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MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

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Owner	Dana James
Policy Area	Wraparound (Wrap, REACH, youth CCS)-Administration

#066: Fraudulent Activity (Fraud & Abuse)

I. POLICY

It is the policy of Children's Community Mental Health Services and Wraparound Milwaukee (hereby referenced as Wraparound Milwaukee) that controls are implemented to detect and prevent fraudulent and abusive activity and that allegations of fraudulent activity are thoroughly investigated and that corrective/legal measures/actions be implemented/taken as appropriate. This policy applies to any fraud/abuse or suspected fraud/abuse, involving enrolled families, consultants, providers, contractors and outside agencies doing business with Wraparound Milwaukee and/or any other parties that have a business relationship with Wraparound Milwaukee.

Wraparound Milwaukee considers all fraud to be material and expects that the agency/individual take corrective action for weaknesses that led to the fraud and to repay the program for all losses due to fraud, regardless of the amount involved.

The program has an identified Compliance Officer who is accountable to the Program Administrative/ Senior Management staff and coordinates all investigations with the appropriate parties, both internal and external. The Compliance Officer must possess, at minimum, a bachelor's degree in a mental/ behavioral health, criminal justice or accounting/medical records type field and/or an unrelated bachelor's degree with at least two (2) years experience working in a mental/behavioral health type program with experience in quality assurance/investigative activities and reports directly to the Director of Wraparound Milwaukee.

Wraparound Milwaukee and any/all Subcontractors are committed to comply with all applicable Federal and State requirements and standards identified within the current Medicaid Contract that Wraparound Milwaukee has with the State of Wisconsin.

Milwaukee County agrees to cooperate with the State of Wisconsin Department of Health Services (DHS) and applicable Milwaukee County Departments and Divisions on fraud and abuse investigations. In addition, Wraparound Milwaukee agrees to report credible allegations of Medicaid fraud and abuse (both provider and member) to the DHS Office of Inspector General within 10 days of becoming aware of the credible allegation.

II. DEFINITIONS

Fraud - An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to themself, itself or to some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Examples – A provider who knowingly documents and/or bills for services that were not rendered, bills multiple times for the same service or bills for more costly services than furnished, or a provider who misrepresents their qualifications or bills for services furnished by unqualified staff.

Additional examples of actions constituting fraud (not all-inclusive):

- Embezzlement.
- Alteration or falsification of documents.
- Theft of any asset (money, tangible property, etc.).
  Note: Fraud resembles theft in that both involve some form of illegal taking, but the two should not be confused. Fraud requires an additional element of False Pretenses created to induce a victim to turn over property, services or money. Theft, by contrast, requires only the unauthorized taking of another's property with the intent to permanently deprive the other of the property. Because fraud involves more planning than does theft, it is punished more severely.
- Authorizing or receiving compensation for goods not received, services not performed or hours not worked.
- Misrepresentation of fact.
- A caseworker enrolling his or her family member in government programs so that they receive benefits for which they are not eligible.
- An agency reporting false financial or performance information to improve the likelihood that the funding agency will renew the contract.
- An agency knowingly reports non-allowable expenses for reimbursement from grants.

In several of these examples, someone was injured: an eligible person who didn't receive services because slots were filled with ineligible people; an agency that didn't get a contract it was qualified for because the contract went to an agency that cheated; and the funding agency that paid more for services than it should have.

Fraud involving government funding also violates the public trust. So, in addition to each individually identifiable victim, another victim is the public as a whole.

The risk of fraud is much higher when two key factors are present: pressure or incentive to commit fraud and the perceived opportunity to do so. The incentive could be personal or organizational. The

opportunity could be weakness in internal controls or the belief that the internal controls can be circumvented.

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to BadgerCare Plus, in reimbursement for services that fail to meet professionally recognized standards of health. Abuse also includes client or member practices that result in unnecessary costs to BadgerCare Plus.

- ***Examples: A provider who furnishes services that are no longer medically necessary or are inappropriate for the client's condition and a client who repeatedly changes providers for inappropriate reasons.***

Any required investigative activity will be conducted without regard to the suspected wrongdoer's length of service, position/title or relationship to Wraparound Milwaukee.

III. PREVENTION

Wraparound Milwaukee is aware of the potential for fraud within the program and within the numerous community agencies that we have Contracts/Fee-for-Service Agreements with. Listed below are several steps/internal controls/activities the program employs to prevent/lessen the opportunity for fraud to occur.

