The Health Plan Management Team members are responsible for establishing appropriate internal controls to detect FWA associated with assets under their custody or under their control.

C. Required Information:

1. The Health Plan investigates all incoming FWA Leads within 3 working days of identification and gathers the following information to include, at a minimally, the following:

a. Involved parties, including the full name of the individual, organization, address, phone number, email address (if available).

   b. Identifiers such as the Health Plan's identification number, National Provider Identifier (NPI), claim ID, and/or license number.
   c. A summary of the issue being reported.

D. Investigation of FWA Leads and Case Conversion:

1. Within 7 working days of identification, all Leads are assessed to determine if enough evidence exists to launch a preliminary investigation or if the Leads will close due to low risk, not enough information, or because it does not represent FWA. If enough evidence or information exists to launch a full investigation, an FWA Case will be opened, and a full FWA investigation will be launched.
2. Leads that are conceived FWA Cases will be reported to DHCS on an MC609 within 10 working days of the date that the original Lead was received into the Program Integrity Unit.
3. The Preliminary Investigation period of a Case begins the date the Lead is converted to Case and is completed no later than 30 days. This means that some of the time the Preliminary Investigation is not completed prior to the reporting of MC609. When this occurs, the Health Plan submits an investigative summary on the MC609 that is current to date of the MC609 report date.
4. The following required investigative actions are completed as part of the Preliminary Investigation:
   a. Data extraction and analysis
   b. Licensure verification and federal and state exclusion checks.
5. The Health Plan's Program Integrity Unit employs the following additional activities, as applicable, during investigation. These additional investigative activities are usually conducted after the Preliminary Investigation is completed.
   a. Interviews – providers, members, former members, former employees, and others.
   b. Medical review of records to determine overpayment.

c. Medical review of records to verify services were rendered to members as billed.
d. Surveys.
e. Prepayment review of services.
f. Enhanced monitoring for a specified period of time.

E. Corrective Actions for FWA Violations"

1. In compliance with HIPAA Federal and State regulations, and the Health Plan's Workforce Disciplinary policy individuals who attempt or conspire to commit fraud, conceal fraud, aid and abet in the commission of fraud, or who fail to report fraud are subject to appropriate corrective or disciplinary action. One or more of the following actions may be taken against Workforce, subcontractors, downstream subcontractors, and network providers, but are not limited to these:
   a. Additional education and training.
   b. Seek recoupment of overpayment.
   c. Prepayment review of services.
   d. Subject to regulatory reporting to state licensing boards and other agencies as appropriate.
   e. Assess future payment deduction, withhold or stop payment for services.
   f. Suspension or termination from the network.
   g. Suspension or termination from employment.

F. FWA and False Claims Act Training:

1. In accordance with the Compliance Program Training and Education and the Code of Conduct, the Health Plan's Workforce is responsible for taking appropriate actions to prevent all identified FWA. A training report for the Health Plan Workforce containing the mandatory training record of completion is regularly tracked and monitored.
2. The Health Plan requires its Workforce, subcontractors, downstream subcontractors, and network providers to be trained on detailed information about the False Claims Act and other Federal and State laws described in 42 USC section

1396a(a)(68), including information about the rights of employees to be protected as Whistleblowers.

a. The Workforce is trained annually and within the first 30 days of hire as outlined in CMP24 – Compliance Trainings and Education.
b. Providers participate or attest that they and their staff are trained annually and within the first 30 days of contracting with the Health Plan.
c. Business Associates, per the Business Associate Agreement, are contractually required to maintain their own training programs and attest or show proof of training when requested to do so.

G. Response to Law Enforcement:

1. When directed that a law enforcement hold or delay has been requested, the Health Plan follows the direction given by law enforcement. [3] Active case statuses will be updated in the case management system to "Monitor" with a sub status of "Law Enforcement Hold".

H. Actions Following a Credible Allegation of Fraud

1. Upon notification from DHCS of a credible allegation of fraud for a provider, the Health Plan informs DHCS what action was taken with the provider. Below is summary of possible actions per APL:
   a. Terminate the provider from its network.
   b. Temporarily suspend the provider from its network pending resolution of the fraud allegation.
   c. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
   d. Conduct additional monitoring including audits of the provider's claim history and future claims submissions for appropriate billing.
2. If option "iv" above is adopted, the Health Plan will:
   a. Implement enhanced monitoring for 30 days.

[3] 45 CFR §164.412

b. Send weekly updates to DHCS during the monitoring period.
c. Launch an investigation into the providers billing practices to validate the credible allegation of fraud within 10 days of notification by DHCS to the Health Plan; and,
d. Inform DHCS of the investigation findings, to include a final investigation report and corrective action plan, within 10 days after the conclusion of the investigation.

IV. ATTACHMENT(S)

A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
B. Glossary of Terms Link
C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. 45 CFR §164.412
B. Anti-Kickback Statute, 42 U.S.C. §1320a-7b
C. Civil Monetary Penalty Law, Section 1128A of the Social Security Act
D. CMP24 Compliance Program Training and Education
E. DHHS Laws Against Health Care Fraud Resource Guide, September 2015
F. Exclusion Provisions, Section 1128 of the Social Security Act
G. False Claims Act, 31 U.S.C. §3729-3733
H. Fraud, Waste, and Abuse Referral Guidelines for Use by Managed Care Plans, May 2012
I. HPA09 HPSJ Workforce Sanctions
J. HPA10 Whistleblowers and Workforce Crime Victims
K. Program Integrity: Medicaid 42 CFR §455
L. Program Integrity Requirements Under the Contract, 42 CFR §438.608
M. Prohibited affiliations, 42 CFR §438.610
N. Memorandum of Understanding Health Plan of San Joaquin and SEIU Local 1021 section 14
O. Section 6038 of the Deficit Reduction Act 2005

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VI. REVISION HISTORY

Version*	Revision Summary	Date
001	Edits made to policy for 2024 DHCS Contract sectionR.0238	1/25/2023
002	Edits made to policy to included DHCS 2024 Contract sections 1.3.6 and 1.3.7	11/1/2023
003		
004		
Initial Effective Date: 1/1/1999		

VII. COMMITTEE REVIEW AND APPROVAL

Committee Name	Version	Date
Compliance Committee	002	2/15/2024
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	002	12/20/2023
Quality and Utilization Management		
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager (File & use)	002	1/4/2024

Department of Managed Care (DMHC)			

IX. APPROVAL SIGNATURE(S)*

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy