

 <p><b>VALUE BEHAVIORAL HEALTH</b> of PENNSYLVANIA A VALUEOPTIONS® COMPANY</p>	<p>Page 1 of 14</p>	<p><b>Late Review Date:</b> 02/28/12</p>
<p><b>Service Center/Operating Unit:</b> Pennsylvania Service Center, Trafford, PA</p>	<p><b>Subject:</b> Fraud, Waste, and Abuse</p>	<p><b>Approved by DPW on</b> 02/28/12</p>

**I. Purpose** - To establish a uniform protocol that Value Behavioral Health of PA, Inc. (VBH-PA) staff utilizes when there is a question of fraud, waste and abuse in connection with health care claims and services. To adhere to the Fraud, Waste and Abuse Program Requirement defined in the *Commonwealth of Pennsylvania, HealthChoices Behavioral Health, Program, Standards and Requirements – Primary Contractor, Appendix F* as well as federal requirements.

**II. Committee(s)/Department(s)**

- A. Compliance is the responsibility of all employees as defined in the ValueOptions Code of Conduct.
- B. The VBH-PA compliance functions are independent from the VBH-PA operations and reporting structure. The VBH-PA compliance functions are managed and maintained by the VBH-PA Compliance Committee and the Compliance Department.
- C. The following departments could actively participate as Audit Staff in investigations, discovery reviews, compliance audits, and compliance committees. (All participants must sign Confidentiality Agreements for audits and compliance committee.)
  - 1. Compliance Department
  - 2. Quality Management Department
  - 3. Claims Department
  - 4. Clinical Department
  - 5. Finance Department
  - 6. Information Systems Department

**III. Definitions**

- A. Fraud (PA HealthChoices Program Service Description: Appendix F Definition) - Any intentional deception or misrepresentation made by entity or person with the knowledge that the deception could result in an unauthorized benefit to the entity, him/herself or another responsible person in a managed care setting.
- B. Fraud (Federal Definition 42 CFR 455.2) - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

- C. Waste - Thoughtless careless expenditure, consumption, mismanagement, use or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices systems or controls.
- D. Abuse (PA HealthChoices Program Service Description: Appendix F Definition) - Any practices that are inconsistent with sound fiscal, business, or medical practice and which result in unnecessary cost to the PA Medicaid (MA) Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized or contractual obligations (including the terms of the RFP contracts, and requirements of state or federal regulations) for health care in the managed care setting
- E. Abuse (Federal Definition 42 CFR 455.2) - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

#### **IV. Policy**

- A. It is the policy of VBH-PA to review and investigate all allegations of fraud, waste and abuse, whether internal or external, to take corrective action for any supported allegation and to report confirmed misconduct to the appropriate parties, both internal and external. Additionally, as a PA HealthChoices Behavioral Health Primary Contractor, VBH-PA will be responsible for the following fraud, waste and abuse requirements:
  - 1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations.
  - 2. The designation of a Compliance Officer and a Compliance Committee that is accountable to senior management.
  - 3. Effective training and education for the Compliance Officer and Managed Care Organization (MCO) employees.
  - 4. Effective lines of communication between the Compliance Officer and MCO employees.
  - 5. Enforcement of standards through well publicized diplomacy guidelines.
  - 6. Provisions for internal monitoring and auditing.
  - 7. Provisions for prompt response to detected offenses and the development of corrective action initiatives.

#### **V. Procedure(s)**

- A. Code of Conduct and Written Policies and Procedure:
  - 1. VBH-PA maintains current policies and procedures that ensure the timeliness and accuracy of processing claims.

