Medicaid Program Integrity for Managed Care Entities (MCEs)

Rules, Regulations, Compliance and Operations

FISCAL AND OPERATIONS DIVISION
Office of Program Integrity

PRESENTATION

This training is intended to assist Oregon Managed Care Entities (MCE) to responsibly carry out their fraud, waste and abuse prevention, and compliance and oversight obligations under the applicable contract with OHA and federal and state Medicaid laws.

This presentation and the links imbedded in this document were prepared as educational resources; they are not intended to grant or create any rights, privileges, or benefits for you or your organization. No part of this training should be taken as the opinion of, or as legal advice from, any of the Office of Program Integrity (OPI), the Oregon Health Authority (OHA) or the State of Oregon.

Although every reasonable effort has been made to ensure the accuracy of the information within these training materials, the ultimate responsibility for complying with the federal and state fraud and abuse laws and Medicaid program requirements lies with the provider of services.

What we will cover

- Key rules and regulations for MCE
- Foundational health care laws
- MCE contract provisions
- Contract Actions

Oversight of MCEs

- When states contract with MCEs, they are privatizing some portion of their Medicaid program subject to state oversight.
- States must have a strong contracting, compliance, and monitoring process to reduce risk.
- The MCE and SMA:
  - Must have a joint commitment to protect public funds from FWA.
  - Share their successes and failures.
  - Should work closely together and align program integrity efforts to mitigate risk.

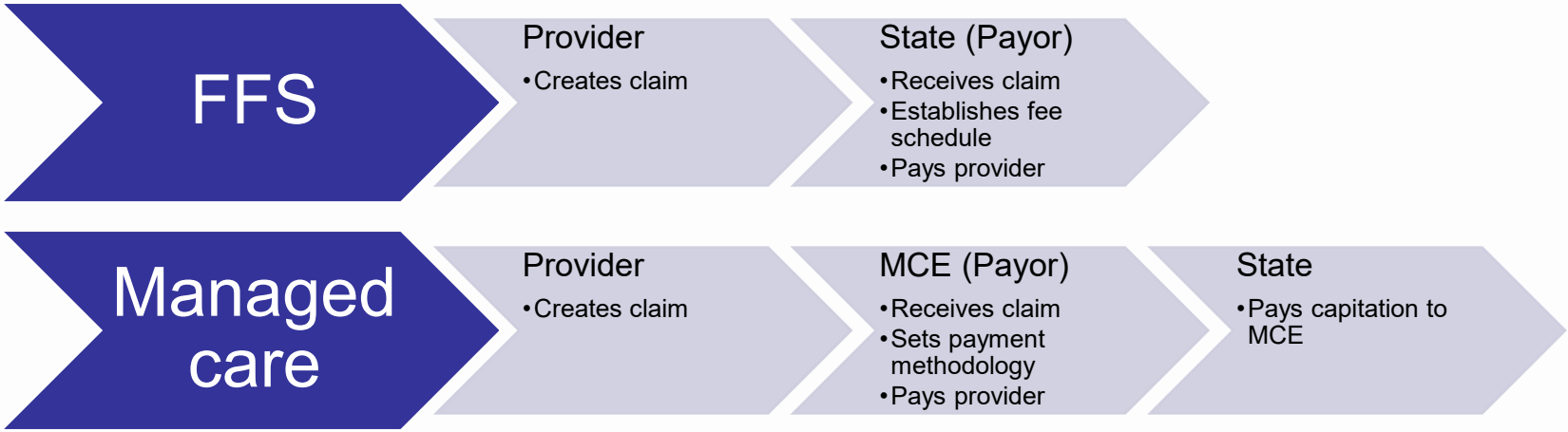
Oversight of MCEs

- The overall responsibility of a SMA is to the providers, enrollees, and public
- Any success and failure of the contracted MCEs will ultimately be the SMA's as well. Working closely together will mitigate that risk

FFS vs. managed care

Managed care is a health care delivery system organized to manage cost, utilization, and quality. Health benefits are delivered using contracted arrangements between SMAs and MCEs that accept a capitation payment for services (per member per month).

- There are different program integrity risks in FFS than in managed care.
- As the intersection between FFS and managed care, OPI works to address all risks.



Program integrity risks in managed care

State pays MCE a capitated payment

Risk Incorrect or inappropriate payment to MCE.

Underutilization of services by MCE members.

MCE processes claims

Risk Inaccurate encounter (claims) data submitted by MCE.

MCE staff may fail to cooperate with state investigations and prosecutions of fraudulent claims.

Focuses on cost avoidance, not recovery of state dollars.

State oversees MCE contract. MCE can subcontract

Risk Incomplete or inaccurate information about MCE performance.

Cannot access subcontractor information about contract performance or falsification of information.

Program integrity risks in managed care

MCE can pay providers using subcapitation, alternate methodologies or other incentives

Risk Underutilization by MCE members.

Inappropriate physician incentive plans.

MCE only covers their enrolled members

Risk State may pay MCE for services to non-enrolled members.

Marketing or enrollment fraud by the MCE.

MCE contracts with a select provider network

Risk Network inadequacy.

MCE must choose between removing risky providers and maintaining network adequacy.

Disqualified provider terminated from one MCE may be hired by another MCE.

Key rules and regulations

Code of Federal Regulations (CFR) for MCEs

CFR for MCE program integrity

- Federal regulations (CFR) for all Medicaid programs operated by states have:
  - Program integrity requirements for contracted MCEs. In Oregon this is coordinated care organization (CCO) contractors.
  - Some of these CFRs are noted in the following slides.

CFR for MCE program integrity

438.3(m)
- Submit audited financial reports specific to the Medicaid contract

438.242; 438.604(a)(1)
- Maintain a health information system; submit encounter data

438.604(a)(2)
- Submit data for capitation rate development and certification

438.8(k); 438.604(a)(3)
- Submit data used to determine compliance with solvency requirements

438.207(a), (b); 438.604(a)(5)
- Submit documentation demonstrating compliance with the availability, accessibility and timeliness of services and network adequacy

438.604(a)(6); 438.608(c)
- Submit information on ownership, control and disclosure of any prohibited affiliation of managed care plans and subcontractors

438.604(a)(7); 438.608(d)
- Submit annual report of overpayment recoveries

438.608(a)(1)
- Maintain written program integrity policies and procedures; designate a compliance officer; establish a regulatory compliance committee; provide employee training and education; establish disciplinary guidelines; and designate staff to audit and respond to compliance issues

CFR for MCE program integrity

438.608(a)(2)

- Promptly report overpayments, specifying overpayments due to potential fraud

438.608(a)(3)

- Promptly notify the state about changes in an enrollee's circumstances that may affect an enrollee's eligibility

438.608(a)(4)

- Notify the state about a change in a network provider's circumstances that affects the provider's eligibility to participate in the program

438.608(a)(5)

- Establish a method to verify that services represented as delivered by network providers were received by enrollees

438.608(a)(6)

- Provide written policies to all employees, contractors, and agents that provide detailed information about the False Claims Act

438.608(a)(7)

- Promptly refer any potential FWA identified to the state Medicaid program integrity unit or to the state Medicaid Fraud Control Unit

438.608(a)(8)

- Suspend payments to a network provider when the state determines a credible allegation of fraud

CFR for MCE program integrity

- The MCE CFRs rely on and reference definitions located in other sections of CFR.
- For reference, some of these CFRs are noted on the following slides.

CFR for MCE program integrity

438.66(e)
- Implement an annual managed care program report

438.68
- Develop and enforce network adequacy standards

438.104
- Monitor managed care organization marketing activities

438.332
- Require and monitor accreditation status of managed care plans

438.334
- Establish a Medicaid managed care quality rating system

438.340
- Establish quality measures and performance outcomes in the state quality strategy, review and evaluate the effective of the strategy

438.364
- Develop an annual external quality review technical report

438.2
- Definitions: “Rating period,” “overpayment,” “network provider,” among others

CFR for MCE program integrity

438.3(c), (e)
- Describes the services for inclusion in rate development

438.4
- Actuarial soundness definitions and requirements

438.5
- Establish rate development standards

438.6
- Special contract provisions related to payment

438.7
- Rate certification submission

438.8, 438.74
- Medical loss ratio (MLR) and state oversight of MLR requirements

438.60
- Prohibition of additional payments for services covered under managed care contracts

Foundational health care fraud laws

Read the laws!

In addition to CFRs there are also foundational healthcare fraud laws that all MCE must be aware of and abide by.

- These laws are included in all state-issued contracts, including MCE contracts.
- With every provision of law that you work with, it is critical that you read the law — Even if you aren't a lawyer or have never read laws before.
  - Go to the actual provision of law and read it. This is the first step in any level of familiarity.
  - Then break the law down into the pieces a prosecutor would have to prove.
  - Ask your state or federal fraud prevention teams or your MCE's legal department to have someone with a prosecutor's background go through these and other laws in more detail with you. It will be the best training you could ever get.

Foundational health care fraud laws

Health Care Fraud Statute • 18 USC § 1347	Criminal penalties for acts involving federal health care programs • 42 USC § 1320a-7b	Stark Anti-Referral Statute • 42 USC § 1395nn	False Claims Act • 31 USC §§ 3729-3733	Health Care Benefit Program - False Statements Statute • 18 USC § 1035
Mail Fraud • 18 USC § 1341	Wire Fraud • 18 USC § 1343	Criminal False Statements • 18 USC § 1001	Money Laundering • 18 USC § 1956	USA PATRIOT Act
Congressional acts	State-specific laws	HHS OIG published guidance about compliance plans	Key components of the ACA	HIPAA (Title 2)
	The Health Information Technology for Economic and Clinical Health Act (HITEC)	Federal antitrust laws		

Criminal vs. civil laws

- Another aspect to be familiar with is knowing whether a law is criminal or civil, and what the penalties are.
- This will help you:
  - Know who investigates and prosecutes the actions.
  - Prioritize what to refer to the Department of Justice Medicaid Fraud Control Unit (DOJ MFCU), Oregon Health Authority Office of Program Integrity (OHA OPI), and law enforcement.
- Some of these foundational laws are noted on the following slides.

Health Care Fraud Statute

- 18 USC § 1347 prohibits defrauding any health care benefit program, including commercial health insurance.
- A person can be held liable for:
  - Intentional or willful conduct or
  - Using false statements to obtain funds held by a federal health care program. They don't need to know this law or intend to break it to be held liable.

Prohibits:

- Knowingly and willfully executing or attempting to execute a scheme to defraud any health care benefit program; or
- Obtaining by false or fraudulent pretenses property under the custody/control of such a program, in connection with the delivery or payment for items or services.

Penalties:

- Up to 10 years in prison and a fine of up to $500,000 or twice the amount of the fraud.
- Other provisions can result in up to 20 years if someone is harmed and even potentially life in prison.

Criminal penalties for acts involving federal health care programs

- 42 USC § 1320a-7b covers a range of criminal acts.
- To be found guilty of any of these acts, a person need not have actual knowledge of this law or specific intent to violate this law.

(a) Making or causing to be made false statements or representations
- Client fraud
- False claims

(b) Illegal remunerations
- Anti-kickback provisions

(c) False statements or representations with respect to condition or operation of institutions
- For certification required for federal program participation

(d) Illegal patient admittance and retention practices
- Overcharging or accepting other payment for services already paid by Medicaid

(e) Violation of assignment terms
- Provider agrees to, but repeatedly violates, terms of 42 USC § 1395u(b)(3)(B)(ii)

Anti-kickback provision: 42 USC § 1320a-7b(b)

- This section provides the elements for:
  - The recipient of the remuneration and
  - The payor or offeror.
- There must be a recipient and offeror of the remuneration.
- Remuneration does not have to be money. It can be anything of value for purchase, lease or rent below its fair market value.

(1) Whoever knowingly and willfully **solicits or receives** any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind-

- (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

(2) Whoever knowingly and willfully **offers or pays** any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-

- (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

Anti-kickback provision: 42 USC § 1320a-7b(b)

- Key elements:
  - The activity is done knowingly and willfully.
  - One purpose is to induce a referral or arrange for the purchase or order for an item.
  - The item or service to be furnished **could** be paid for in whole or in part by a federal health care program.

Knowing and willful solicitation, receipt, offer, or payment of remuneration

- It does not happen by accident.
- It is voluntary, intentional misconduct.
- They know there is some law or rule that they are not complying with.

"One purpose" of the solicitation was to induce a referral/order for services

- It doesn't have to be the only purpose but must be proven to be one of the purposes.

The service/good could be paid for by a federal health care program.

- Medicare, Medicaid, TriCare

Anti-kickback provision: 42 USC § 1320a-7b(b)

- Safe harbors:
  - Statute and regulations cover a broad range of transactions where this law is not applied.
  - The key to safe harbor is arms' length transactions at fair market value.
- The Office of Health and Human Services Office of Inspector General (HHS OIG) website has good resources about the safe harbors.

Anti-kickback provision: 42 USC § 1320a-7b(b)

- Penalties:
  - Administrative and civil: Fines. This is grounds for a permissive exclusion*.
  - Criminal: This is a felony and can result in 5 years prison or $25,000 fine, or both. Convictions result in mandatory exclusion*.

*Learn more about exclusions on the HHS OIG website.

Anti-kickback provision: 42 USC § 1320a-7b(b)

"Whether you pay them or receive them, kickbacks undermine the integrity of our health care system. Patients need to know the health care referrals they receive are in their best interest, not in the best interest of someone else's bottom line. Our office will always be on guard to prevent unscrupulous operators from trying to take financial advantage of our health care system."

U.S. Attorney Philip R. Sellinger

Stark Anti-Referral Statute: 42 USC § 1395nn

- If a physician (or their family member) and a health care entity have a financial relationship, this law prohibits the physician and entity as described here.
- There are some exceptions.
- Learn more on the Centers for Medicare & Medicaid Services website.

The physician may not:

- Make a referral for the entity to provide "designated health services" that may be paid for by a federal health care program.

The entity may not:

- Present or cause to be presented a claim payable by a federal health care program or
- Bill to any individual, third party payor, or other entity for services furnished based on a prohibited referral.

False Claims Act: 31 USC § 3729

- This law addresses all types of fraud that might result in financial loss to the United States government.
- It identifies seven violations.

1. False Claims

- Presenting, or causing to present, a false claim for payment or approval.

2. False Records or Statements

- Making, using, or causing others to make or use a false record or statement material to a false claim.

3. Conspiracy

- Conspiring to violate the False Claims Act.

4. Conversion

- Failing to return government property.

5. False Receipts

- Making or delivering a receipt of government property without completely knowing that the information in it is true.

6. Unlawful Purchase of Government Property

- Buying public property from a government employee who may not lawfully sell it.

7. Reverse False Claims

- Making, using, or causing others to make or use a false record or statement material an obligation to pay money to the government in order to conceal, avoid, or decrease that obligation.

False Claims Act: 31 USC § 3729

- To be considered a violation, the false claim must be knowingly submitted.
- This means the person who submitted the false claim:
  - Knew the truth, or
  - Submitted it in deliberate ignorance or reckless disregard for the truth.
- It does not require proof of intent; just proof that basis for the claim was not truthful.

§ 3729. False claims

- (a) LIABILITY FOR CERTAIN ACTS.—
- (1) IN GENERAL.—Subject to paragraph (2), any person who—
- (A) **knowingly** presents, or causes to be presented, a false or fraudulent claim for payment or approval;
- (B) **knowingly** makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

False Claims Act: 31 USC § 3729(a)

- Damages are joint and several.
  - Several: Each defendant is responsible for the full amount of damages.
  - Joint: Both parties share responsibility for the full amount of damages, with no right to indemnification or contribution.
- Also see False Claims and Statements; Liability, 31 USC. § 3802

Civil penalty

- Not less than $5,000 and not more than $10,000. Adjusted for inflation, this is $5,500 to $11,000 per false claim.
- Effective Aug. 1, 2016, the penalty is now $10,781 to $21,563 per false claim.

