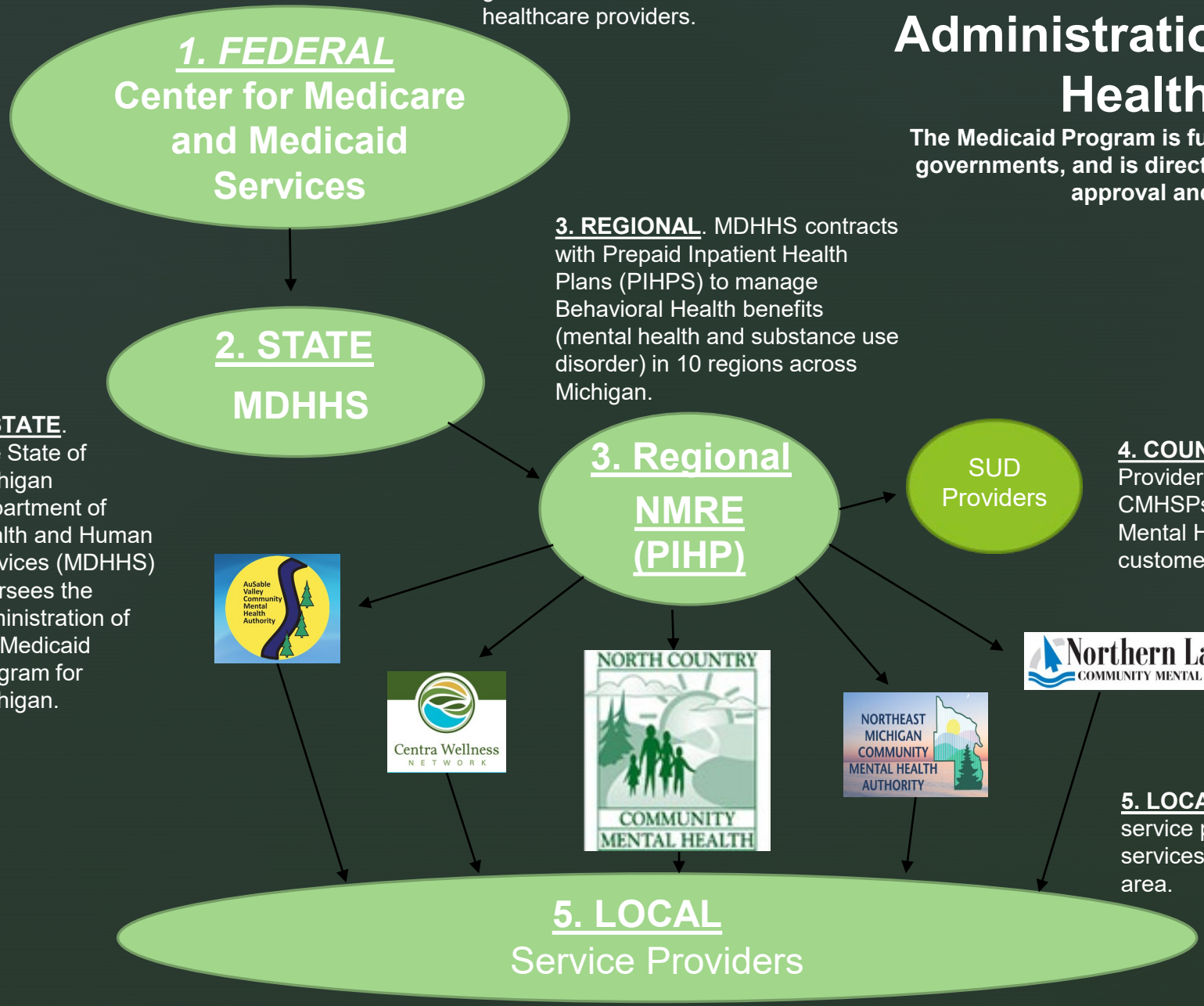
Compliance Training NCCMH

Brian Babbitt
Provider Meeting
May 4, 2021

Overview of Medicaid Program Administration for Behavioral Health Services

The Medicaid Program is funded by both the federal and state governments, and is directly administered by the States with approval and oversight by CMS.

1. FEDERAL. CMS provides operational direction and policy guidance to the States and to healthcare providers.



3. REGIONAL. MDHHS contracts with Prepaid Inpatient Health Plans (PIHPS) to manage Behavioral Health benefits (mental health and substance use disorder) in 10 regions across Michigan.

2. STATE. The State of Michigan Department of Health and Human Services (MDHHS) oversees the administration of the Medicaid Program for Michigan.

