Bureau of Corporate Compliance (BCC) Operations and Procedures Manual

Bureau of Corporate Compliance

This manual is intended to provide a high level overview of ADHS/DBHS’ BCC Program, and to provide guidance to DBHS Contractors and subcontractors.
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Overview

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has created the Bureau of Corporate Compliance (BCC) to comply with Corporate Compliance requirements mandated by federal and state law, and with ADHS/DBHS' contract with the Arizona Health Care Cost Containment System (AHCCCS). The BCC administers ADHS/DBHS’ Corporate Compliance Program consisting of all applicable program integrity rules, regulations and contractual requirements.

ADHS/DBHS' BCC Program includes the seven (7) required elements listed in 42 CFR §438.608 including: a Corporate Compliance Plan; Corporate Compliance Officer; a Corporate Compliance Committee; effective training and education, communication, monitoring/auditing; and effective written policies and procedures. Additionally, the ADHS/DBHS/BCC is tasked with three primary functions for the detection of fraud, waste and program abuse: application of risk management principles, the audit process and the investigative process.

The designated Corporate Compliance Officer is also the designated Bureau Chief for Corporate Compliance and is the higher authority responsible for the general administration of the Compliance Program and the Corporate Compliance Plan.

The essential functions, policies, procedures, and initiatives that define an effective, robust program are discussed herein and constitute the ADHS/DBHS/BCC Program.

Purpose

The purpose of this manual is to provide a high level overview of ADHS/DBHS' BCC Program, and to provide guidance to DBHS Contractors and subcontractors to jointly prevent, deter and detect fraud, waste and program abuse by creating a system-wide culture that promotes understanding of, and adherence to, all applicable federal, state and local laws and regulations.

ADHS/DBHS BCC Program will continuously be reviewed for modifications necessary to meet the changing regulatory landscape, as well as to address areas of identified or potential risk.

Corporate Compliance Plan

ADHS/DBHS' BCC Program has been developed and is implemented through a Corporate Compliance Plan (Plan).

The Plan is comprised of several systematic processes and risk management initiatives in order to address the different stages of compliance, such as assessing, identifying, detecting, deterring, and preventing fraud, waste and program abuse. As a result of those processes, the Plan provides a strategy to mitigate risk, while consistently improving the existent internal monitoring mechanisms and controls that are in place.

The Plan is a strategic approach, based on an analysis of the strengths and opportunities for the achievement of the Corporate Compliance goals. The processes and risk management initiatives address all required AHCCCS and ADHS contractual requirements, and the applicable state and federal rules and regulations.

Corporate Compliance Officer:

The Corporate Compliance Officer (CCO) is the highest authority within the ADHS/DBHS/BCC. The ADHS/DBHS CCO develops, implements, and addresses all mandated elements of the BCC Program. The ADHS/DBHS CCO is a full-time management
position that reports directly to ADHS/DBHS’ Assistant Director, Compliance and Consumer Rights, who is a member of ADHS/DBHS’ senior management.

The ADHS/DBHS CCO is responsible for the development and implementation of the plan, policies, processes, monitoring tools and other mechanisms to prevent, detect and deter fraud, waste and program abuse in the Public Behavioral Health System; to include assisting ADHS/DBHS contractors’ and subcontractors’ Compliance Officers as they facilitate their own compliance programs.

**Corporate Compliance Committee:**

The purpose of the ADHS/DBHS Corporate Compliance Committee (Committee) is to provide high-level oversight for the Plan. This oversight includes periodic reviews, recommendations and support based on emerging trends and risk analysis presented by the ADHS/DBHS CCO. The Committee’s key responsibilities are as follows:

1. Ensure effective communication and understanding regarding fraud, waste and program abuse prevention, detection, and deterrence responsibilities to the entire DBHS agency.
2. Review and approve the Plan annually to ensure that it meets the requirements of the ADHS/AHCCCS Contract, any state and federal regulations (42 CFR § 438.608) and the needs of ADHS/DBHS.
3. Provide high-level oversight, monitoring and guidance to implement improvements to critical ADHS/DBHS internal controls.

   a. Committee Meetings:

      1. The Committee has a standing quarterly meeting with additional meetings scheduled on an “as-needed” basis.
      2. The standing quarterly meeting of the Committee provides the forum necessary to review the ongoing activities of the ADHS/DBHS BCC Program, other ADHS/DBHS BCC activities, and to discuss audits, trends and specific investigative cases from the past period.
      3. Committee meeting agendas and notes are confidential and will be maintained in the designated ADHS/DBHS BCC administrative record area.

**Corporate Compliance Officers’ Workgroup Meetings (CCOW):**

In order to facilitate fraud, waste and program abuse training and to encourage communication amongst ADHS/DBHS’ contractors’ Compliance Officers, the ADHS/DBHS CCO will schedule Workgroup (Workgroup) meetings throughout the year.

The Workgroup meetings are intended to provide a forum for discussion of relevant fraud, waste and program abuse topics, emerging trends, and changes in ADHS/DBHS corporate compliance policy/contract language, as well as provide a setting for technical assistance on methods and techniques in deterring and detecting fraud, waste and program abuse.

1. The Workgroup meetings will be scheduled, at a minimum, semi-annually and will be held at the ADHS building in Phoenix or at ADHS/DBHS agreed upon locations convenient for the participants. All designated contractor Compliance Officers and acting Compliance Officers are to attend in-person. In the event a Compliance Officer cannot attend in person, they shall appoint a designee to attend in their place and notify the DBHS CCO or Investigative Coordinator prior to the meeting. Special
accommodations may be provided for telephonic and video conferencing capabilities; however, attendance in person is highly recommended.

2. The Compliance Officers will be notified in advance to confirm each Workgroup meeting. All Compliance Officers are invited to contact the ADHS/DBHS CCO to suggest items for discussion or to request presentations be placed on the agenda. All requests for items or presentations must be received by the ADHS/DBHS CCO at least one month prior to the meeting date and must be approved for inclusion on the agenda.

3. Agendas and meeting notes are not confidential and will be retained as part of ADHS/DBHS/BCC’s administrative records.

**Effective Education and Training Programs**

*For Contractors:*
The ADHS/DBHS contractors and subcontractors are responsible for providing effective ongoing fraud, waste and program abuse training and awareness activities to their compliance committee, employees, managers, and supervisors, per contractual requirement.

On an as-needed basis, the ADHS/DBHS CCO provides education, technical assistance and high level training to the ADHS/DBHS Contractor’s CCOs.

*For ADHS/DBHS Employees:*
All ADHS/DBHS employees, as a condition of employment, are required to strictly adhere to the State’s Standards of Conduct. All employees receive continual access to the Arizona State Personnel System Employee Handbook (Part Three: Conditions of Employment).

All new ADHS/DBHS employees receive mandatory initial training through the New Employee Orientation Process. This training provides ADHS/DBHS’ expectations for the effective identification and reporting of any suspected fraud, waste and program abuse within the ADHS/DBHS/BCC scope. Annual mandatory refresher trainings are also administered to all DBHS employees in an online web-based format.

All ADHS/DBHS/BCC staff, including the ADHS/DBHS CCO, attends professional training in order to maintain their understanding and expertise in the area of fraud, waste and program abuse prevention, detection, investigations and auditing standards.

Additionally, awareness campaigns are conducted during each year to include, but not limited to, the distribution of the ADHS/DBHS/BCC announcements, electronic mail, posters, and miscellaneous outreach mechanisms for all ADHS/DBHS employees.

*On-going Training:*
As new federal and state laws and regulations are implemented within the fraud, waste and program abuse scope, the ADHS/DBHS/BCC will develop and/or modify appropriate training programs and implement accordingly.

**Deficit Reduction Act (DRA) Requirements**
As a part of the compliance program and as required by the Deficit Reduction Act (DRA) of 2005, Title 42, U.S.C., §1396(a), ADHS provides all employees with training and information regarding the False Claims Act, the employee Whistleblower Protection and Qui Tam Provisions. This information is shared during new employee orientation and administered
through the annual online web-based refresher course. The DBHS Employee Resource Guide is the employee's resource of information for immediate reference on all respective areas.

ADHS’ contractors must provide information regarding the False Claims Act through their designated CCO’s implemented training activities. Citations: USC Title 31, Sections 3729 – 3733; USC Title 31, Chapter 38; public law 109-171.

System for Routine Monitoring, Auditing and Identification of Compliance Risks

The ADHS/DBHS/BCC employs three (3) standard mechanisms for systematic fraud, waste and program abuse monitoring that serve as a foundation for BCC’s routine daily operations: (1) risk management, (2) investigations, (3) audits, reviews and evaluations.

Prevention Initiative - Risk Management Overview:

The risk management process outlines the ADHS/DBHS/BCC’s comprehensive and systematic risk prevention and management practices in order to reduce gaps, loss and liability exposure. Risks change and evolve with changes in the law, contract requirements and operational matters. Therefore, in addition to monitoring changes in requirements, BCC reviews identified areas of non-compliance organizationally as well as from findings through investigation and audit activities for purposes of identifying and addressing known areas of risks.

The ADHS/DBHS/BCC has developed and implemented a uniform risk management approach through all steps from the identification of initial and ongoing risk, through the implementation of a plan of correction that addresses all areas of identified concern.

This risk management-based approach is a critical element in the prevention of future fraud, waste and program abuse, through the identification and mitigation of risk associated with non-compliance, which impacts across all operational areas within ADHS/DBHS.

Investigations:

The ADHS/DBHS/BCC investigation process includes all requirements from initial reporting, through the investigation, to the determination of a credible allegation of suspected fraud, waste and program abuse for all Non-Title XIX/XXI state-funded and grant funded services.

The ADHS/DBHS CCO is responsible for creating and maintaining ADHS/DBHS’ investigative process and procedures, assigning, overseeing and assuring the quality of audit and investigations, and summarizing and reporting of all fraud, waste and program abuse trending and statistical data.

The ADHS/DBHS CCO is the ADHS/DBHS liaison with the AHCCCS-OIG, Department of Health and Human Services, Office of Inspector General, the State Attorney General’s Office as well as other state and federal law enforcement agencies.

The ADHS/DBHS CCO is the point of contact for ADHS/DBHS contractors, subcontractors and internal employees reporting fraud, waste and program abuse. All external ADHS/DBHS fraud, waste and program abuse reporting (i.e. state, federal agencies or law enforcement authorities) are also conducted by the ADHS/DBHS CCO, or designee, as the sole point of reference.

The purpose of the investigative process is to provide a methodical process that describes the fraud, waste and program abuse reporting responsibilities for all ADHS/DBHS contractors and subcontractors. The process serves as the primary tool to assist ADHS/DBHS contractors
and investigators to understand the processes, activities, tasks, measures, and standards when reporting suspected fraud, waste and program abuse.

All applicable authorities to investigate contractors and subcontractors can be found in the following area: Applicable Authorities.

**Audits, Reviews & Evaluations:**

In order to prevent, deter and detect fraud, waste and program abuse, the audit, reviews and evaluation component ensures that appropriate monitoring, reviewing, and auditing processes are performed. These activities, referred to generally as audits or reviews, are focused on identifying high-risk areas and contract requirements and other vulnerable processes and systems where trends and patterns of fraud, waste and program abuse may be emerging.

While the information below reflects regular ADHS/DBHS audits, reviews and evaluation activities, ADHS/DBHS reserves the right to conduct all monitoring, to include, audits and reviews, without any prior notice to ensure effective monitoring of all applicable contractual requirements and performance, as needed.

The Corporate Compliance Plan’s Audit component is separated into four independent but inter-related processes:

- **Encounter Data Validation Ride-Along Program/Provider Audits**
- **Community Service Agency Monitoring**
- **Internal/Special Project Audits/Reviews**
- **Ad hoc Audits/Reviews and other Program Orientations and Evaluations (as needed)**

These processes are outlined as follows:

- **Encounter Data Validation Ride-Along Program (RA) and Provider Audits**
  
  The purpose of the specialized BCC RA Program is to evaluate the current processes of the Contractor and to ensure that they are accurately and thoroughly performing effective audits and data validation reviews.

  This also gives the ADHS/DBHS/BCC a presence in the community to routinely meet with T/RBHA staff, provide increased oversight, technical assistance and provide clarification, as needed to maintain the program’s integrity.

  The BCC Provider Audit is independent of any T/RBHA audits and is used to evaluate provider operations with a view towards improving future performance. Recommendations from the Audit report can be used as a basis for adjusting policies, priorities or procedures to increase operational efficiency and effectiveness.

- **Field Audits, Reviews and Evaluations – review process for Community Service Agencies only**

  ADHS/DBHS/BCC is developing a new independent monitoring process to specifically assess the services provided by the Community Service Agencies (CSA). The CSA Provider Reviews ensure that CSAs provide services in accordance with Arizona Department of Health Services standards and certification requirements.
This process presents an opportunity for ADHS/DBHS/BCC to provide on-site technical assistance and oversight to Tribal and Regional Behavioral Health Authorities (T/RBHA) and CSAs.

- **Internal/Special Project Audits/Reviews**

  Internal and Special Project Audits will provide independent, objective assurance designed to add value and improve ADHS/DBHS/BCC’s operations. The purpose of the internal and special project monitoring is to ensure DBHS programs are in accordance with all applicable rules, regulations and contractual requirements.

  The internal and special project monitoring will be conducted as part of any and all special requests due to high profile and/or other specific circumstances that may arise. Examples include, but are not limited to, legislative and executive leadership requests, etc.

**Authority to Conduct Audits of Contractors and Subcontractors:**

ADHS/DBHS/BCC establishes its authority to conduct audits, reviews and investigations of ADHS/DBHS/BCC contractors and subcontractors from the following Arizona statutes and contract provisions:

- ARS 41-2548. Right to Audit Records
- ARS 41-2547. Right to Inspect Place of Business
- Respective RBHA Contract; Uniform Terms and Conditions
- Respective RBHA Contract; Special Terms and Conditions

The BCC conducts audits of behavioral health services providers pursuant to standardized audit protocols. These standards require that BCC plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objective. The BCC primary audit objective is meant to determine if paid claims and encounters are supported by sufficient documentation and if the provider is suspected of fraud, waste and/or program abuse.

**Fraud, Waste and Program Abuse Hotline and Electronic Mailbox**

In order to provide an anonymous and user-friendly method(s) for contractors, providers, members, our general public and ADHS/DBHS employees to report suspected fraud, waste and program abuse, a dedicated, toll-free hotline has been established.

Information regarding this hotline is provided on the ADHS/DBHS website and posted in prominent places throughout ADHS/DBHS, and by any other method or medium that encourages individuals to report fraud, waste and program abuse.

a) The hotline is managed by ADHS/DBHS/BCC. The respective hotline numbers are: 866-569-4927 or 602-364-3758. The dedicated e-mail address, reportfraud@azdhs.gov, has also been established for individuals to report suspected fraud, waste and program abuse electronically.

b) The hotline voice-mail recording and electronic email address are available 24 hours a day, seven (7) days a week for reporting. All complaints, tips and reports received from
the hotline are tracked in the ADHS/DBHS/BCC database and weekly summary reports are provided to the BCC Chief.

c) In the event that information received on the hotline is not related to the jurisdiction and scope of ADHS/DBHS/BCC, the caller and/or the call or information is triaged to the appropriate area within ADHS or other state agency. All information received from the hotline is maintained confidentially and callers may remain anonymous to the extent permitted by law.

RBHA Reporting Responsibilities

Title XIX / XXI Funding
As outlined in the ADHS/DBHS / T/RBHA contracts, the T/RBHAs are required to report immediately upon identification, all suspected Fraud, Waste and/or Program Abuse involving any Title XIX/XXI funds to AHCCCS-OIG. The methods for reporting are listed below:

Online form:  http://www.azahcccs.gov/fraud/reporting/reporting.aspx
Email:  AHCCCSFraud@azahcccs.gov
Phone:  (602) 417-4193 or (602) 417-4045
Fax:  (602) 417-4102

Due to the potential for overlapping funding streams, a copy of the referral, any preliminary research conducted, along with any and all supporting documentation, shall also be provided to ADHS/DBHS/BCC using one of the methods shown below.

Non-Title XIX / XXI or Grant Funding
In addition, DBHS’ contractors are also required to immediately report all other instances of suspected fraud, waste and program abuse involving any funding sources other than the Title XIX/XXI, to ADHS/DBHS/BCC directly.

1. This reporting shall be completed in written format using the approved designated ADHS/DBHS/BCC reporting form and sent to the reportfraud@azdhs.gov mailbox.
2. When reporting Non-Title XIX and Non-Title XXI funds or Grants it shall be submitted in a format which identifies the amount(s) by each appropriate fiscal year.
3. The reporting format should also identify the different funding streams for each dollar amount and whether it was a claim or an encounter.

DBHS Contractors must submit referrals using the Suspected Fraud, Waste or Program Abuse Report form provided on the AZDHS/DBHS Public Website. All pertinent documentation and/or investigative reports that would assist DBHS in its investigation shall be attached to the referral. The documentation may be submitted via any of the following methods:

Mail:  Arizona Department of Health Services
Division of Behavioral Health Services
Bureau of Corporate Compliance
150 North 18th Avenue, Suite 250
Phoenix, AZ 85007

Email:  ReportFraud@azdhs.gov
The ADHS/DBHS Policy and Procedure Manual, Section 5, Chapter 1500, Policy 1502, Corporate Compliance, provides additional reporting guidance.

**AHCCCS Office of Inspector General (OIG) Communications**

DBHS Contractors shall report to ADHS/DBHS/BCC, within ten (10) days of notification, any contact made by AHCCCS-OIG in reference to any open/closed fraud, waste and program abuse case, a voluntary self-disclosure settlement and or any other type of fraud, waste and program abuse activity involving official communications by AHCCCS-OIG.

ADHS/DBHS/BCC shall be advised of the final disposition of any case and/or settlement agreement made between the contractor or provider and AHCCCS-OIG.