Government damages

- Plus 3 times the amount of damages which the Government sustains because of the act of that person.
- Each instance of an item or a service billed to Medicare/Medicaid counts as a claim. Trebling is mandatory.

False Claims Act: 31 USC §§ 3729-3733

- Many other issues come under the umbrella of false claims:
  - Qui tam cases
  - Whistleblower status
- Best practice to consult with legal professionals in these cases.
- Whistleblowers may be entitled to some of the recoveries related to false claims.

§ 3729. False claims

§ 3730. Civil actions for false claims

- Allows private persons (a.k.a. "whistleblowers") to file suit for false claim violations on behalf of the government (known as a "qui tam" action)
- Defines protections and relief from whistleblower retaliation

§ 3731. False claims procedure

- Procedures for qui tam actions

§ 3732. False claims jurisdiction

- Jurisdiction for qui tam actions

§ 3733. Civil investigative demands

Health Care False Statements Statute

- 18 USC § 1035 prohibits materially false statements related to health care.
  - "Materially" has specific meaning; consult with your legal professional.
  - The conduct must be knowing and willful.
- "Health care benefit program" is any plan or contract that provides or pays for the care.
- Also see 18 USC § 287.

§ 1035. False statements relating to health care matters

- **(a)** Whoever, in any matter involving a health care benefit program, **knowingly and willfully**—
  - **(1)** falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or
  - **(2)** makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry,
  - in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.
- **(b)** As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

Oregon False Claims Act

- Oregon Revised Statute (ORS) 180.750-785 is Oregon's False Claims Act.

180.750
- Definitions

180.755
- Prohibited acts

180.760
- Civil action for violation; remedies; penalty

180.765
- Statute of limitation

180.770
- Estoppel

180.775
- Investigative demand

180.780
- Distribution of recovered amounts

180.785
- Remedy not exclusive

Oregon False Claims Act: ORS 180.750 Definitions

(1) “Claim”

- means a request or demand made to a public agency, including a request or demand made pursuant to a contract, that seeks moneys, property, services or benefits that will be provided in whole or in part by a public body, whether directly or through reimbursement of another public agency that provides the moneys, property, services or benefits.

(2) “False claim”

- means a claim that:
  - (a) Contains, or is based on, false or fraudulent information;
  - (b) Contains any statement or representation that is untrue in whole or part; or
  - (c) Omits information that could have a material effect on the value, validity or authenticity of the claim.

(3) “Public agency”

- means:
  - (a) A public body;
  - (b) The United States or a federal agency;
  - (c) A person who contracts with a public body; or
  - (d) A person other than an individual who receives a grant from a public body.

(4) “Public body”

- has the meaning given that term in ORS 174.109.

Oregon False Claims Act: ORS 180.755 Prohibited acts

(1) A person may not:

- (a) Present for payment or approval, or cause to be presented for payment or approval, a claim that the person knows is a false claim.
- (b) In the course of presenting a claim for payment or approval, make or use, or cause to be made or used, a record or statement that the person knows to contain, or to be based on, false or fraudulent information.
- (c) Agree or conspire with other persons to present for payment or approval a claim that the person knows is a false claim.
- (d) Deliver, or cause to be delivered, property to a public agency in an amount the person knows is less than the amount for which the person receives a certificate or receipt.
- (e) Make or deliver a document certifying receipt of property used by a public agency, or intended to be used by a public agency, that the person knows contains false or fraudulent information.
- (f) Buy property of a public agency from an officer or employee of a public agency if the person knows that the officer or employee is not authorized to sell the property.
- (g) Receive property of a public agency from an officer or employee of the public agency as a pledge of an obligation or debt if the person knows that the officer or employee is not authorized to pledge the property.
- (h) Make or use, or cause to be made or used, a false or fraudulent statement to conceal, avoid or decrease an obligation to pay or transmit moneys or property to a public agency if the person knows that the statement is false or fraudulent.
- (i) Fail to disclose a false claim that benefits the person within a reasonable time after discovering that the false claim has been presented or submitted for payment or approval.

(2) For the purposes of this section, a person has knowledge that a claim, record, statement, document or information is false or fraudulent if the person:

- (a) Has actual knowledge of the false or fraudulent nature of the claim, record, statement, document or information;
- (b) Acts in deliberate ignorance of the false or fraudulent nature of the claim, record, statement, document or information; or
- (c) Acts in reckless disregard of the false or fraudulent nature of the claim, record, statement, document or information.

(3) In an action under ORS 180.760, the Attorney General need not prove that a person specifically intended to defraud a public agency to establish that a person acted with knowledge as described in subsection (2) of this section.

Contract provisions

Healthcare fraud laws in State contracts

General provisions

- In state contracts, including MCE contracts with OHA, foundational health care fraud laws are primarily included in one or both of these sections:
  - General provisions
  - Federal terms and conditions
- The next slides are examples of where to find these laws in MCE contracts.