4. COUNTY. NMRE contracts with SUD Providers, inpatient hospitals and 5 CMHSPs in 21 County region to provide Mental Health and SUD services to customers.

5. LOCAL. NCCMH contracts with various service providers to provide behavioral health services to people located in our service area.

What is Compliance?

- **What does compliance look like in an ORGANIZATION'S BEHAVIOR?**
  - It is a formal program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of laws and regulations.
- **What does compliance look like in INDIVIDUAL BEHAVIOR?**
  - Following laws and rules that govern healthcare
  - Being honest, responsible, and ethical
  - Preventing, detecting, and reporting unethical and illegal conduct
  - Preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA) of Federal and/or State funds
  - Auditing and Monitoring to make sure funds are being used correctly

OIG's 7 Elements for Effective Compliance

- **ELEMENT 1 Standards, Policies and Procedures** = NCCMH Administrative Manual
- **ELEMENT 2 Compliance Program Administration** = Compliance Officer, Regional Compliance Committee
- **ELEMENT 3 Screening and Evaluation of Employees, Physicians, Vendors, and other Agents** = criminal history background check, OIG exclusions, provider disclosures
- **ELEMENT 4 Communication, Education and Training** = open-door policy to Compliance Officer, anonymous reporting & whistleblower protections, annual compliance training
- **ELEMENT 5 Monitoring, Auditing, and Internal Reporting** = internal compliance auditing, NMRE reporting and audits, OIG submissions, external audits
- **ELEMENT 6 Discipline for Non-Compliance** = NCCMH progressive discipline includes coaching, records of counseling, performance improvement plans, suspension, and termination
- **ELEMENT 7 Investigations and Remedial Measures** = promptly and confidentially investigated, appropriate remedial action taken, response provided

NCCMH Standards of Conduct

Code of Conduct

- Do not exploit one's position for personal gain or gratification.
- Do not intentionally physically, verbally, or emotionally abuse a person with whom they work or provide direct services.
- Do not engage in intimate touch or sexual relations with a person with whom they work or provide direct services.
- Respect and safeguard personal property of the persons served, visitors, employees, and property owned by the organization.
- Do not use drugs with, provide drugs to, or purchase drugs from employees or a person to whom they provide direct services.
- Do not allow personal problems, psychosocial distress, alcohol or substance use, or health difficulties to interfere with professional judgment and performance or jeopardize the best interest of the client.

Ethics

- The principle of beneficence.
- The principle of non-malfeasance.
- The principle of autonomy.
- The principle of fairness and justice.
- The principle of veracity.
- The principle of informed consent.
- The principle of privacy and confidentiality.
- The principle of mandatory reporting.
- The principle of honesty in billing services.
- The principle of competence.
- The principle of consultation.

Conflict of Interest

- Governs outside employment, requires confidentiality, prohibits use of position for financial gain, limits receipt of gifts, prohibits undue influence, and specifies reporting responsibilities

Ethical Dilemmas

Steps for Approaching An Ethical Dilemma

E – Examine relevant values (yours, client's, organization's)

T – Think about relevant law, practice, policies

H – Hypothesize about possible consequences of different decisions

I – Identify who will be helped or harmed

C – Consult with supervisor & colleagues about most ethical choice

(ETHIC Model by Dr. Elaine P. Congress)

Legislation

- Deficit Reduction Act (DRA)
- Federal False Claims Act
- State of Michigan False Claims Act
- Federal Whistleblowers Act
- State of Michigan Whistleblowers Act
- Affordable Care Act

Deficit Reduction Act (DRA)

- The 2005 Act made massive cuts to many federal budget line items, including Medicaid.
- Focused on preventing and detecting **Fraud**, **Waste**, and **Abuse** in the Federal health care programs.
- DRA reformed Medicaid by providing monetary incentives for states to enact similar false claims acts; and
- Requires compliance programs for health care entities, including mandatory annual training for all employees and contractors.

Deficit Reduction Act (DRA)

- Established new audit procedures for Medicaid services by 3rd party companies called Recovery Audit Contractors (RAC).
- RACs are paid a percentage of all claims found as overpayment or underpayments.
- Non-compliance with the Act include: Fines up to $500,000 for entities, civil penalties of $10,000 per claim AND exclusion as a provider.
- Information collected, including SS#s is used to verify employees and providers have not been excluded.

Federal False Claims Act

- Covers fraud involving any federally funded contract or program, including the Medicaid program.
- Includes whistleblower provisions that rewards citizens who report offenders (known as Qui Tam).
  - Qui Tam - allows a 3rd party to bring an action on behalf of the government and receive a share of the award.
- Provisions also give Federal Office of Inspector General (OIG) the authority to audit and investigate health care programs.
- If OIG determines there is credible evidence, the case is turned over to Dept. of Justice for prosecution.