**ADHS/DBHS Excluded Provider Guidelines**

As outlined in 42 CFR §438.610 and 42 CFR §1001.1901, ADHS/DBHS does not knowingly maintain relationships with an individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

The contractor must notify AHCCCS-OIG and ADHS/DBHS/BCC immediately of any instances of an excluded provider that is, or appears to be, in a prohibited relationship with the contractor or subcontractors.

**Disclosure of Ownership and Control [42 CFR 455.104]**

The Contractor must furnish to ADHS, AHCCCS and CMS within thirty-five (35) days of receiving the request, full and complete information, pertaining to the following business transactions [42 CFR 455.105):

- The ownership of any subcontractor with whom the Contractor has had business transaction totaling more than $25,000 during the twelve (12) month period ending on the date of such request; and
- Any significant business transactions between the Contractor and wholly owned supplier, or between the Contractor and any subcontractor ending on the date of such request.
- In the event that AHCCCS Office of Inspector General, either through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. Furthermore, the Contractor is fully subrogated to AHCCCS for all civil recoveries.

The Contractor must provide the following information to AHCCCS and DBHS:
• The Name and Address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

• The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the Contractor.

• The Tax Identification Number of any corporation with an ownership or control interest in the Contractor.

• Whether any person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether any person (individual or corporation) with an ownership or control interest in any subcontractor of the Contractor has a 5% or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.

• The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the Contractor has an ownership or control interest.

• The Name, Address, Date of Birth and Social Security Number of any managing employee of the Contractor as defined in 42 CFR 455.101.

The Contractor shall provide the above-listed information to AHCCCS and DBHS at any of the following times:

• Upon the Contractor submitting a proposal in accordance with the State’s procurement process.

• Upon the Contractor executing the contract with the State.

• Upon renewal or extension of the contract.

• Within 35 days after any change in ownership of the Contractor.

The Contractor shall also, with regard to its fiscal agents, obtain the following information regarding ownership and control:

• The Name and Address of any person (individual or corporation) with an ownership or control interest in the Fiscal Agent. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

• The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the fiscal agent.

• The Tax Identification Number of any corporation with an ownership or control interest in the fiscal agent.

• Whether any person (individual or corporation) with an ownership or control interest in the fiscal agent is related to another person with ownership or control interest in the fiscal agent as a spouse, parent, child, or sibling; or whether any person (individual or corporation) with an ownership or control interest in any subcontractor of the fiscal agent has a 5% or more interest is related to another person with ownership or control interest in the fiscal agent as a spouse, parent, child, or sibling.

• The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the fiscal agent has an ownership or control interest.
The Name, Address, Date of Birth and Social Security Number of any managing employee of the fiscal agent as defined in 42 CFR 455.101.

**Disclosure of Information On Persons Convicted Of Crimes [42 CFR 455.101; 106; 436]**

The Contractor must identify all persons associated with the Contractor and its fiscal agents who have an ownership or control interest or managing employee interest and determine if they have been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XX services program.

The Contractor shall, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

- The List of Excluded Individuals (LEIE).
- The System for Award Management (SAM).
- The AHCCCS-OIG List of Excluded Providers.
- Any other databases as directed by AHCCCS or CMS.

The Contractor must immediately notify AHCCCS and DBHS of any person who has been excluded through these checks.

The results of the Disclosure of Ownership and Control and the Disclosure of Information on Persons Convicted of Crimes shall be held by the Contractor.

The Contractor shall submit, consistent with ACOM Policy 103, Attachment C, an annual attestation, that the above-listed information has been requested and obtained.

Upon request, the Contractor shall provide AHCCCS and or DBHS with the above-listed information.

**Contractor Corporate Compliance Deliverables**

All Contractors are to submit the Corporate Compliance Deliverables and reports, as required, in their current contract. The ADHS/DBHS CCO is responsible for the analysis and monitoring of all required contractor deliverables related to the required Corporate Compliance Program elements. Secure electronic files will be maintained for all deliverables.

The following are the current contractor deliverables (see most current contract for frequency and deadlines as these are subject to change):

1. Annual Corporate Compliance Program/Plan
2. Excluded provider employee and contractor screening/Reporting checks
3. Completed Internal and External Audit Reports & Findings
4. Quarterly CC Ride-Along Program (Data Validation Review Schedule)
5. Fraud, Waste and Program Abuse Record & Trend Analysis – Quarterly and Year to Date
6. ACOM 424 Verification of Receipt of Paid Services

All deliverables that contain protected health information (PHI) and/or other confidential or other sensitive content must be in compliance with all applicable HIPAA provisions and uploaded to the secure designated ADHS/DBHS/BCC SharePoint site.
Additionally, the Contractor need only send notification (no attached supporting materials) to the following email box: BHSCONTRACTCOMPLIANCE@AZDHS.gov that the deliverable has been sent to the respective program area.