General provisions

5.1 Certification and Acknowledgement

- Without limiting the applicability of any other State or federal law, by signature on this Contract, Contractor hereby certifies and acknowledges that:
- 5.1.1 The Oregon False Claims Act, ORS 180.750 to 180.785, applies to any “claim” (as defined by ORS 180.750) that is made by (or caused by) Contractor and that pertains to this Contract.
- 5.1.1.1. No claim described in Sec. 5.1.1 above is or will be a “False Claim” (as defined by ORS 180.750) or an act prohibited by ORS 180.755.
- 5.1.1.2. In addition to the remedies under this Contract, if Contractor makes (or causes to be made) a False Claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against Contractor.

Terms and conditions

Exhibit A Definitions

"**False Claim**" has the meaning provided for in OAR 410-120-0000. See also Oregon False Claims Act as set forth in ORS 180.750-180.785 and federal False Claims Act as set forth in 31 USC 3729 through 3733.

Exhibit D Standard Terms and Conditions

- (2)(c) Contractor shall comply with the federal laws as set forth or incorporated, or both, in this Contract and all other federal laws applicable to Contractor's performance under this Contract as they may be adopted, amended or repealed from time to time.

Exhibit E Required Federal Terms and Conditions

- (5) By signing this Contract, Contractor certifies, to the best of Contractor's knowledge and belief that:
  - (d) The certification made under this Section 5 of this Exhibit E is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, of the U.S. Code. Any Person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Terms and conditions

Exhibit E, Section 11 Additional Medicaid and CHIP

- Contractor shall comply with all Applicable Laws pertaining to the provision of OHP services under the Medicaid Act, Title XIX, 42 USC Section 1396 et seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:
  a. Keep such Records as are necessary to fully disclose the extent of the services provided to individuals receiving OHP assistance and shall furnish such information to any State or federal agency responsible for administering the OHP program regarding any payments claimed by such Person or institution for providing OHP services as the State or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR § 431.107(b)(1) & (2); and 42 CFR § 457.950(a)(3).
  b. Comply with all disclosure requirements of 42 CFR § 1002.3(a); 42 CFR § 455 Subpart (B); and 42 CFR § 457.900(a)(2).
  c. Certify when submitting any claim for the provision of OHP services that the information submitted is true, accurate and complete. Contractor shall acknowledge Contractor's understanding that payment of the claim will be from federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and State laws.

Contract provisions

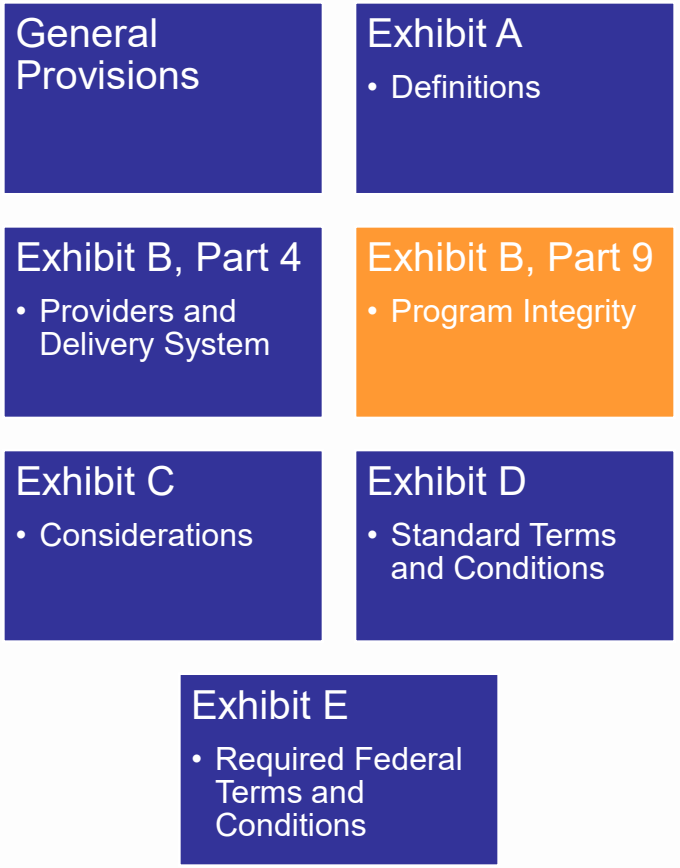
Program integrity CFR in MCE contracts

Contracts

- By signing a contract with the Oregon Health Authority (OHA), the MCE certifies they will comply with all contract requirements.
- This next portion of the presentation focuses on the Medicaid program integrity requirements in the MCE contract.
- MCEs may hold other agreements or contracts (e.g. Cover All Kids).
  - This presentation will not cover those agreements.
  - MCE subcontractors, vendors, providers and other third parties should follow up with their MCE partners to understand what activities they may be responsible for.

Program integrity contract language

- This presentation is focused on Exhibit B, Part 9 of the contract, but this is not the only section of contract that addresses program integrity.
- Other sections are listed here.



Program integrity in the Contract

- The activities, work and deliverables in the managed care contract are to address the federal and state Medicaid requirements in CFR and OAR. These regulations are included in the MCE contract. Links to these regulations are included on the next slide.

- Sections (10)-(18) of Ex B, Part 9, of the contract is designed to specify the work and activities expected of each MCE who signs a contract with OHA.

