

South Florida Community Care Network Anti-Fraud Plan 2010

Fraud Investigative Unit/ Anti-Fraud Team Leads

South Florida Community Care Network (SFCCN):

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Memorial Healthcare System (MHS):

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Tracy Harswick, Director of Claims/Decision Support, Compliance Lead

Public Health Trust (PHT):

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University of Miami Behavioral Health (UMBH)/ ad hoc

Terry Deochand, UMBH Director of Finance and Compliance Officer

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Children's Medical Services (CMS):

Tobi Goodman, Director of Managed Care

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Applicable Lines of Business:

Reform and Non-Reform Provider Service Network (PSN) Plans

Children's Medical Services Title 19 MHS/NBHD Reform Plans

Children's Medical Services Title 21 PHT/MHS/NBHD Plans

Overall Objective:

To develop an anti-fraud plan addressing the detection and prevention of overpayments, abuse and fraud relating to the provision of and payment for PSN Medicaid, CMS Title 19 and CMS Title 21 services in conjunction with the SFCCN Compliance Program/Committee.

South Florida Community Care Network (SFCCN) Anti-Fraud Plan

Administration and Management:

The South Florida Community Care Network (SFCCN) is a partnership of three major community health systems all having an SFCCN Anti-Fraud Team Lead who participates in the SFCCN Fraud Investigative Unit. All SFCCN personnel are responsible for the investigation, and reporting of possible overpayment, fraud and abuse through the identified Anti-Fraud Team Leads/Fraud Investigative Unit. The SFCCN Executive Director shall be the person responsible for carrying out the SFCCN Anti-Fraud Plan (as the SFCCN Compliance Officer) and will serve to integrate the efforts of the three health systems in the investigation, detection and prevention of overpayment, fraud and abuse relating to the provision of PSN Medicaid, CMS Title 19 and CMS Title 21 Services. The three health systems, also known as “Subnetwork(s)” are: the Public Health Trust, Memorial Healthcare System and North Broward Hospital District dba Broward Health. In addition, the SFCCN shall engage its significant provider or administrative partners in anti-fraud activities.

The SFCCN Fraud Investigative Unit shall track provider as well as enrollee fraud and abuse activities. This unit is also responsible for reporting suspected fraud and abuse by non-participating providers when detected. The SFCCN Fraud Investigative Unit will have ad hoc representation from the behavioral health network administrator with the expectation of compliance with SFCCN and Medicaid policy as well as provider education regarding fraud prevention and detection. In addition, the SFCCN retains a copy of the Fraud and Abuse policy and procedure from its Transportation Network Administrator.

Elements of the SFCCN Anti-Fraud Plan:

To ensure program effectiveness, the SFCCN Anti-Fraud Plan shall have the following key elements:

1. Education and Training
2. Process for Reporting Concerns
3. System for Responding to Identification of Improper Activities/Conduct
4. Development of an Auditing and Monitoring System
5. Corrective Action Process for Correcting Problems Identified

Role of the SFCCN Fraud Investigative Unit

The SFCCN Governing Board has authorized the SFCCN Executive Director with responsibility for SFCCN fraud and abuse (as well as overpayment) prevention, detection, and investigation through the SFCCN Anti-Fraud Plan.

The SFCCN Executive Director shall report all activities/findings to the SFCCN governing board via the SFCCN Compliance Committee Report.

The SFCCN Fraud Investigative Unit is responsible for overseeing the administration of the SFCCN Anti-Fraud Plan and ensuring integration of Subnetwork processes. This shall include but not be limited to employee training, investigation and response to complaints,

implementation of internal controls and audits. Responsibilities shall also include but not be limited to: identifying personnel responsible for the investigation and reporting of possible overpayment, abuse or fraud; identifying procedures for detecting and investigating possible acts of fraud, abuse and overpayment; and identifying procedures for educating and training personnel on how to detect and prevent fraud, abuse and overpayment.