**ADHS/DBHS Provider Self-Disclosure Protocol**

The U.S. Department of Health & Human Services Office of Inspector General, the State of Arizona’s Health Care Cost Containment System’s OIG (AHCCCS-OIG), and BCC understand the importance of advancing the program integrity of federal and state funded health care programs.

As part of a multi-dimensional approach to detecting potential fraud, waste and program abuse and recovering improper payments related thereto, ADHS/DBHS/BCC supports the recognition and creation of incentives for providers who find problems within their own organization, completely self-disclose the issue to AHCCCS-OIG and BCC, and return improper payments.

**Self-Disclosure Reporting Protocol (All Funding Sources)**

When the contractor self-discloses potential fraud, waste and program abuse to the AHCCCS-OIG, the contractor must also disclose all funding sources outside the disclosed TXIX/XXI, directly to ADHS/DBHS/BCC simultaneously.

The contractor will follow all AHCCCS-OIG guidelines put forth, as referenced in the below guidance in regards to the disclosure process in its entirety to include, but not limited to, eligibility criteria, statute of limitations, disclosure requirements and cooperation expectations (click below for immediate reference).

- U.S. Department of Health & Human Services Office of Inspector General
- State of Arizona’s Health Care Cost Containment System’s OIG (AHCCCS-OIG)

The contractor is expected to conduct an internal investigation and report its findings to ADHS/DBHS/BCC in its contractual submission. Disclosures may be submitted through the below methods or to the ADHS/DBHS Corporate Compliance Officer/Bureau Chief directly.

- E-mail: REPORTFRAUD@AZDHS.GOV
- Fax: 602-542-3940

Upon review of the contractor’s disclosure and related information, ADHS/DBHS may independently conclude that the disclosed matter warrants referral to the State of Arizona Attorney General’s Office for further action.

**AHCCCS Operational Review (OR)**

Annually, AHCCCS conducts an Operational Review (OR) of the DBHS contract in order to determine contractual compliance with key organization, management and administrative standards, including those areas related to corporate compliance encompassing fraud, waste and program abuse.

The ADHS/DBHS CCO responds to all requests for information and documentation related to corporate compliance requested by AHCCCS, and participates in any required interviews. ADHS/DBHS/BCC staff will also make themselves available for interviews and questions during the OR period, as needed.
In the event that AHCCCS requires corrective action in an area of BCC or the DBHS Compliance Plan or program, the ADHS/DBHS CCO will immediately develop corrective measures and notify AHCCCS of the changes by way of the communication method established by ADHS for the OR process.

**Contractor ADHS Administrative Review Process**

The annual Administrative Review is a monitoring tool used by BCC to ensure compliance with regulatory and programmatic requirements. The ADHS/DBHS CCO will provide support and information, as required, for the DBHS Administrative Review for the specific BCC standards of each T/RBHA, as a provision of their contracts/IGAs. The ADHS/DBHS CCO will provide oversight and feedback on all related corporate compliance standards and requirements, as needed.

The ADHS/DBHS/BCC standards address compliance with the CSA monitoring, the Encounter Data Validations, and other applicable audits and reviews of the subcontracted providers. The tool will be disseminated to the RBHAs for the FY 2014 with many standards coded as informational purposes only.

The final version of the BCC standards is expected to be fully implemented by FY 2015.

**Contractor Compliance Officers and Compliance Plans**

All contractors are required by contract to have a high functioning Corporate Compliance Program, a Corporate Compliance Plan, and a designated CCO, all of which must be based upon the seven (7) specific program integrity elements as required in 42 CFR §438.608.

*The Seven Elements of a Corporate Compliance Program:*

The U.S. Sentencing Commission Guidelines have outlined seven (7) elements that comprise an effective Compliance Program. These elements include:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards.
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 the Contractor’s employees.
4. Creation and maintenance of an effective line of communication between Compliance Officer and all employees and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Provisions for internal monitoring and auditing.
7. Provision for prompt response to detected offenses, and for development of corrective action initiatives.
Conclusion

The Corporate Compliance Program plays an integral part in assisting the Arizona Department of Health Services, Division of Behavioral Health Services in achieving its commitment to the highest standards of conduct, honesty, integrity, and reliability in its business practices.

The Corporate Compliance Program also assists in preventing, detecting, and deterring any fraud, waste, or program abuse in health care practices.

The Corporate Compliance Program is a constantly evolving Program responding to changes in federal and state laws and regulations, billing, coding and documentation rules, and the results of ongoing audit/investigative findings and risk assessments.