Program integrity in the Contract

Medicaid program integrity requirements in Exhibit B, Part 9

Federal

- 42 CFR § 433.116
- 42 CFR § 438.214
- 42 CFR § 438, Subpart H (438.600-438.610)
- 43 CFR § 438.808
- 42 CFR § 455
- 42 CFR § 456
- 42 CFR § 1001
- 42 CFR § 1002

State

- OAR 410-141-3520
- OAR 410-141-3625
- OAR 410-120-1510

Program integrity in the Contract

- Unless specifically stated in the contract, every activity, delivery date, information, data and reports listed in the contract are the responsibility of the MCE (the Contractor). MCEs who sign a contract with OHA are accountable for fulfilling all requirements of the contract, including the federal and state regulations in the contract.

- Effective program integrity requires coordination and cooperation between federal Medicaid agencies, state Medicaid agencies and MCEs. The MCE contract also addresses these points of coordination between the Contractor (MCE) and the contract holder (OHA).

Program integrity in the Contract

Program integrity in the Medicaid program is not only intentional deception, but also mistakes and inefficiencies that impact payments made with Medicaid dollars. The work and contract deliverables in MCE contract Ex B, part 9, are to:

- address the full spectrum of program integrity and
- provide information to OHA about MCE activities to prevent and detect FWA and the outcomes of MCE actions.

Exhibit B, Part 9

Exhibit B, Part 9 is the Program Integrity section of the MCE contract.

Sections 10 through 18 list:

- the specific activities required of MCEs; and
- required coordination with OHA, Oregon DOJ MFCU, Office of Inspectors General (OIG) and law enforcement.

10. Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures

11. Contractor's Fraud, Waste, and Abuse Prevention Policies and Procedures

12. Annual FWA Prevention Plan

13. Review and Approval of FWA Prevention Handbook and Annual FWA Prevention Plan

14. OHA and Contractor Program Integrity Audits of Network Providers

15. Documenting and Processing Contractor Recovery of Overpayments Made to Third Parties

16. Examples of Fraud, Waste, and Abuse

17. Contractor's Obligations to Report Fraud, Waste and Abuse

18. Assessment of Compliance Activities

Contract provisions

Exhibit B, Part 9, Sections 10-18

- MCE Contracts address two separate but interrelated requirements for Medicaid program integrity and FWA prevention:
  - Required contractor activities (including mandatory referrals) and
  - Required contract deliverables.

Read the Contract!

- The next slides have examples of several contract requirements.
- This presentation does not cover each and every requirement in contract Exhibit B, Part 9, Sec. (10)-(18).
- With every contract that you work with, it is critical that you read the contract — Even if you aren't a lawyer or have never read a contract before.
  - Go to the actual contract and read it. This is the first step in any level of familiarity.

Exhibit B, Part 9, Sections 10-18

- To develop and maintain a fraud, waste and abuse prevention and compliance program, the MCE must have an internal structure and operations that meets the requirements described in the contract.

- MCE who sign contracts with OHA for payment under the Medicaid program are certifying that the MCE (the Contractor) has and will maintain a program that complies with the Contract requirements.

Responsibility for FWA activities

- Section 10(a) addresses:
  - Minimum standards for MCE's policies and procedures and
  - Development of an annual plan to implement those policies and procedures.

10. FWA Plans, Policies, and Procedures

- a. As set forth in additional detail in Sections. 11-18 below of this Exhibit B, Part 9, Contractor is responsible for:
  - (i) developing and implementing a Fraud, Waste, and Abuse (FWA) prevention and detection program and policies and procedures that ensure compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510; and
  - (ii) annually creating a plan for implementing its policies and procedures.

Exhibit B, Part 9, Sections 10-18

Required MCE activities and work:

- Developing and Implementing Policies and Procedures
- Compliance org. structure
- Education/Training
- Provider screening/credentialing
- Member enrollment validation
- Receiving tips and allegations
- Investigating
- Auditing
- Referrals

Responsibility for subcontractors' FWA compliance

- Section 10(b) requires MCEs to ensure subcontractors who serve members or process/pay for claims also comply with the requirements in Exhibit B, Part 9.
  - Your written agreements with subcontractors must include the requirements.
  - You need to provide evidence to OHA that the subcontractors comply with the requirements (see Exhibit B, Part 4 for details).

10. FWA Plans, Policies, and Procedures

- b. Pursuant to 42 CFR § 438.608, to the extent that Contractor Subcontracts to any third parties any responsibility for providing services to Members or processing and paying for claims, Contractor shall require its Subcontractors, pursuant to its Subcontracts, to comply with the terms and conditions set forth in Sections 11-18 below of this Exhibit B, Part 9. With respect to the requirements specified in Sections 11-18 below, a prospective or existing Subcontractor's or Participating Provider's attestation of compliance may not replace Contractor conducting, as applicable, a precontracting readiness review or a formal annual compliance review.