Reporting Structure:

The reporting of offenses may occur by the SFCCN, Subnetwork or partner entity as a decentralized function or the reporting may occur through the SFCCN centrally to AHCA's Bureau of Medicaid Program Integrity and the Department of Health depending on the contract under which the offense falls. If the reporting occurs by the Subnetwork or partner entity, the SFCCN shall be contemporaneously notified. It is further recognized that an individual may report suspected Medicaid fraud or abuse by contacting the Medicaid Program Integrity (MPI) hotline at 1-888-419-3456 or complete a complaint form online at http://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaint-form.aspx. In such cases, neither the SFCCN, the Subnetworks nor the partner entity may have knowledge of the reported fraudulent claim or act.

Upon detection of a potential or suspected fraudulent claim or act by an enrollee, the SFCCN shall file a report with the Agency for Health Care Administration, Medicaid Program Integrity and Medicaid Fraud Control Unit (MFCU) or Department of Health depending on the line(s) of business. For PSN and CMS Title 19 lines of business, the report must be sent to the contract analyst at the Bureau of Managed Health Care, MPI and MFCU. If the reporting involves a CMS Title 19 or Title 21 enrollee or provider, CMS Headquarters/the Department of Health will also be notified by the reporting entity.

The report shall contain at a minimum:

For Enrollees-

- a) The name of the Enrollee,
- b) The Enrollee's PSN identification number (as applicable)
- c) The Enrollee's Medicaid identification number,
- d) A description of the suspected fraudulent act, and
- e) The narrative report

For Providers -

- a) The name of the Provider
- b) The Provider's Medicaid identification number
- c) The Provider's tax identification number
- d) A description of the Provider's suspected fraudulent act; and
- e) The narrative report

Flow Chart From the First Point of Suspicious Activity Through Reporting

Refer to attachment

Resources:

- SFCCN Compliance Program/Committee
- OIG Website <http://oig.hhs.org>
- SFCCN Policy and Procedure ADM #615R entitled Fraud and Abuse Prevention and Detection
- miami.edu/compliance

All SFCCN staff, Subnetwork staff as well as UMBH and CMS staff have hard copy as well as on-line access to the SFCCN Policy ADM #615R: Fraud and Abuse Prevention and Detection. A copy of which is included as part of the SFCCN Anti-Fraud Plan and is given to all new employees as part of the orientation to the SFCCN and annually at the time of recertification. (See attached Statement of Understanding). Revisions will be issued whenever an update or modification is required.

RECORD KEEPING AND CONFIDENTIALITY

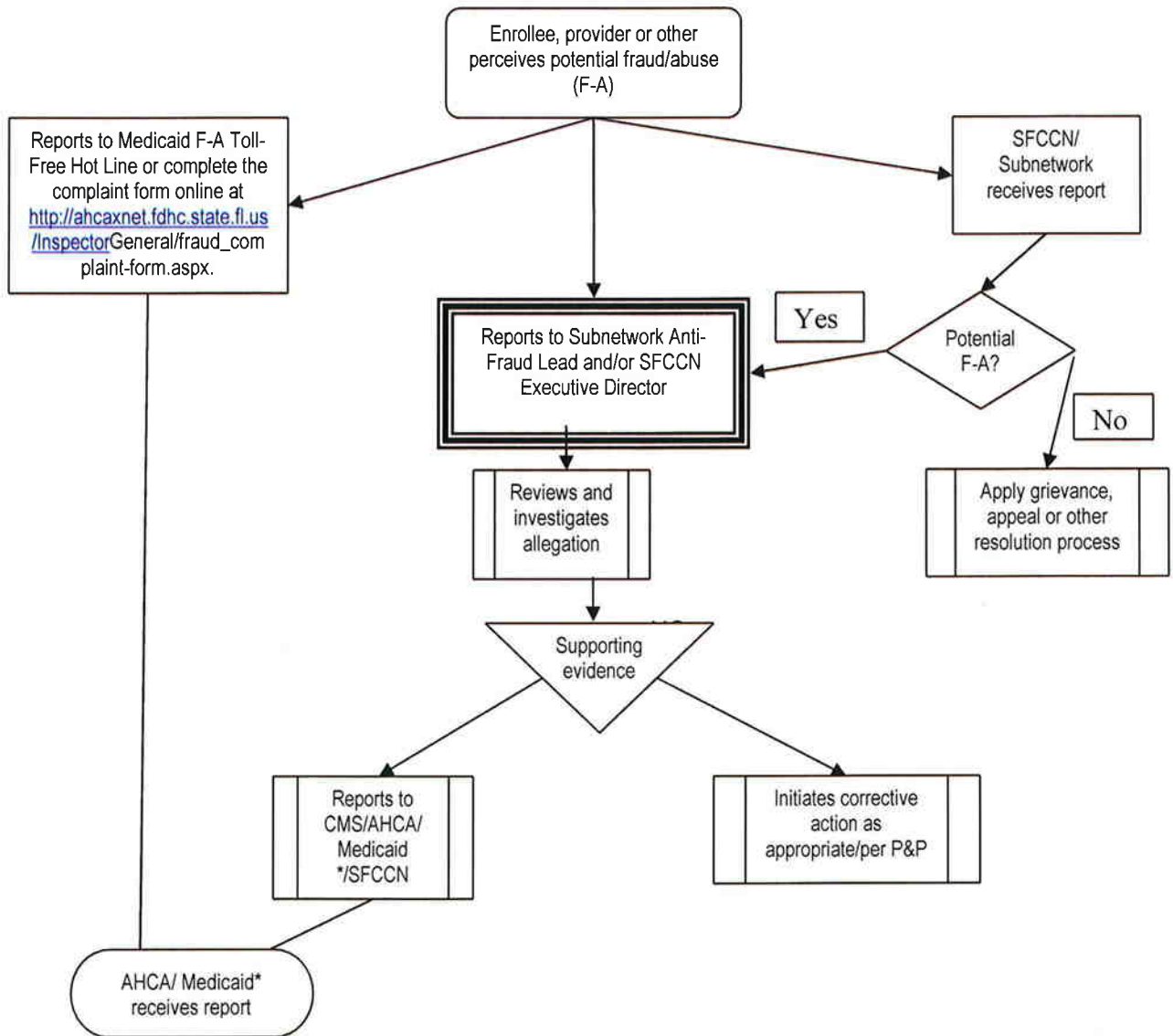
Tracking and reporting of cases. A designated model reporting form has been developed for use by all health system entities/network administrators.

Report Structure to AHCA/Medicaid Program Integrity/Medicaid Fraud Control Unit:

Any cases reported to AHCA through the SFCCN Administrative Office shall be done by the SFCCN Executive Director or the Finance Manager in the Executive Director's absence.

Required Statement of Understanding and Compliance Document shall be completed by PSN Reform, PSN Non-Reform and CMS Title 19 and Title 21 Staff.

Flow Chart From the First Point of Suspicious Activity Through Reporting





**Statement of Understanding and Compliance with
Fraud and Abuse Detection and Prevention
For PSN Reform, PSN Non-Reform, CMS-19 and CMS-21 Lines of Business**

I certify that I have attended the **Fraud and Abuse Detection and Prevention Education Program** and that I understand it is my duty to adhere to the standards presented and conduct all business in the highest ethical manner.

I acknowledge that I have read and understand the Health System's and South Florida Community Care Network's **Fraud and Abuse Detection and Prevention Policies and Procedures** and agree to abide by them and their requirements.

I acknowledge and understand that I have a duty to report any alleged or suspected fraud or abuse of which I become aware.