Federal False Claims Act

- Prohibits any person from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval of gov't funds.
- Knowingly means:
  - Actual knowledge of the information;
  - Acting in deliberate ignorance of the truth or falsity of the information; or
  - Acting in reckless disregard of the truth or falsity of the information.
  - No proof of specific intent to defraud is required!
- Any person convicted under the Act is liable for 3 times the amount of the government damages plus penalties of $5,000 to $10,000 per false or fraudulent claim.

MCL 400.602

Michigan False Claims Act

- Mirrors the Federal False Claims Act, with expanded definition of "knowledge"
- "Knowing" and "knowingly" means that a person is in possession of facts under which he or she is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the payment of a Medicaid benefit.
- Knowing or knowingly includes acting in deliberate ignorance of the truth or falsity of facts or acting in reckless disregard of the truth or falsity of facts. Proof of specific intent to defraud is not required.
- Allows for constructive knowledge. This means that if the course of conduct "reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

Whistleblower Protection

Federal Statute

- Designed to protect against the fraudulent use of public funds by encouraging people with knowledge of fraud against the government to “blow the whistle” on wrongdoers.
- Individuals can file a “Qui tam” lawsuit on behalf of the government. The law provides for a reward in the form of a share of the recovery.
- Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the False Claims Act to initiate court proceedings to make themselves whole for any job-related losses resulting from any such discrimination or retaliation.

Michigan Statute

- Provides protection for employees who report a violation or suspected violation of a State or Federal law, rule, or regulation to a public body; unless the employee knows the report is false.
- Employers may not discharge, threaten, or otherwise discriminate against an employee regarding the employee’s compensations, terms, conditions, location, or privileges of employment

Other Applicable Laws

Anti-Kickback Statute

- Healthcare providers may not give or receive “remuneration” in exchange for the referral of patients or services covered by Medicaid or Medicare

Exclusion Authorities

- Providers must ensure that no federal funds are used to pay for any items or services furnished by an individual who is debarred, suspended or otherwise excluded from participation in any federal health care program. This includes salary, benefits, and services furnished, prescribed, or ordered.

Civil Monetary Penalties Law

- Allows the Office of the Inspector General (OIG) to impose civil monetary penalties for violations of the Anti-Kickback Statute and other violations including submitting false claims and making false statements on applications or contracts to participate in a Federal health care program.

Criminal Health Care Fraud Statute

- Makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment of up to 10 years, and fines of up to $250,000. Specific intent is not required for conviction.

Fraud, Waste, and Abuse

- **Fraud** - An intentional deception or misrepresentation by a person with the knowledge the deception could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.
- **Waste** - Overutilization of services, or other practices, that result in unnecessary costs. Generally, not considered caused by criminally negligent actions, but rather the misuse of resources.
- **Abuse** - Practices that are inconsistent with sound fiscal, business or medical practices & result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare.

Improper Payments

Mistakes	Result in errors: such as incorrect coding
Inefficiencies	Result in **waste**: such as providing unnecessary services
Bending the rules	Result in **abuse**: such as improper billing practices
Intentional deceptions	Result in **fraud**: such as billing for services that were not provided

Even honest mistakes lead to repayment of funds!

What are Examples of a False Claim?

- Reporting two encounters when only one was provided
- Reporting services not rendered (if not properly documented, the service wasn't provided)
- Billing for medically unnecessary services (not authorized in the plan of service)
- Unbundling or billing separately for services that should be billed as one (reporting nursing services same day as physician's office visit)
- Failing to report and refund overpayments

Service Documentation

Michigan Medicaid Provider Manual requirements (non-exhaustive list)

- The clinical record must be **sufficiently detailed** to allow reconstruction of what transpired for each service billed.
- All documentation must be legibly **signed with credentials and dated** by the rendering health care professional and client.
- For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the **actual begin time and end time** of the service.
- Progress notes must include a description of service that describes:
  - Presenting problems, treatment modality, customer response to treatment
  - Goal(s) and/or Objective(s) of the Plan of Service addressed
  - Progress/lack thereof toward desired outcome
  - Current status of the customer/Future treatment recommendations
  - Specific clinician/staff interventions offered during the service contact

Medicaid Provider Manual Section 12: Record Keeping

Medicaid Services Verification

- Code is approved under the contract
- Eligibility of the beneficiary on the date of service
- Service is included in the person's individual plan of service
- Date/time of service on progress note
- Service provided by a qualified practitioner and falls within the scope of the code billed/paid
- Amount billed does not exceed the payer (PIHP or CMHSP) contracted amount
- Amount paid does not exceed the payer (PIHP or CMHSP) contracted amount
- Any additional elements to support the PIHP quality improvement efforts with claims/encounters data