This Corporate Compliance Program document represents the current state of the Program. This document will be updated as required to adapt to the changing environment.

Glossary of Information

Applicable Authorities

- Title 18, U.S.C., § 286, Conspiracy to defraud the Government with respect to claims
- Title 18, U.S.C., § 1345, Injunction against fraud
- Title 18, U.S.C., § 287, False Claims
- Title 18, U.S.C., § 371, Conspiracy to defraud
- Title 18, U.S.C., § 669, Theft/embezzlement Re: healthcare
- Title 18, U.S. C., § 1001, General false statements
- Title 18, U. S. C., § 1031, Major fraud against US
- Title 18, U.S.C., § 1035, False Statements relating to Health Care Matters
- Title 31, U.S.C., § 3729-3733, False claims act & Qui Tam actions
- Title 31, U.S.C., Sections 3729 – 3733
- Title 31, U.S.C., § 3802, Civil false claims administrative
- Title 42, U.S.C., § 1320a-7A, Civil monetary penalties
- Title 42 CFR § 1001.1901, Waivers and Effect of Exclusion
- Deficit Reduction Act (DRA) of 2005, Title 42, U.S.C., §1396(a)
- 42 C.F.R. §438.608, Exclusion
- 42 C.F.R. §438.610, Exclusion
- Public law 109-171
- Patient Protection and Affordable Care Act (PPACA)
- Medicaid Program Integrity Manual by CMS
- A.R.S. § 36-2918, AHCCCS - Prohibited acts
- A.R.S. § 41-2548
- A.R.S. § 36-3410
- R9-21-209
Element Determination of Fraud, Waste and Program Abuse

The following are the elements of fraud, waste and program abuse according to the applicable rules and regulations, contracts and guidelines to determine if fraud, waste and/or program abuse is suspected from the allegations and the supporting documentation:

Evidence of the following:
  a. Duplicate billings
  b. False claims or data
  c. Upcoding
  d. Miscoding
  e. Unbundling
  f. Misrepresentation of services
  g. Misrepresentation of credentials
  h. Billing for services not rendered
  i. False or altered documents
  j. Missing documentation
  k. Pattern of irregularities
  l. Unlicensed or excluded professional or facility at time of services
  m. Management knowledge of fraudulent or abusive activity
  n. Reports of material irregularities by more than one reliable source

Additional Criteria:
  a. Pattern of occurrence of irregularities
  b. Unnecessary cost/loss to a government program
c. Loss would be considered material for nature and type of activity and contractor/provider

At least one of the following criteria is met:

a. Direct personal knowledge of fraudulent or abusive activity by known reliable individual
b. ADHS/DBHS Contractor documented audit findings that show evidence of suspected fraud, waste or program abuse
c. Referral or report showing evidence of suspected fraud, waste or program abuse from another government or law enforcement agency

Definitions

For the purposes of the ADHS/DBHS/BCC Compliance Program, and all the operational activities outlined in this manual, the following will be used as the definitions when conducting investigations of suspected fraud, waste and program abuse.

Fraud:

“Fraud means 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.” (42 CFR § 455.2) Elements of Fraud:

a. The act (evidence of wrongdoing).
b. Knowledge and intent (willfully intended to commit act – generally evidenced by a pattern of wrongdoing).
c. Benefit (some type of measurable benefit obtained from the act by the person committing the act).

Program Abuse:

“Abuse means 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.” (42 CFR §455.2).

Elements of Program Abuse:

a. Inconsistency (pattern of not following known laws, rules, regulations, contracts or industry practices/procedures).
b. Costs (unnecessary loss to a government program).
c. Not necessary/does not meet standards (general disregard for professional or industry standards and practices).

Waste: Per the Centers for Medicare & Medicaid Services (CMS), Waste is defined as follows:

“…overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.”
Payment Holds:

A payment hold is a temporary denial of reimbursement under the Medicaid or other HHS program for items or services furnished by the provider of interest. This stoppage is considered an administrative sanction that stays in place until the matter in dispute between the provider and the Health and Human Services Commission is resolved.

Payment Holds Due to a Credible Allegation of Fraud (CAF):

Federal law defines a credible allegation of fraud as an “allegation, which has been verified by the state, from any source.” 42 CFR § 455.2 states that the source of these allegations may include, but are not limited to: “(1) fraud hotline complaints, (2) claims data mining, (3) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered credible when they have indicia of reliability and the state Medicaid Agency has reviewed all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis.”