2. VBH-PA maintains current policies and procedures that identify and mitigate potential fraud, waste and abuse.
  - a) The Compliance Department maintains a Compliance Program Description.
  - b) On an annual basis, the Compliance Department completes a Compliance Assessment that determines the Compliance Plan.
3. VBH-PA maintains a current Code of Conduct that requires the following of the Compliance Department and other VBH-PA staff:
  - a) Commitment to comply with all Federal and State standards related to the Medicaid Managed Care organizations.
  - b) Requirements of annual training and certification of completion.
  - c) Enforcement of standards through well-publicized disciplinary guidelines.
  - d) Department of State licensing requirements.
  - e) Other applicable professional standards.
4. VBH-PA demonstrates a commitment to comply with laws and regulations by enforcing the Code of Conduct and disciplinary actions by adhering to the following laws and regulations, which include but are not limited to:
  - a) Balance Budget Act (H.R.2015: Balanced Budget Act of 1997)
  - b) Deficit Reduction Act (S.1613: Deficit Reduction Act of 2009)
  - c) Provider Prohibited Acts (55 Pa. Code § 1101.75)
  - d) Recipient Prohibited Acts (55 Pa. Code § 1101.92)
  - e) Federal False Claims Act (31 U.S.C. Subsection 3729-3733: False Claims Act Clarification Act of 2009)
  - f) Pennsylvania Fraud and Abuse Control Act - Provider (62 PS S.1407)
  - g) Pennsylvania Fraud and Abuse Control Act - Other (62 PS S.1408)
  - h) Crimes and Criminal Procedure (US Code - Title 18)
  - i) Fraud and Abuse Sanctions (42 USC 1320)
  - j) Social Security Act Sanctions (Social Security Act Section 1128 A)
  - k) Anti-Kickback Statute (42 C.F.R. §411.350 through §411.389)
  - l) Health Insurance Portability and Accountability Act (P.L. 104-191)
  - m) Health Information Technology for Economic and Clinical Health Act (P.L. 111-5)
  - n) Fraud Enforcement and Recovery Act (S.386: FERA)
  - o) Patient Protection and Affordable Care Act (H.R.3590)

B. Compliance Committee and Compliance Department:

1. VBH-PA Compliance Committee
  - a) VBH-PA has a Compliance Committee that meets on a monthly basis to oversee the compliance functions independently of the VBH-PA operations and reporting structure.
  - b) The Chair Member is the Compliance Director.
  - c) The VBH-PA Compliance Committee members include the following: CEO, CFO, Medical Director, IT Director, Provider Relations Director, Clinical Director, Claims and Customer Service Manager, Account Executive, Quality Director, and Compliance Auditor.

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- (1) All VBH-PA Compliance Committee members must sign a confidentiality agreement prior to attending meetings.
  - (2) Confidentiality Agreements are maintained by the Compliance Director.
  - d) The Compliance Director maintains the VBH-PA Compliance Committee Charter along with VBH-PA Compliance Committee agendas and minutes.
2. Compliance Director (Compliance Officer):
- a) The Compliance Director reports indirectly to the National Compliance Director, ValueOptions and the CEO, VBH-PA.
  - b) The Compliance Director reports directly to the VBH-PA Compliance Committee
  - c) On an ad-hoc basis, the Compliance Director reports directly to VBH-PA Audit Committees and ValueOptions National Ethics and Compliance Committee.
  - d) The Compliance Director participates and reports to the ValueOptions National Integrity Workgroup.
  - e) The Compliance Director reports to the VBH-PA Quality of Care Committee.
3. Compliance, Clinical, and/or Internal Auditors
- a) The compliance, clinical, and/or internal auditors report to the Compliance Director.
4. Units of the Compliance Department – All compliance units have subcommittee workgroups that report directly to the VBH-PA Compliance Committee and the Compliance Director.
- a) Special Investigations Unit (FWA)
  - b) Privacy and Security (HIPAA) Unit
  - c) Internal Policy Unit
  - d) Ethics and Code of Conduct Unit
- C. Fraud, Waste and Abuse Training:
1. Staff Training
- a) New Hire Training
    - (1) ValueOptions requires new employees to complete and attest to training modules within 2 weeks of hire related to the following in accordance with federal and state laws:
      - (a) ValueOptions Code of Conduct
      - (b) Privacy and Security - Health Insurance Portability and Accountability Act
      - (c) Fraud, waste and abuse
    - (2) The Compliance Director and Compliance Auditor provide new hire training to all new staff within 30 days of hire in person that expands on the ValueOptions training modules and incorporates specific training related to Pennsylvania.
  - b) Annual Training for All Employees

