



Program Integrity (PI) for Network Providers

Purpose of Program Integrity

- Quality providers
 - Improved outcomes for members
 - Reduced oversight for provider
 - Confidence in network for LME-MCOs
- Financial accountability
 - Investigate provider billing practices
 - Ensure dollars are spent in a way that complies with Federal and State mandates
 - Ensure that tax dollars buy appropriate, quality care for members

PI Definitions and Acronyms

Acronym	Meaning
PI	Program Integrity
OCPI	Office of Compliance and Program Integrity
LME/MCO	Local Management Entity/Managed Care Organization
DHB	Division of Health Benefits
MID	Medicaid Investigations Division
CMS	The Centers for Medicare and Medicaid Services
OIG	Office of Inspector General
EOB	Explanation of Benefits

Fraud

- 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
- Includes any act that constitutes fraud under applicable Federal or State law

Abuse

- Provider practices inconsistent with sound fiscal, business or medical practices, resulting in unnecessary cost to the Medicaid program, or in reimbursement for services not medically necessary or that fail to meet professionally recognized standards for health care
- Also includes member/enrollee practices resulting in unnecessary cost to the Medicaid program

Waste

- Misuse, underutilization or overutilization of items or services or other inappropriate or unnecessary billing or medical practices that directly or indirectly add to healthcare costs or unwarranted or unexplained variation in care that results in no discernible differences in health or patient outcomes

Program Integrity is Everyone's Responsibility

Shared Responsibility

- Members
- Provider agencies and their employees
- LME/MCO and their employees
- State oversight agencies and employees
- Federal oversight agencies and employees
- Other stakeholders

Members

- Use Medicaid responsibly
- Coordination of Benefits (COB)
 - Individuals should inform provider, LME/MCO and Department of Social Services of ALL insurance coverage
- Identify suspicious practices of providers
 - Observation
 - Complete EOB surveys by LME/MCOs
- Report suspicious behavior of other members

Provider Agencies

- Have a Compliance Plan designed to guard against fraud and abuse, including:
 - Written policies, procedures and standards of conduct that articulate agency's commitment to comply with the law
 - Designated Compliance Officer and Compliance Committee
 - A training program for the Compliance Officer and employees
 - Systems for reporting suspected fraud and abuse and protections for those that report these suspicions

Provider Agencies

- Have a Compliance Plan designed to guard against fraud and abuse, including:
 - Provisions for internal monitoring and auditing
 - Procedure for response to detected offenses and development of corrective action plans
 - Procedures to promptly report to Alliance, other outside agencies and law enforcement as indicated

Provider Agencies

- Follow rules/regulations
- Provide services within clinical coverage policies and best practice guidelines
- Coordination of Benefits (COB)
 - Verify a member's eligibility for Medicaid coverage, State funding, and other third party insurance coverage, or if any other payer is involved such as worker's compensation, or other liable parties

Provider Agencies

- Self-audits and self-reporting
 - Self-audit templates and instructions available at:
https://www.alliancehealthplan.org/providers/publications-forms-documents/#Other_Forms_and_Documents_for_Providers
- Comply with monitoring and investigations

LME/MCOs

- Have a Compliance Plan designed to guard against fraud and abuse
- Follow rules/regulations
- Provide technical assistance to providers and members regarding clinical coverage policies and best practice guidelines
- Routinely monitor the provision of services by providers

LME/MCOs

- Coordination of Benefits (COB)
 - Determine the liability of third parties
- Accept and look into all referrals of suspicious practices of members and providers
- Maintain integrity and professionalism through referral and investigation process

State Oversight Agencies

- DHB OCPI – Division of Health Benefits Office of Compliance and Program Integrity
- DOJ MID – Department of Justice Medicaid Investigations Division

State Oversight Agencies

- Create and enforce consistent guidelines for PI
- Enforce and follow federal rules/regulations
- Educate LME/MCOs, providers and members regarding PI practice guidelines
- Provide guidance to LME/MCOs in their PI efforts

State Oversight Agencies

- Accept referrals of suspicious practices of LME/MCOs, members and providers
- Investigate appropriate referrals

Federal Oversight Agencies

- CMS – Centers for Medicare and Medicaid Services (CMS)
 - “Committed to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients”
- 5-Year Comprehensive Medicaid Integrity Plan

Federal Oversight Agencies

- **OIG**

- “Since its 1976 establishment, the Office of Inspector General of the U.S. Department of Health and Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs”
- Certifies and annually recertifies DHB OCPI
- Analyzes PI performance based on 12 performance standards
- Develops, implements, publishes annual work plan