Date

Signature

Print Name

Date

Manager's Signature

Print Name

**SFCCN Policy and Procedure – ADM 615, Fraud Abuse Prevention and Detection
AHCA Core Contract, Attachment II, Section VII.D.1.c, VIII.B.1, X.E & XV.F**

Purpose: To establish guidelines for the detection, investigation and prevention of Fraud and Abuse, and comply with all state and federal program requirements including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 455; 45 CFR Part 74; the provisions of Chapters 409, 414, 458, 459, 460, 461, 626, 641, 932, F.S. and 59A-12.0073, 59G and 69D-2, FAC.

To establish a mechanism whereby the PSN's identification of possible fraudulent claims by Enrollees or by Providers of service is/are reported to appropriate internal and external parties for investigation.

To provide general information for PSN staff with use of the PSN Compliance Program (referred to herein). Through this policy and the PSN's Compliance Program, the PSN shall have functions and activities governing program integrity to reduce the incidence of Fraud and Abuse.

The PSN through this policy and procedure and its Compliance Program shall uphold the Compliance Plan at PSN. The PSN Compliance Program shall integrate the processes and resulting activities of the Compliance Plans.

Definition: Abuse: Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care; or recipient practices that result in unnecessary cost to the Medicaid program.

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

False Claims Act: Under the False Claims Act, 31 U.S. C Section 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

Whistleblower Protections: The False Claims Act contains a whistleblower provision which provides protection provided by Federal acts and related statutes that shield employees from retaliation for reporting illegal acts of employers. An employer can't rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates anyway, whistle blower protection might

entitle the employee to file a charge with a government agency, sue the employer, or both.

- Policy:**
1. The PSN Compliance Officer, shall ensure that all officers, directors, managers and employees know and understand the provision of the PSN's Fraud and Abuse policies and procedures and PSN Compliance Program. The PSN shall have adequate staffing and resources to enable the compliance officer to investigate unusual incidents and develop and implement corrective action plans relating to fraud and abuse. The compliance office shall have unrestricted access to the plan's governing body for compliance reporting, including fraud and abuse.
 2. The PSN shall investigate possible fraudulent claims or activities that are either identified through the claims system or reported by any party who has knowledge of or who believes a fraudulent act has been committed.
 3. When the PSN identifies evidence of possible Fraud or Abuse by a PSN or other Medicaid provider (participating or non participating) or Medicaid/PSN beneficiary/enrollee, or receives communication regarding possible fraudulent or abusive activity, the PSN policy is to be followed. This may include referral to Risk Management, referral to a Fraud Compliance Plan Specialist, Special Investigative Unit or the like. The PSN designated staff shall file a confidential report to the Bureau of Medicaid Program Integrity (MPI), Medicaid Fraud Control Unit (MFCU), Agency Contract Manager and other agencies as required by law within 15 Calendar days of detection. The PSN shall not cease an investigation or resolve the suspicion, knowledge or action without first informing AHCA, MPI, and the MFCU. Additional, any final resolution reached by the PSN must include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter. The report shall contain a minimum:

For Enrollees:

- (a) The Enrollee's PSN identification number;
- (b) The Enrollee's Medicaid identification number;
- (c) A description of the suspected fraudulent act; and
- (d) The narrative report

For Providers:

- (a) The name of the Provider;
- (b) The Provider's Medicaid identification number;
- (c) The Provider's tax identification number;
- (d) A description of the Provider's suspected fraudulent act; and
- (e) The narrative report

4. The PSN's Credentialing/Re-credentialing process shall use the list of Excluded Individuals and Entities (LEIE), to identify excluded parties during the process of

contracting providers to ensure that the Providers are not in a nonpayment status or sanctioned from participation in federal health care programs under Sections 1128 and 1128 A of the Social Security Act. The PSN shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI. The PSN shall not employ or contract the services of excluded Providers or subcontractors and must terminate the contract between the PSN and the Provider or subcontractors that excluded from participation in federal health care program.