- (1) ValueOptions requires all employees to complete and attest to training modules on annual basis for the following in accordance with federal and state laws:
        - (a) ValueOptions Code of Conduct
        - (b) Privacy and Security - Health Insurance Portability and Accountability Act
        - (c) Fraud, waste and abuse
      - (2) The Compliance Director and Compliance Auditor provide annual training in person to each department that expands on the ValueOptions training modules and incorporates specific training related to the Pennsylvania HealthChoices Program Services Requirements and the PA Code.
    2. Compliance Director and Department Training
      - a) The Compliance Director maintains Certified Fraud Examiner status and participates in all PA Bureau of Program Integrity (BPI) trainings, seminars, and workgroups.
      - b) The Compliance Department is encouraged to obtain certifications and attend trainings related to program integrity and/or fraud, waste and abuse.
    3. Provider Training
      - a) Annual Provider Trainings
        - (1) VBH-PA conducts provider forums related to fraud, waste and abuse on annual basis at several locations.
        - (2) The Compliance Department offers providers fraud, waste, and abuse training on the internet at the following address:
          - (a) [http://www.vbh-pa.com/fraud\\_abuse.htm](http://www.vbh-pa.com/fraud_abuse.htm)
      - b) The Provider Relations Department offers various provider trainings related to clinical and quality topics throughout the year.
    4. New Provider Trainings
      - a) VBH-PA requires that all new providers complete the fraud, waste and abuse training available on internet during the credentialing process at the following address:
        - (1) [http://www.vbh-pa.com/fraud\\_abuse.htm](http://www.vbh-pa.com/fraud_abuse.htm)
- D. Referral and Audit Procedures:
1. Departmental Guidelines - Potential cases involving fraud, waste and abuse may be identified by other departments with the following guidelines:
    - a) Guidelines for Claims Processing Staff: The Claims Processor will use the following list of fraud indicators to alert them that a provider's activities may be suspect. Any processor identifying a potentially fraudulent provider or billing situation must complete a ServiceConnect Inquiry and forward it to the VBH-PA Fraud, Waste and Abuse queue. (NOTE: This is not an all-inclusive list.)
      - (1) Medication management and therapy on the same day.

- (2) Excessive diagnostic evaluations.
  - (3) Multiple procedures on the same day.
  - (4) Place of service variations.
  - (5) Unbundling or billing services separately to overstate treatment given and maximize billing.
  - (6) Alteration of claim forms.
  - (7) Suspicious handwriting.
  - (8) Missing or incorrect information.
  - (9) Inconsistency between diagnosis and procedure code.
  - (10) Billing of outpatient services for dates of service shown as inpatient.
  - (11) Automated data mining analysis performed by the ValueOptions Audit and Department:
    - (a) Third party liability and coordination of benefits
  - (12) Health Management Systems (HMS) audits and reviews
- b) Guidelines for Claims Auditor and Team Lead: The Claims Auditor and the Team Lead will use the following list of fraud indicators to alert them that a provider's activities may be suspect. The Claims Auditor or Team Lead identifying a potentially fraudulent provider or billing situation must complete a ServiceConnect Inquiry and forward it to the VBH-PA Fraud, Waste and Abuse Queue. (NOTE: This is not an all-inclusive list.)
- (1) Duplicate claim submission.
  - (2) Misrepresentation through:
    - (a) The nature of services.
    - (b) The dates of the services.
    - (c) The diagnosis.
    - (d) The identity of either the provider or the recipient of services.
  - (3) Unbundling or billing services separately.
  - (4) Over-utilization of services.
  - (5) Billed invalid number of units.
  - (6) Provider billed outpatient services while the member was in an inpatient facility.
  - (7) Billed incorrect number of units for time span of inpatient claims.
  - (8) Billed two services not allowable on the same day.
- c) Guidelines for Clinical Staff: The Clinical Staff will use the following indicators to alert them to activities that may be suspect. Any clinician identifying a potentially fraudulent situation must complete a ServiceConnect Inquiry and forward it to the VBH-PA Fraud, Waste and Abuse Queue. (NOTE: This is not an all-inclusive list.)
- (1) Excessive authorization requests.
  - (2) Multiple authorization requests for the same enrollee.
  - (3) Identical or "cookbook" authorization requests for enrollees.
  - (4) Enrollee dissatisfaction or complaint.
  - (5) Poor patient outcome/quality of care data (could indicate deliberate lack of treatment).
  - (6) Misrepresentation of credentials or qualifications in credentialing information.
  - (7) Suspected member fraud, waste and abuse which include:

- (a) Prescription alteration or forgery.
- (b) Inappropriate use of member's card.
- (c) Duplication of medications/services.
- d) Guidelines for Provider Field Coordinator: The Provider Field Coordinator will use the following indicators to alert them to providers' activities that may be suspect. Any representative identifying a potentially fraudulent provider situation should complete a ServiceConnect Inquiry and forward it to the VBH-PA Fraud, Waste and Abuse Queue. (NOTE: This is not an all-inclusive list.)
  - (1) Excessive billing problems, issues, or complaints.
  - (2) Excessive provider calls regarding check or payment status.
  - (3) Excessive denied claims.
  - (4) Notification from an enrollee that services were not rendered.
  - (5) Notification from some other provider that services are not being rendered.
  - (6) Notification from some other provider that enrollees are presenting over medicated.
  - (7) Provider site visits and record audits.

## 2. Initial Identification (Leads)

- a) Potential fraud, waste and abuse may be identified by the following means:
  - (1) Service calls from members or providers.
  - (2) Reports from members, providers, clients, or other sources.
  - (3) Reports from VBH-PA and ValueOptions departments and staff.
  - (4) Complaints filed with VBH-PA.
  - (5) Clinical and Quality of Management Chart Audits.
    - (a) Refer to VBH-PA Chart Audit Policy.
  - (6) Patterns identified by data analysis of the financial and outliers reports that may include the following reports:
    - (a) Discrepancies between monthly VBH-PA Provider BHR (Behavioral Health Rehabilitation) Services Report and claims.
    - (b) "Frequency Distribution of CPT/Procedure Code Report – Looking at Billing Patterns of Providers."
    - (c) "Pend Reports Looking for Patterns of Hold Code Frequencies."
    - (d) "Authorization Reports Compared to Billed Services Report."
    - (e) "Outpatient Charges paid While Client is Inpatient Report."
  - (7) BPI Fraud, Waste and Abuse Hotline.
  - (8) Other sources (internal and external) including law enforcement and regulatory agencies.
  - (9) Reports of provider, members, and employees that are excluded or have been convicted of healthcare crimes.
  - (10) Recipient verification reviews.
    - (a) VBH-PA will select members to determine whether services billed were received according to statistical standards and as deemed appropriate.

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- (b) If member verification reveals that services paid were not received, the Compliance Department will initiate a referral and conduct a Discovery Audit.
    - (11) Member satisfaction surveys.
  - b) Potential fraud, waste and abuse referrals should be submitted to the Compliance Department through a ServiceConnect Inquiry.
  - c) The Compliance Auditor will enter the ServiceConnect Inquiry into the FWA Case System and close the ServiceConnect Inquiry.
  