OIG’s Provider Self-Disclosure Protocol:

In 1998, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) published the Provider Self-Disclosure Protocol (the SDP) at 63 Fed Reg. 58399 (October 21, 1998); and Section 6402 (a) of H.R. 3590, the Patient Protection and Affordable care Act of 2010 (“PPACA”), to establish a process for health care providers to voluntarily identify, disclose, and resolve instances of potential fraud involving the Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act), 42 U.S.C. 1320a–7b(f)).

All health care providers, suppliers, or other individuals or entities who are subject to OIG’s CMP authorities found at 42 C.F.R. Part 1003 are eligible to use the SDP. Requirements for All Disclosures can be located through the following link: https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf

Patient Protection and Affordable Care Act (PPACA) Provisions

The Patient Protection and Affordable Care Act (PPACA) contains thirty-two sections focused on fraud, waste and program abuse and the strengthening of the program integrity component.

1. The PPACA will improve and expand consumer protections, strengthen Medicare, and reduce health care costs. One important way it achieves these goals is by improving government-wide efforts to fight fraud, waste and program abuse.

2. The new law contains some critical new tools to improve and enhance the Administration’s efforts to prevent, detect and take strong enforcement action against fraud, waste and program abuse in Medicare, Medicaid and the Children’s Health Insurance Program as well as private insurance.

3. Beginning January 1, 2012, AHCCCS started the implementation of program integrity changes related to:
   - Provider Registration
   - Suspension of Provider payment based on a Credible Allegation of Fraud
The Background Screening:
The final rule creates procedures for screening with enhanced processes regarding how AHCCCS registers new and existing providers. This includes current practices such as licensure verification, National Provider ID number (NPI), address verifications, and additional procedures utilizing national databases. For certain types of providers, additional measures may be required such as on-site visits.

All current AHCCCS providers will be required to re-enroll with AHCCCS using its new processes. CMS has given Medicaid agencies a five year timeframe within which to complete the re-enrollment process for existing providers. AHCCCS will notify existing providers when their re-enrollment is due and once they are re-enrolled, the existing providers will revalidate every five years. Newly enrolling providers will be required to revalidate their enrollment every five years.

Suspension of Provider Payments (42 C.F.R. §455.23):
The second set of regulations requires AHCCCS to suspend payments to a provider if AHCCCS determines that there is a credible allegation of fraud against the Medicaid Program. A credible allegation of fraud is defined as an allegation which has been verified by the state from any source including, but not limited to:

1. Fraud Hotline Complaints.
2. Claims Data Mining.
3. Patterns identified through provider audits, civil false claims cases and law enforcement investigations. Allegations are considered credible when they have indicia of reliability and the State Medicaid Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

Prior to the PPACA, suspending payment to a provider for alleged fraud was discretionary with the Agency. Now it is mandatory and AHCCCS could be subject to federal disallowance for failing to follow these requirements. Furthermore, under the old regulation, the standard of proof for whether suspension of payment was warranted was higher. The state Medicaid agency could suspend a provider’s payment only if reliable evidence of fraud was found. Now the state Medicaid agency must suspend payment if a credible allegation of fraud is found.

The regulation also lists the following good cause exceptions to the suspension:

1. Law enforcement requests that suspension not happen because the suspension may compromise or jeopardize an investigation.
2. Other available remedies implemented by the state more effectively or quickly protect Medicaid funds.
3. The state determines after submission of written evidence by the provider that the suspension should be removed.
4. Member/recipient access to care would be jeopardized by the suspension because either of the following:
   a. The provider is the sole community physician or the sole source of essential specialized services.
   b. The provider services a large number of recipients within a HRSA-designated medically underserved area.
5. Law enforcement declines to certify that the matter is still under investigation.

6. The state determines that payment suspension is not in the best interests of the Medicaid Program.

7. The credible allegation focuses solely on a specific type of claim or arises from only a specific business unit of a provider and the state determines that a suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

If AHCCCS finds that good cause exists, the suspension may not be imposed or may be lifted. In some cases, the suspension can be a partial payment suspension.

This regulation also requires AHCCCS to refer every provider whose payments have been suspended to the Medicaid Fraud Control Unit (MFCU) at the State Attorney General’s Office.

The referral must occur within 24 hours of the suspension and the MFCU will provide a quarterly report to AHCCCS that their investigation is either ongoing and the suspension should continue, or that MFCU is declining the investigation and the suspension may be lifted absent another law enforcement agency’s acceptance of the case.

For more detailed information, you may refer to the following links:

- Provider Screening and Enrollment Fee
- HHS-OIG FAQS On Provider Payment Suspension


**Links to SAM LEIE, and AHCCCS-OIG Exclusions Databases**

- The Arizona AHCCCS-OIG list of excluded providers is found at http://www.azahcccs.gov/OIG/ExcludedProviders.aspx