Investigation vs. Monitoring

Monitoring Standard Procedure

- Types
 - Routine
 - Focused
- Possible outcomes
 - Report of findings
 - Notice of overpayment
 - Plan of Correction
 - Technical assistance
 - Referrals for investigation

Investigation

- Based upon an allegation
- Compliance issues suspected
- Higher level provider actions possible

Continuum of Investigations

- Grievance
- Provider network
- Special investigations
- Other

Internal Referrals

- Internal staff
- Electronic entry
 - Website
 - Hotline
 - Alpha
- Internal committees
- Data analytics

External Referrals

- Hotline
- DHHS
- Mail
- Electronic entry
- Members
- Stakeholder
- Access line/call center
- EOB survey

Investigations

- Preliminary
- Full
- Announced/unannounced on-site
- Desk review

Possible Outcomes

- Provider actions*
- Technical assistance
- Referral to oversight agency
- Local reconsideration for provider actions*

**refer to Provider Operations Manual*

Laws/Regulations/Statutes Related to Program Integrity

Federal Anti-Kickback Statute

- Establishes criminal penalties for certain acts impacting Medicare and Medicaid reimbursable services
 - Prohibits the offer or receipt of “remuneration” in return for referrals for or recommending purchase of supplies and services reimbursable under government health care programs
 - Includes providers offering gifts of any kind to members to induce them to switch provider agencies
 - Felony conviction punishable up to \$25,000 in fines, imprisonment, or both

Federal False Claims Act (FCA)

- Establishes liability for any person who knowingly and willingly submits for payment or reimbursement a claim known to be false or fraudulent, or who knowingly makes or uses a false record or statement material to a false or fraudulent claim or to an “obligation” to pay money to the government

Federal False Claims Act (FCA)

- Intended to reduce the amount of fraud, waste and abuse in federally funded programs, including federally funded health care programs such as Medicare or Medicaid
- Financial penalties of \$5,000 to \$10,000 for each false claim submitted and repayment of three times the amount of damages sustained by the U.S. government

NC False Claims Act (FCA)

- NC's version of the federal False Claims Act and contains parallel provisions
 - Combats fraud and abuse and is applicable to all billing under the NC Medical Assistance Program, including services provided under the 1915(b)/(c) waiver and billed to Alliance
 - Financial penalties of \$5,000 to \$10,000 for each false claim plus at least two times the amount of damages plus interest and payment of the government's expenses to pursue reimbursement

Deficit Reduction Act

- Designed to restrain Federal spending while maintaining the commitment to the federal program beneficiaries
 - Requires compliance for continued participation in the programs by agencies providing billing \$5 million or more annually
 - Felony conviction and a fine up to \$25,000 and/or imprisonment for no more than 5 years for false statements

HIPAA

- Health Insurance Portability and Accountability Act
 - Regulates the way certain health plans, health providers, and health clearinghouses (covered entities) handle Protected Health Information (PHI)
 - Creates Federal standards for maintaining the confidentiality of PHI; governs its use and disclosure
 - Civil penalties up to \$100/violation up to \$25,000/year
 - Criminal penalties \$50,000 and 1 year imprisonment up to \$250,000 and 10 years imprisonment

Civil Monetary Penalties Law

- Intended to prevent health care providers from improperly influencing how Medicare and Medicaid members select their care provider
 - Penalties are imposed when entities or individuals offer or give something of value to Medicare/Medicaid members so that they will choose a particular provider or supplier
 - Fines of up to \$50,000 per wrongful action

Whistle Blower Act

- Allows any person with actual knowledge of allegedly false claims, who has first made a good faith effort to exhaust internal reporting procedures, to file a lawsuit on behalf of the government and potentially share in a percentage of the amount recovered
 - Designed to encourage individuals to come forward and report misconduct involving false claims

Resources

- Alliance Fraud and Abuse Line: (855) 727-6721
- NC Department of Health and Human Services Customer Service Center: (800) 662-7030
- Medicaid Fraud, Waste and Program Abuse Tip Line: (877) DMA-TIP1 or (877) 362-8471
- Health Care Financing Administration Office of Inspector General's Fraud Line: (800) 447-8477
- State Auditor's Waste Line: (800) 730-TIPS or (800) 730-8477

Resources

- Alliance Provider Operations Manual: <https://www.alliancehealthplan.org/providers/publications-forms-documents/>
- Office of the Inspector General: <https://oig.hhs.gov/>
- System for Award Management: www.sam.gov
- Provider Monitoring: www.ncdhhs.gov/providers/provider-info/mental-health/provider-monitoring

Resources

- Centers for Medicare and Medicaid Services:
www.cms.gov
- NC Division of Health Benefits Clinical Coverage Policies:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>