- 3. Referral Review and Screening - conducted by the VBH-PA Compliance Auditor.
  - a) The screenings will include:
    - (1) Evaluation of the reasons for referral.
    - (2) Evaluation of any supporting documentation.
    - (3) Review of historical data for previous referrals for similar reasons.
    - (4) Evaluation of the potential magnitude of the problem.
    - (5) Review with other appropriate internal resources.
    - (6) Member verification of services and/or referral.
      - (a) VBH-PA will select members to determine whether services billed were received according to statistical standards and as deemed appropriate.
      - (b) If member verification reveals that services paid were not received, the Compliance Department will review the referral.
    - (7) The Compliance Department will notify the County HealthChoices Designee and VBH-PA Account Executive if a Discovery Audit warrants a BPI referral.
  
- 4. Discovery Audit – A claims sample that will identify potential patterns and errors that will be utilized to determine estimated error rates or occurrences.
  - a) The Compliance Department will review the reports or findings to determine the patterns.
  - b) The Compliance Department will conduct a Discovery Audit to determine if the patterns are deemed to be fraud, waste and abuse that would require recoveries or reimbursements.
    - (1) The Compliance Department will review at least 5% or 30 whichever is smaller to establish an anticipated error rate or will utilize RAT-STATs to determine sample size with a Confidence Interval of 95%, Precision Rate of 10%, and Anticipated Rate of 95%.
    - (2) The Compliance Department will utilize RAT-STATs to select the random sample numbers.
    - (3) The Compliance Department will save and document the output in the ServiceConnect Inquiry.
  - c) The Compliance Department will compile the results of the Discovery Audit and report to the Compliance Director.
  - d) The Compliance Department may utilize previous Clinical and Chart Audits as the Discovery Audit if deemed appropriate by the Compliance Director.
  
- 5. Review of Discovery Audit Results

- a) The Compliance Department will review the results of the Discovery Audit and determine the anticipated rate of error.
  - b) The Compliance Department will run a claims report for the entire population and determine the expected error rate and anticipated recovery or reimbursement amount.
  - c) If the error rate is over 10%, the Compliance Director will submit the findings and expected error rates to the VBH-PA Compliance Committee and Chief Executive Officer.
  - d) The VBH-PA Compliance Committee will approve the Full Compliance Audit.
  - e) The Compliance Auditor will notify the County HealthChoices Designee and VBH-PA Account Executive if a Full Compliance Audit is warranted from the Discovery Audit.
  - f) The Compliance Auditor will submit a referral to BPI and enter or update the Inquiry.
6. Random Audit – An audit of a provider or services that is selected at random.
- a) The VBH-PA Compliance Department does not need to have received a referral, completed an investigation, or conducted a discovery review.
  - b) The Compliance Director will coordinate all random audits and when appropriate utilize random selection tools, such as RAT-STATs.
  - c) The random audits will be structured as a Full Compliance Audit with the following options:
    - (1) Desk and/or on-site audits
    - (2) Scheduled and/or unannounced audits
7. Scheduled Audit – An audit of a service that is selected by the VBH-PA Compliance Committee and is included in the annual VBH-PA Compliance Plan based on contractual risks and/or cost-drivers.
- a) The VBH-PA Compliance Department does not need to have received a referral, completed an investigation, or conducted a discovery review.
  - b) The Compliance Director will coordinate all scheduled audits through VBH-PA Compliance Committee.
  - c) The VBH-PA Compliance Director will select the claims and members ratio thresholds for selecting the Top 10 providers for the schedule audits of the selected service.
  - d) The scheduled audits will be structured as a Full Compliance Audit with the following options:
    - (1) Desk and/or on-site audits
    - (2) Scheduled and/or unannounced audits
8. Full Compliance Audit - The Full Compliance and Quality Chart Audits have two primary objectives. First, VBH-PA conducts annual Full Audits according to the Quality Management Plan and Compliance Audit Program to meet PA PSR requirements, specifically, the elements related to monitoring and auditing of providers through random and scheduled audits. Additionally, VBH-PA conducts ad-hoc Full Audits to further investigate errors and non-compliance identified in the discovery

reviews. The Full Audits determine corrective action recommendations and plans, which may include recoveries for claim overpayments and additional quality reviews by the VBH-PA Quality of Care Committee. The Full Audit will evaluate providers based on the following components: Service Description or APA Assessment; Quality Chart Audit; Clinical Assessment; Claims Billing Audit; and Compliance Evaluation