Responsibility for an effective compliance program

Contract Ex B, Part 9 (11)(a)-(d)

- Oversight and management of the Compliance Program
- Written compliance guidance
- Education and training
- Effective lines of communication
- Enforcement of written standards
- Auditing and monitoring
- Response to detected offenses and corrective action

Written policies and procedures

All MCE contracts require the MCE create and put into operation policies and procedures

- required by 42 CFR § 438.608
- written policies and procedures:
  - Codify established practices
  - Maintain the decision-making process
  - Maintain consistency
  - Assist new employees
    - Step-by-step guide
    - Establish protocols
- Contract calls these policies and procedures the “FWA Prevention Handbook”

FWA policies and procedures

- Section 11 lists the elements of an effective compliance program, required in 42 CFR § 438.608.
- The MCE's policies and procedures (FWA Prevention Handbook), structure and operations must comply with the federal and state Medicaid regulations as described in this section.

11. Contractor's FWA Prevention Policies and Procedures

- a. Contractor shall develop a FWA Prevention Handbook wherein Contractor sets forth its written policies and procedures in accordance with the requirements set forth in 42 CFR §§ 438.600-438.610, 42 CFR § 433.116, 42 CFR § 438.214, 438.808, 42 CFR §§ 455.20, 455.104 through 455.106, 42 CFR § 1002, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510 that will enable Contractor to detect and prevent potential Fraud, Waste, and Abuse activities that have been engaged in by its employees, Subcontractors, Participating Providers, Members, and other third parties.
- b. Contractor's FWA Prevention Handbook must include, at a minimum, all of the following:

Compliance structure

- These requirements ensure MCE has dedicated staffing, maintenance and oversight for MCE program integrity activities.
- Section 11(b)(1)-(3) lists the minimum requirements for the MCE's compliance staff.

11(b)(1) Chief Compliance Officer

- Reports directly to the CEO and the Board of Directors
- Responsible for the written policies and procedures and Annual FWA Prevention Plan

11(b)(2) Regulatory Compliance Committee

- Include Contractor's Chief Compliance Officer, senior level management employees, and members of the Board of Directors.
- Responsible for overseeing Contractor's FWA prevention program and contract compliance

11(b)(3) Establishment of a division, department, or team of employees that is dedicated to and responsible for implementing the annual FWA Prevention Plan

Compliance team requirements

Section 11(b)(3) … a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan and

- which includes at least one professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor.
- The MCE must demonstrate continuous work towards increasing qualifications of its employees.
- Investigators must meet mandatory core and specialized training program requirements for such employees.
- The team must employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care providers.
- The team may employ or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases.

Education and training

Required MCE activities and work:

11(b)(7) A system to provide and require annual attendance at training and education regarding Contractor's FWA policies and procedures.

- Must include, without limitation, the right, pursuant to Section 1902(a)(68) of the Social Security Act, to be protected as a whistleblower for reporting any FWA.
- Must provide all information necessary for its employees, Subcontractors and Participating Providers to fully comply with the FWA requirements of this Contract.
- Must be specific and applicable to FWA in Medicaid program.
- Must include Medicaid-specific referral and reporting information and training regarding Contractor's Medicaid FWA policies and procedures, including any time parameters required for compliance with Exhibit B, Part 9.
- Must be provided to, and attended by, Compliance Officer, senior management, and all other employees.

11(b)(8) A system to provide annual training for employees who credential providers or subcontract with third parties

- must include material relating to, as set forth in 42 CFR §§ 438.608(b) and 438.214(d):
  - (i) the credentialing and enrollment of Providers and Subcontractors and
  - (ii) the prohibition of employing, Subcontracting, or otherwise being Affiliated with (or any combination or all of the foregoing) with sanctioned individuals

Effective communication and response

- Section 11(b) requires MCE activities and work.
- Communication between the MCE, OHA and MFCU is critical

11(b)(10) Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions

- against employees, Participating Providers, or Subcontractors who have violated Fraud, Waste and Abuse policies and procedures and any other Applicable Laws

11(b)(11) Procedures for reporting Fraud, Waste, and Abuse

- to the appropriate agencies in accordance with Sec. 17 below of this Exhibit B, Part 9.

11(b)(18) A process for members to report fraud, waste and abuse

- anonymously and to be protected from retaliation under applicable whistleblower laws.

Communication best practices

- Have a specific MCE contact to receive complaints and questions
- Make reporting suspect behavior a duty for all MCE employees
- Protect employees from retaliation for reporting
- Offer multiple ways to make a report, including an option for making an anonymous report
- Allow complaints, questions and reports to come from anyone – inside or outside the MCE. No wrong door for making a good faith report of potential FWA!

Contract provisions

Required contract deliverables

FWA reporting requirements

- MCEs must refer any employees, providers, members or third parties suspected of FWA to OHA.
- MCE must also provide quarterly and annual reports to the OHA.

Contractor's Obligations to Report Fraud, Waste and Abuse

- Excluded providers
- All suspected cases of FWA
- Any instances described in Exhibit B, Part 9, Section 16.

FWA Contract Deliverables

- FWA Prevention Handbook
- FWA Prevention Plan
- FWA Audit Report
- FWA Referrals and Investigations Report
- Annual FWA Assessment Report

Contract deliverables

- This presentation mainly covers the program integrity deliverables in Exhibit B, Part 9 of the MCE contract.
- Some other deliverables also apply to program integrity. For example:
  - Exhibit L has many other required financial reporting pieces.
  - Exhibit B, Part 4 requires corrective action plans for subcontractors for provider network management.
- The Contract Forms and Deliverables page provides templates and resources related to completing required deliverables.