5. The PSN shall minimally integrate their utilization management processes and claims processing system as a means of identifying/reviewing for potential fraudulent claims, including but not limited to:
 - A. Claim Edits
 - B. Post-processing review of claims
 - C. Provider profiling, credentialing and recredentialing, including a review process for claims and encounters that will include participating and non-participating Providers:
 - 1) Who demonstrate a pattern of submitting falsified encounter data or service reports;
 - 2) Who consistently demonstrate a pattern of overstated reports or up-coded levels of service;
 - 3) Who altered, falsified, or destroyed clinical record documentation;
 - 4) Who make false statements relating to credentials;
 - 5) Who misrepresent medical information to justify referrals;
 - 6) Who fail to render medically necessary covered services; as per Provider contract
 - 7) Who charge or attempt to charge Medicaid beneficiaries for covered services.
 - D. Prior Authorization
 - E. Utilization Management
 - F. Relevant Subcontract and Provider contract provisions
 - G. Pertinent provisions from the Provider and Enrollee Handbook
 - H. Standards for a code of conduct
- 6 As requested by AHCA, the PSN will cooperate and provide on-going information as requested, relating to any PSN provider or activity being monitored, including the provision of or access to applicable records on supporting evidence. The PSN ensure that all providers and subcontractors upon request shall make available to all authorized federal and state oversight agencies and their agent., including but not limited to AHCA, and the Florida Attorney General, any and all administrative, financial and Medical Records and data relating to the delivery of items or services for which Medicaid monies are expended.
- 7 The PSN, and its providers and subcontractors will allow access to all authorized

federal and state oversight agencies and their agents, including but not limited to the Agency and the Florida Attorney General, to any place of business and all Medical, data and Financial Records, as required by state and/or federal law. The Agency and the Florida Attorney General shall have access during normal business hours, except under special circumstances shall have after hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstance.

8. The PSN shall cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation.
9. The PSN shall ensure that it will not retaliate against any individual who reports violations of the PSN's Fraud and Abuse policies and procedures or suspected Fraud and Abuse. The PSN will also ensure the confidential reporting of any violations in addition to protecting the identities of any individuals who report in good faith alleged acts of Fraud and Abuse. The PSN's Compliance Officer shall investigate and follow-up on all reports of Fraud and Abuse.
10. Not knowingly have affiliations with individuals debarred or excluded by federal agencies under ss. 1128 and 1128A of the Social Security Act and 42 CFR 438.610.
11. The PSN shall provide training to new staff, an annual update to all staff and additional training or dissemination of materials as warranted, which shall include fraud detection awareness, and PSN policies and procedures in accordance with Section 6032 (Provider receives or earns five million dollars or greater annually under the state plan) of the Federal Deficit Reduction Act of 2005. If PSN has an employee handbook, the PSN shall include specific information about s. 6032, PSN policies and the rights of employees to be protected as whistleblowers. Providers, subcontractors and Enrollees shall be educated through provisions in the PSN Provider Manual, PSN Enrollee Handbook, and Subnetwork-specific materials.
12. The PSN shall submit its Fraud and Abuse policies and procedures, and its Compliance Program to the Bureau of Managed Health Care for written approval before implementation and annually thereafter. At a minimum the compliance plan must include:
 - a) Written policies, procedures and standards of conduct that articulate the PSN's commitment to comply with all applicable federal and state standards;
 - b) The designation of a compliance office and a compliance committee accountable to senior management;
 - c) Effective training and education of the compliance officer and the PSN's employee;