- a) The Compliance Director or a Compliance Auditor will be the Audit Supervisor/Team Lead for all Full Compliance Audits.
  - b) The Audit Team Lead will select the Audit Team members and send audit notification when applicable.
  - c) The Audit Team Lead will develop and submit the Scope to the VBH-PA Compliance Committee.
  - d) The Audit Team Lead will utilize RAT-STATs to determine sample size based on confidence interval, precision rate, and anticipated error rate based on the discovery review or at a 97% accuracy rate.
  - e) The Audit Team Lead will review 100% of population when necessary and when the member population is less than 10 member charts.
  - f) The Audit Team Lead will compile results of Full Compliance Audit and calculate recovery or reimbursement amounts.
    - (1) If 100% of charts reviewed, the recovery will be calculated based on 100% of error rate.
    - (2) If Full Sample is utilized, the recovery can be extrapolated according to RAT-STATs. (All extrapolation must be approved by the VBH-PA Compliance Committee and sent to BPI for review.)
  - g) The Full Compliance Audit results will be submitted to the VBH-PA Compliance Committee.
  - h) The VBH-PA Compliance Committee will approve the results and recovery of overpayments for the Full Compliance Audit.
  - i) The Audit Team Lead will update the status of the case.
  - j) The Audit Team Lead will notify the County HealthChoices Designee and VBH-PA Account Executive of the audit results.
9. Report to Providers – The Compliance Director will notify the provider of the results from Discovery and Full Compliance Audits. The report to the provider could include the following:
- a) Corrective Action Plans
    - (1) Corrective Action from VBH-PA
      - (a) The Compliance Department will manage communications with providers and recommend corrective action and implement sanctions as appropriate.
      - (b) The Compliance Department will monitor, review, and recommend appropriate disciplinary actions/sanctions to the Quality of Care (QOC) Committee that includes County HealthChoices representation.
      - (c) The Compliance Department may flag provider or member records in the claims system to continue monitoring following the corrective action

- (d) The Compliance Director will notify the Human Resource Department to manage disciplinary processes when internal staff is involved.
    - (2) Corrective Action by ValueOptions
      - (a) The Compliance Director may refer investigations, audit results, and corrective actions to the National Credentialing Committee for review which may result in sanctioning or terminating the Provider.
      - (b) The HealthChoices County Designee may be offered the opportunity to participate in the review via telephone.
      - (c) The ValueOptions Credentialing Committee will report findings to credentialing, licensing, and public bodies and will review participation in ValueOptions networks.
    - (3) Corrective Action as defined by Pennsylvania Department of Public Welfare.
  - b) Recoveries / Reimbursements of Claim Overpayments / Underpayments
    - (1) The Compliance Director and VBH-PA Compliance Committee will approve all recoveries and reimbursements
    - (2) The Compliance Director will coordinate all recoveries and reimbursements with the Claims Manager.
      - (a) Recoveries and reimbursements will begin after the timeframe for an appeal has expired.
    - (3) The VBH-PA Compliance Committee and Counties will be notified of all recoveries and reimbursements.
    - (4) The Compliance Auditor will include recoveries from claim overpayments in the BPI referral.
10. Audit Appeals - The provider has the right to appeal audit results.
- a) The provider must submit a letter of appeal to the Compliance Director within two weeks of receiving audit results.
    - (1) The provider must submit additional documentation or evidence with the letter of appeal.
  - b) The Compliance Director will review the letter of appeal and evidence to determine when the information will be reviewed by the Appeals Committee.
  - c) The Compliance Director will schedule an Appeals Committee Meeting.
  - d) The Compliance Director will send notification to the provider, County HealthChoices Designee, and BPI that the appeal has been received and scheduled within two weeks of receiving the letter of appeal.
  - e) The Compliance Director will provide a written notification of the appeal decision within 30 days after the Appeals Committee has adjourned.

