

Fraud, Waste, & Abuse

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Fraud

*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.*⁴

Waste

*Waste is not defined in the rules, but is “generally understood to encompass over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.”*⁵

Abuse

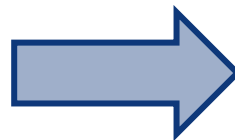
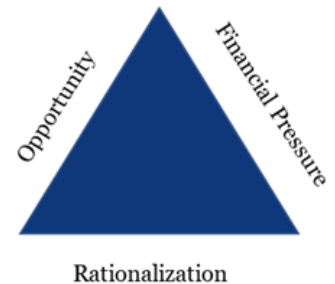
*Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program. [This can also include] reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.*⁶

Context

As part of the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Initiative, the Department of Health Care Services (DHCS) has changed its auditing and recoupment policies to focus on fraud, waste, and abuse.¹ This document offers a starting point for Medi-Cal Specialty Mental Health Services (SMHS) Providers as they revisit and strengthen their required compliance programs.

The Fraud Triangle

The Fraud Triangle, developed by criminologist Dr. Donald Cressey, describes the psychological and social determinants of fraudulent behavior. The determinants are three-fold: the person is experiencing financial stress; the person sees the opportunity to commit fraud; and the person is able to justify their behavior.²



The prevention, detection, and correction of fraud, waste, and abuse must be INTENTIONAL, STRATEGIC, and PROACTIVE.

Organizations that utilize productivity expectations should consider how these expectations may potentially impact the financial pressure component of the Fraud Triangle. Also, the policies and practices of all organizations should be clear that evaluation of service delivery providers *also* includes recognition of ethical behavior and excellence in relationship-building and clinical outcomes.

Strategies

The strategies on the next page are organized using the Office of Inspector General’s seven elements of an effective compliance program.³ The elements are interconnected, and the specific pointers are some key considerations but are in no way all-encompassing.

Compliance Program Strategies



1. Policies & Procedures

- * Establish a stand-alone Code of Conduct that represents the organization's unique culture, values, and mission and sets the expectation for honest and ethical behavior at all times.



2. Training

- * Educate all staff on the organization's Fraud, Waste, and Abuse (FWA) policy, including the responsibility for and process of reporting suspected fraud and non-retaliation for reporting.



3. Open Lines of Communication

- * Ensure compliance activities are carried out within the context of trusting relationships, which in turn encourage staff to bring forward questions and concerns without fear of retaliation.



4. Auditing and Monitoring

- * Establish and report on "red flag" thresholds (for example, total time claimed in one day by one provider) and audit the corresponding records for clinical appropriateness.



5. Response and Corrective Action

- * Correct confirmed instances of fraud through appropriate disciplinary action, reporting and return of overpayment as per DHCS policy,⁷ and the use of legal counsel as appropriate.



6. Enforcement and Discipline

- * Emphasize a zero tolerance for fraud and outline potential consequences including termination of employment and repercussions from the provider's licensing board.



7. Oversight

- * Utilize the agency's Compliance Committee as a critical platform to operationalize FWA, identifying concrete ways staff can protect the integrity of resources in their day-to-day work.

References

¹ Department of Health Care Services (DHCS) (2022), *Behavioral Health Information Notice No: 22-063*, Retrieved from <https://www.dhcs.ca.gov/Documents/BHIN-22-063-Annual-Review-Protocol-for-FY-2022-23.pdf>

² Association of Certified Fraud Examiners, *Fraud 101: What is Fraud?* Retrieved from <https://www.acfe.com/fraud-resources/fraud-101-what-is-fraud>

³ Office of Inspector General, *Compliance Guidance*, Retrieved from <https://oig.hhs.gov/compliance/compliance-guidance/>

⁴ 42 Code of Federal Regulations Section 455.2

⁵ Centers for Medicare and Medicaid, *Fraud, Waste, and Abuse Toolkit*, Retrieved from <https://www.cms.gov/files/document/overviewfwaprovidersbooklet072616pdf>

⁶ 42 Code of Federal Regulations Section 455.2

⁷ DHCS (2019), *MHSUDS INFORMATION NOTICE NO.: 19-034*, Retrieved from [https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS Information Notices 2019/MHSUDS IN 19-034/MHSUDS-Information-Notice-19-034-Overpayment-Recovery-and-Reporting-Procudures.pdf](https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS%20Information%20Notices%2019-034/MHSUDS%20IN%2019-034/MHSUDS-Information-Notice-19-034-Overpayment-Recovery-and-Reporting-Procudures.pdf)



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