- d) Effective lines of communication between the compliance officer and the PSN's employees;
 - e) Enforcement of standards through well-publicized disciplinary guidelines;
 - f) Provision for internal monitoring and auditing; and
 - g) Provisions for prompt response to detected offenses and for development of corrective action initiatives.
13. The PSN shall ensure that all employees, subcontractors and providers are fully compliant with Section 6032 of the Federal Deficit Reduction Act of 2005, and will provide detail information regarding:
- 1) False Claims Act,
 - 2) Penalties for submitting false claims and statements,
 - 3) Whistle Blower Protection,
 - 4) The law's role in preventing and detecting fraud, waste and abuse,
 - 5) Each person's responsibility relating to detection and prevention,
 - 6) The toll-free state telephone numbers for reporting fraud and abuse.
14. The PSN shall comply with all reporting requirements set forth in Section XII, Reporting Requirements.
15. The PSN shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect and overpayment issues. For purpose of this section, the PSN's Compliance Officer, shall be point of contact for the PSN.
16. The state, CMS, and DHHS may inspect and audit any financial records of the plan or its subcontractors. Pursuant to s. 1903 (m) (4) (A) of the Social Security Act and state Medicaid Manual 2087.6 (A-B), non-federally qualified health plans must report to the state, upon request, and to the Secretary and the Inspector General of DHHS, a description of certain transactions with parties of interest as defined in s. 1318 (b) of the Social Security Act.

- Procedures:**
- 1. Since the PSN does not pay claims, Medicaid would direct and be responsible for claims recovery on behalf of the PSN if fraudulent claims have been paid. The PSN will make best effort to assist in the recovery of the identified claims dollars from the provider.
 - 2. The PSN's written fraud and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected Fraud and Abuse activities. These controls and policies shall be delineated by the PSN.
 - 3. The PSN shall have procedures designed to prevent and detect potential or suspected Fraud and Abuse in the administration and delivery of services. This shall include Provider profiling and credentialing.

4. The PSN has a Whistleblower protection system in place, and will not make or tolerate any intimidating or retaliatory act against an individual who, in good faith makes a report of practices reasonable believed to be a violation of this policy.

For additional information regarding Medicaid's Fraud and Abuse policies, Provider rights relative to abuse and fraud investigations, Provider responsibilities, etc., refer to Medicaid's General Provider Handbook, Chapter 5 entitled Medicaid Fraud and Abuse. This policy shall also be used as a companion to the PSN's Compliance Program.

Resource: Definitions taken from AHCA Core Contract No. FA 912, Attachment II, Section I.

Per Medicaid contractual guidelines, SFCCN reports identified cases of fraud and abuse quarterly and annually – in addition to direct submission within 15 days of discovery via the AHCA website. A summary of the annual reports submitted to AHCA for PSN and CMS Title 19 Broward are listed below.

**2009-2010 Annual Fraud and Abuse Report Summary
South Florida Community Care Network
Children’s Medical Services Network – Broward**

Children’s Medical Services (CMS) contracts with South Florida Community Care Network to provide Title 19 services in Broward County. These services are provided by Memorial Healthcare System as Children’s Medical Services Broward-South (CBS) and by the North Broward Hospital District as Children’s Medical Services Broward-North (CBN). Children’s Medical Services Broward, both North and South, provided a 2009-2010 Annual Fraud and Abuse Report to CMS for submittal to the Agency for Health Care Administration, Medicaid Program Integrity. Both CBN and CBS reported no instances of fraud, abuse and/or overpayment during the reported time period. CBN and CBS follow the SFCCN Anti-Fraud Plan with participation by CMS.

**2009-2010 Annual Fraud and Abuse Report Summary
South Florida Community Care Network Provider Service Network**

All three Subnetworks of the South Florida Community Care Network – Memorial Healthcare System (MHS), North Broward Hospital District (NBD) and Public Health Trust of Miami-Dade County (PHT) – provided a 2009-2010 Annual Fraud and Abuse Report to the Agency for Health Care Administration, Medicaid Program Integrity. MHS reported no instances of fraud, abuse and/or overpayment during the reported time period. NBD reported one provider referral to MPI during 2009-2010 that identified a possible overpayment of \$419.84. PHT had 1 case of possible enrollee fraud referred to MPI during the reported time frame, amounts to be determined upon MPI investigation. All reported referrals were discussed and reported as directed by the SFCCN Anti-Fraud Plan.