#### E. Duty to Report and Notify:

- 1. Upon either initiating suspension or termination, or learning that a provider resigned or voluntarily withdrew from the VBH-PA Provider Network following the initiation of a fraud, waste and abuse review, VBH-PA will submit a written report that includes a full description of the reason for review to the appropriate County HealthChoices Designee,

BPI, and ValueOptions within ten (10) business days. Additionally, if a provider refuses to renew or terminates due to concerns of provider fraud, integrity, or quality or is denied enrollment or credentialing BPI will be notified within ten (10) business days.

2. A report on the status of all cases will be provided to the VBH-PA Compliance Committee at the scheduled monthly meetings.
3. For subcontract relationships, the Compliance Auditor will submit quarterly fraud, waste and abuse reports to the County HealthChoices Designee no later than five (5) business days prior to the due dates of BPI. The Compliance Auditor shall submit to BPI quarterly fraud, waste and abuse reports that depict all the activity of the fraud, waste and abuse unit including cases under review, providers terminated after Medicaid/Medicare preclusion, and overpayments recovered. The online form “MCO Quarterly Compliance Report” is attached (see Attachment B). The following is the schedule of due dates for these reports.

<u>Quarter Ending</u>	<u>Report Due to BPI (No Later Than)</u>
March 31	May 15
June 30	August 15
September 30	November 15
December 31	February 15

4. An annual report that reviews all actions involved with identifying and investigating all cases of suspected fraud, waste and abuse will be included in VBH-PA’s Annual Summary of Quality Management Activities.
5. Fraud, Waste and Abuse Requirements Regarding Notification of Adverse Provider Credentialing Information
  - a) The Compliance Department will immediately notify the DPW, BPI when a provider has disclosed information regarding a criminal conviction obtained on an individual provider application.
  - b) The Value Options Credentialing Department will immediately notify in writing, the VBH-PA Director of Member and Provider Services, when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making application to be credentialed as a VBH-PA network provider or upon renewal of their VBH-PA network provider credentialing. The VBH-PA Director of Member and Provider Services will in turn immediately notify in writing the VBH-PA Compliance Auditor, who will directly notify the DPW, BPI of an adverse action, such as convictions, exclusions, revocations, and suspensions, taken on provider applications, including denial of initial enrollment.
  - c) VBH-PA will access the Office of Medical Assistance Program’s Medichk List at <http://www.dpw.state.pa.us/omap/omapmedchk.asp> for information on providers who have been precluded from the MA Program. Additionally, VBH-PA will check the Centers for Medicare and Medicaid Services (CMS) the Federal List of Excluded individuals and Entities (LEIE) be checked by accessing <http://www.exclusions.oig.hhs.gov> and the Excluded Parties List System (EPLS).

6. DPW Fraud and Abuse Hotline
  - a) VBH-PA will ensure that the Department's toll-free fraud and abuse hotline and accompanying explanatory statement is distributed to Members and Providers through Member and Provider handbooks.
7. Providers
  - a) VBH-PA will include fraud, waste and abuse requirements in provider agreements according to MA regulations.
    - (1) The Compliance Director will provide provider training as deemed necessary.
  - b) VBH-PA will ensure that all providers comply with all fraud, waste and abuse requirements including compliance programs and policies.
  - c) The Compliance Department will conduct Discovery Audit and Full Compliance Audit of providers when necessary.
    - (1) The Compliance Department will include a compliance program review in Full Compliance Audits.
    - (2) Any type of audit can be conducted as the following:
      - (a) Announced and/or unannounced audits
      - (b) Desk and/or on-site audits
    - (3) In accordance with PA HealthChoices Program Standard Requirements, providers may not request or require VBH-PA or DPW to reimbursement for expenses related to audits.
8. Subcontractors
  - a) VBH-PA will include MA regulations and fraud, waste and abuse requirements in all subcontractor agreements.
    - (1) The Compliance Department offers subcontractors fraud, waste, and abuse training on the internet at the following address:
      - (a) [http://www.vbh-pa.com/fraud\\_abuse.htm](http://www.vbh-pa.com/fraud_abuse.htm)
  - b) VBH-PA will report all subcontractors to DPW and Counties and ensure that all subcontractors comply with the fraud, waste and abuse requirements including compliance programs and policies.
  - c) The Compliance Department will complete routine audits of subcontractors.
    - (1) The Compliance Department will include a compliance program review in subcontractor audits.