Annual deliverables

FWA Prevention Handbook

- Exhibit B, Part 9(11)
- Handbook of FWA policies and procedures

FWA Prevention Plan

- Exhibit B, Part 9(12)

FWA Audit Report

- Exhibit B, Part 9(17)(b)

FWA Referrals and Investigations Report

- Exhibit B, Part 9(17)(c)

FWA Assessment Report

- Exhibit B, Part 9(18)

Exhibit L Solvency Plan and Financial Reporting

- Exhibit B, Part 9(11)(b)(17)

Annual deliverables

FWA Prevention Handbook

- means the handbook of Fraud, Waste, and Abuse policies and procedures that complies with the requirements set forth in Section 11 of Exhibit B, Part 9 and any other applicable provisions of this Contract.

FWA Prevention Plan

- means that annual Fraud, Waste, and Abuse prevention plan required to be provided to OHA in accordance with Exhibit B, Part 9 to this Contract.

Annual FWA Audit Report

- means that annual Fraud, Waste, and Abuse audit Report required to be provided to OHA in accordance with Exhibit B, Part 9 to this Contract.

Annual FWA Referrals and Investigations Report

- means that annual Fraud, Waste, and Abuse referrals and investigations Report required to be provided to OHA in accordance with Exhibit B, Part 9 to this Contract.

Annual FWA Assessment Report

- means that annual Fraud, Waste, and Abuse Report required to be provided to OHA in accordance with Exhibit B, Part 9 to this Contract.

Quarterly deliverables

FWA Audit Report

- Exhibit B, Part 9(17)(b)(2)

Copies of any final audit reports

- Exhibit B, Part 9(17)(b)

FWA Referrals and Investigations Report

- Exhibit B, Part 9(17)(c)(2)

Ongoing reporting and referral requirements

- Many elements need to be reported by the MCE to OHA as they are identified or discovered.
  - Changes in provider status
  - Suspected FWA
- Others are made when work is completed.
  - Reporting overpayments

Excluded providers
- Exhibit B, Part 9(17)(a)

Providers terminated for-cause
- Exhibit B, Part 4(5)(k)

Suspected cases of FWA
- Exhibit B, Part 9(17)(d)

Incidents with any of the characteristics listed in Sec. 16, of Exhibit B, Part 9
- Ex. B, Part 9 (17)(e)

Overpayments resulting from suspected FWA
- Exhibit B, Part 9(11)(b)(16)(b)

Required timeframes

Excluded providers	Immediately	HHS OIG **or** OHA Provider Enrollment Unit
Providers terminated for-cause	Within 15 days	OHA Provider Enrollment Unit
Suspected provider FWA	Within 7 days	OHA OPI **and** DOJ MFCU
Suspected member FWA	Within 7 days	ODHS FIU
Incidents with any of the characteristics listed in Sec. 16, of Ex. B, Part 9	Within 7 days	OHA OPI **and** DOJ MFCU
Overpayments resulting from suspected FWA	Within 7 days	OHA OPI

Referring suspected FWA

- MCEs do not need to complete an internal investigation before referring suspected FWA to OHA and MFCU.
  - Report suspected FWA within 7 days of identifying the issue.
  - Investigate the issue as much as possible in these 7 days.
  - Share with OHA and MFCU any information collected.

Who:

- Is the provider?
- Is the member?
- Is making the allegation?

What:

- Is the issue?

When:

- Did the issue occur?

Where:

- Did the allegation come from? (Or how was it discovered?)

Best practices

- The intent of 7-day reporting (i.e. referral) requirement is to ensure coordination between MCE, OHA and MFCU. It gives OHA and MFCU time to:
  - Determine if there is a related investigation or litigation, and
  - Let the MCE know to avoid compromising those investigations.
- Connecting different pieces of information is part of OHA's role as the single Medicaid agency.
  - An issue your MCE reports (i.e. refers) may also be an issue in other areas.
  - OHA can share this information with other MCEs and see if this issue also occurs with fee-for-service claims.
  - This may uncover patterns and trends.
  - Monitoring MCE ongoing reports and MCE contract deliverables ensures that OHA does not lose sight of suspect providers (or members).

Best practices

- Gathering information is part of MCEs role. Best practices for MCE's compliance staff:
  - Internal FWA referral form
  - Methods for anonymous reporting
  - Shared compliance/fraud tips mailbox
  - Monthly FWA meetings
  - Provide FWA training to internal staff, subcontractors and participating providers throughout the year
  - Publicize a compliance/fraud tips 24/7 hotline
  - Index every FWA lead via administrative files in a case management system that can be tracked for reporting purposes

Contract actions

Exhibit B, Part 9, Sections 1-9

Contract actions

- All state contracts, including the MCE contracts, have penalties for:
  - Non-performance of activities/work and
  - Failure to provide contract deliverables.
- OHA may take one or many actions if a contractor fails to:
  - Comply with contract or
  - Perform required work/activities.

Exhibit B, Part 9, Sections 1-9

- Section 1 explains how OHA will monitor the MCE for compliance.
- Section 2 explains when OHA may take contract actions.
- Section 3 describes the range of contract actions (or sanctions) OHA may apply.

Possible sanctions

- These include:
  - Corrective action plans
  - Civil money penalties

- To learn more:
  - Review Exhibit B, Part 9(1)-(9) of the MCE contract.
  - Contact your contract administrator in OHA's Health Systems Division with any questions.