1. Promoting integrity and ethical behavior throughout the organization/provider network.
2. Performing background checks of employees, checking their license or certification status, and checking for their debarment or suspension status.
3. Documenting and reviewing business processes for handling funds.
4. Training on/assuring implementation of applicable job responsibilities and guidelines (i.e., service descriptions, procedures and policies) and the information listed in this Policy and Procedure.
5. Promptly and thoroughly investigating complaints.
6. Ensure that the agency has adequate insurance coverage for employee theft.
7. Conducting quality assurance spot checks, site reviews and site visits, and record reviews.
8. Providing Provider, Care Coordinator and Family Luncheons related to program expectations and best practice.
9. Regularly engaging in Utilization Review processes.
10. Send Confirmation of Benefits to youth/families on a regular basis.

IV. PROCEDURE

All of the following steps might not be applicable to a particular situation and the steps are only roughly in the order in which they are likely to occur. The actual steps taken and the order in which they are taken will vary depending on the circumstances of the suspected fraud or abuse.

1. Any fraud/abuse that is detected or suspected must be reported immediately to the identified program Compliance Officer or to the Milwaukee County Fraud Hotline at (414) 93-FRAUD

(933-7283) or electronically at http://county.milwaukee.gov/Audit/Fraud-Reporting-Form.htm. The individual reporting the detected/suspected fraud or abuse may remain anonymous.

2. The Compliance Officer will appoint a staff member to coordinate the reaction to the suspected fraud and gives this person authority to take the steps described in this section. The staff member will remain in close contact/consultation with the Compliance Officer and any other Management staff or Behavioral Health Services/Milwaukee County staff, following their direction.
    a. The staff member will begin documenting all contact made and steps taken by the provider/agency in reaction to the suspected fraud.
    b. The staff member will handle all correspondence related to the suspected fraud/ abuse.
        a. The staff member will report credible allegations of Medicaid fraud and abuse to the DHS Office of Inspector General (OIG) within 10 days of Wraparound Milwaukee becoming aware of the credible allegation. OIG's web-based reporting form: https://www.reportfraud.wisconsin.gov/rptfrd/ or via email: dhsfraud@dhs.wisconsin.gov.
    c. The staff member will investigate or arrange for an investigation of the suspected fraud/abuse to provide answers to the following questions:
        - How did the program learn of the fraud/abuse?
        - Who was involved?
        - What happened?
        - When did it happen?
        - Did the fraud/abuse involve government funds? If yes, what is the dollar amount involved? Did the agency bill/invoice for those services? How does the agency propose to correct the situation?
        - What was the impact on clients served?
        - What has the agency/individual done in reaction to the fraud/abuse?
    d. The staff member will complete all final reports and assemble all acquired documents/information in an organized fashion.
    e. The staff member and/or Compliance Officer will report all findings to the all applicable parties (i.e.: Compliance Officer/Senior Management, Behavioral Health Services Administration Executive Team, Contract Administration, Milwaukee County Mental Health Board, Mental Health Board- Quality Committee, Corporation Counsel, Audit Services, law enforcement, State of Wisconsin).
    f. Wraparound Milwaukee's decision to terminate, prosecute or refer the investigative results to the appropriate law enforcement and/or regulatory agencies for independent investigation may be made in conjunction with the Behavioral Health Services Executive Team, Contract Administration, Mental Health Board- Quality Committee, Corporation Counsel, Audit Services, law enforcement, State of Wisconsin, and/or other applicable entities.
    g. The determined route for closure is thoroughly documented and all relevant parties

are informed.

h. The closed file is kept in a secure location.

3. Additional Compliance Officer Tasks:
    1. Oversee the Policy and Procedures related to Fraud and Abuse, which includes potential disciplinary actions that may be taken.
    2. Compliance Officer or designee with direction from the Compliance Officer to provide training on this Policy and Procedure.
    3. Maintain effective lines of communication with Agencies, employees of the County, and Senior Management surrounding fraud and abuse.
    4. Complete and submit the Quarterly Integrity Report to Medicaid/State of Wisconsin. The report includes: Program Integrity Log, Provider Education Log, and Overpayment Recovery Log.
    5. Report Providers who are terminated from the Provider Network for just cause by the County, as well as providers the County identifies as excluded. The County must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of the email should include the name of the Provider, NPI and Medicaid ID Numbers, date of termination/exclusion, and reason for termination or exclusion.
    6. Report any terminated contracts to the Mental Health Board- Quality Committee.
    7. Develop and maintain Wraparound Milwaukee's Fraud, Waste, Abuse Strategic Plan that is submitted annually to State of Wisconsin.

Wraparound Milwaukee Compliance Officer:
Dana James, Quality Assurance Manager
(414) 257-7595
Dana.James@milwaukeecountywi.gov

Approval Signatures

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	8/29/2022
	Brian McBride: ExDir2 – Program Administrator	8/29/2022
	Dana James: Integrated Services Manager- Quality Assurance	8/23/2022

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