F. Duty to Cooperate with Oversight Agencies:

1. VBH-PA shall cooperate fully with state detection and prosecution activities. Such agencies include, but are not limited to, the Department's BPI, Governor's Office of the Budget, Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the Federal Office of Inspector General, and the United States Justice Department.
2. The cooperation of VBH-PA shall include providing access to all necessary case information, computer files, and appropriate staff. In addition such cooperation may

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include participating in periodic fraud and abuse training sessions, meetings, and joint reviews of subcontracted providers or members.

3. VBH-PA will submit this policy to DPW on annual basis for approval. All revisions will be submitted on a quarterly basis at the DPW Monitoring Meetings.

## **VI. Attachment(s)**

- A. VBH-PA Policies (Refer to [http://www.vbh-pa.com/fraud\\_abuse.htm](http://www.vbh-pa.com/fraud_abuse.htm) for links to the VBH-PA Compliance policies and processes.)
  1. VBH-PA Fraud, Waste and Abuse Training
  2. VBH-PA Chart Audit Policy
  
- B. Regulations and Laws (Refer to [http://www.vbh-pa.com/fraud\\_abuse.htm](http://www.vbh-pa.com/fraud_abuse.htm) for the attachments related to the regulations and laws.)
  1. Balance Budget Act (H.R.2015: Balanced Budget Act of 1997)
  2. Deficit Reduction Act (S.1613: Deficit Reduction Act of 2009)
  3. Provider Prohibited Acts (55 Pa. Code § 1101.75)
  4. Recipient Prohibited Acts (55 Pa. Code § 1101.92)
  5. Federal False Claims Act (31 U.S.C. Subsection 3729-3733: False Claims Act Clarification Act of 2009)
  6. Pennsylvania Fraud and Abuse Control Act - Provider (62 PS S.1407)
  7. Pennsylvania Fraud and Abuse Control Act - Other (62 PS S.1408)
  8. Crimes and Criminal Procedure (US Code - Title 18)
  9. Fraud and Abuse Sanctions (42 USC 1320)
  10. Social Security Act Sanctions (Social Security Act Section 1128 A)
  11. Anti-Kickback Statute (42 C.F.R. §411.350 through §411.389)
  12. Health Insurance Portability and Accountability Act (P.L. 104-191)
  13. Health Information Technology for Economic and Clinical Health Act (P.L. 111-5)
  14. Fraud Enforcement and Recovery Act (S.386: FERA)
  15. Patient Protection and Affordable Care Act (H.R.3590)
  
- C. Pennsylvania HealthChoices Program Service Requirements (Refer to [http://www.vbh-pa.com/fraud\\_abuse.htm](http://www.vbh-pa.com/fraud_abuse.htm) for a link to the DPW website.)
  1. PURPOSE - The purpose of this document is to set forth the standards and requirements for the HC-BH Program operating under the Centers for Medicare and Medicaid Services (CMS) Waiver of Section 1915(b) of the Social Security Act, through counties that are Primary Contractors. County governments which demonstrate capacity to meet the standards and requirements for the HC-BH Program are provided the first opportunity to enter into a capitated contract with the Commonwealth (the "Agreement"). Subject to the Department's approval, a county may implement the Agreement directly or enter into a contract with a Private Sector BH-MCO. In areas in which the county is unable to meet the HC-BH Program standards and requirements or chooses not to participate in this initiative, the Department will select a Primary Contractor through a competitive process resulting in a direct contract with a qualified Private Sector BH-MCO.