Privacy & Confidentiality

Governing Rules

Privacy & Confidentiality HIPAA

HIPAA Privacy Rule – "A covered entity may not use or disclose protected health information, except as permitted or required…"

- "Use" means internal review or use of PHI (training, customer service, quality improvement)
- "Disclose" means release of PHI externally (records to a provider via the disclosure queue)
- The "Minimum Necessary" information should be disclosed when use or disclosure is permitted or required. This means only the least amount of information that is necessary to accomplish the intended purpose of the use or disclosure should be requested
- "Need to know" – persons or classes or persons (Clinical Record Procedure, Chapter 9 of the Administrative Manual) within the covered entity who need access to the information to carry out their job duties
- NCCMH Confidentiality Use And Disclosure Procedure is found in Chapter Five of the Administrative Manual

Privacy and Confidentiality HIPAA

HIPAA Security Rule – "Covered entities must ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits."

- The Security Rule applies to safeguarding electronic PHI (PHI stored on computers, sent via email, access permissions to PHI)
- Requires covered entities to protect against any reasonably anticipated threats or hazards, and reasonably anticipated unpermitted uses or disclosures, to the security or integrity of ePHI
- Entities must have Administrative, Physical, and Technical safeguards
  - Administrative: Policies and procedures regarding how staff use electronic media that stores ePHI, policies regarding changing of Passwords
  - Physical: Limited access to locked server room, sign in/out logs
  - Technical: Use of encrypted devices, automatic logouts after inactivity

HITECH Act – Extended these requirements to a covered entities' Business Associates

Privacy and Confidentiality
MI Mental Health Code

Michigan Mental Health Code – Confidentiality (MCL 330.1748)

- "Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section or section 748a."
- Was amended effective April 10, 2017 to allow for disclosure of PHI for **Treatment**, **Payment**, and **Coordination of Care** in accordance with HIPAA.
- Best Practice: Always obtain a valid Consent to Share Information to ensure compliance with the MI Mental Health Code. If you have questions regarding a specific situation, contact the Privacy Officer.

Privacy and Confidentiality
MI Mental Health Code

- **TREATMENT:** Means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.
- **PAYMENT:** Encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care. Includes: eligibility/coverage determinations; COB; adjudication of claims; billing; medical necessity review; utilization review activities including preauthorization, and concurrent and retrospective review.
- **COORDINATION of CARE:** Means a set of activities designed to ensure needed, appropriate and cost-effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans.

Privacy and Confidentiality
breach notification

- A breach occurs when there is an unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of that information.
- Depending on the circumstances, a breach may require notice to the consumer that his/her information was inappropriately released, mitigation efforts such as credit monitoring, notification to local media, and/or notification to the Office for Civil Rights (OCR).
- If you suspect or know of any situation involving a potential breach**, it is your responsibility to report it.**
- Examples:
  - Sending a letter containing PHI to the wrong address
  - Medical records/laptop being lost or stolen
  - Posting about a consumer on social media

Privacy and Confidentiality
True or False?

Behavioral health providers cannot ever share records without permission.	FALSE	HIPAA, the MI MHC, and 42 CFR Part 2 all contain specific exceptions for when PHI may be shared without first obtaining patient consent. Check with your Privacy Officer to verify if an exception applies.
Protected Health Information (PHI) cannot be shared by email.	FALSE	Before sending any PHI electronically, check NCCMH's policies and make sure that it is encrypted or otherwise protected, and that it is addressed to the correct recipient.
If NCCMH receives a request from a provider for a patient's most recent Treatment Plan (mental health only) to assist that provider in appropriately treating the patient, it is acceptable to send the provider the patient's entire record.	FALSE	Non-SUD PHI can be shared without a Consent to Share for Treatment, Payment, and Coordination of Care purposes in accordance with HIPAA. HOWEVER, it is best practice to get a Consent to Share and only the minimum amount of information necessary to accomplish the purpose of the disclosure may be disclosed.
Release of records should be done through the Disclosure Queue in NorthStar.	TRUE	Using the Disclosure Queue ensures the release is properly documented.

If you Suspect Noncompliance

It is your right and your responsibility to report actual and suspected compliance violations to the NCCMH's Compliance Officer and/or the NMRE Compliance Officer.

You may not be intimidated, threatened, coerced, discriminated against, or subjected to other retaliatory action for making a good faith report of an actual or suspected violation.

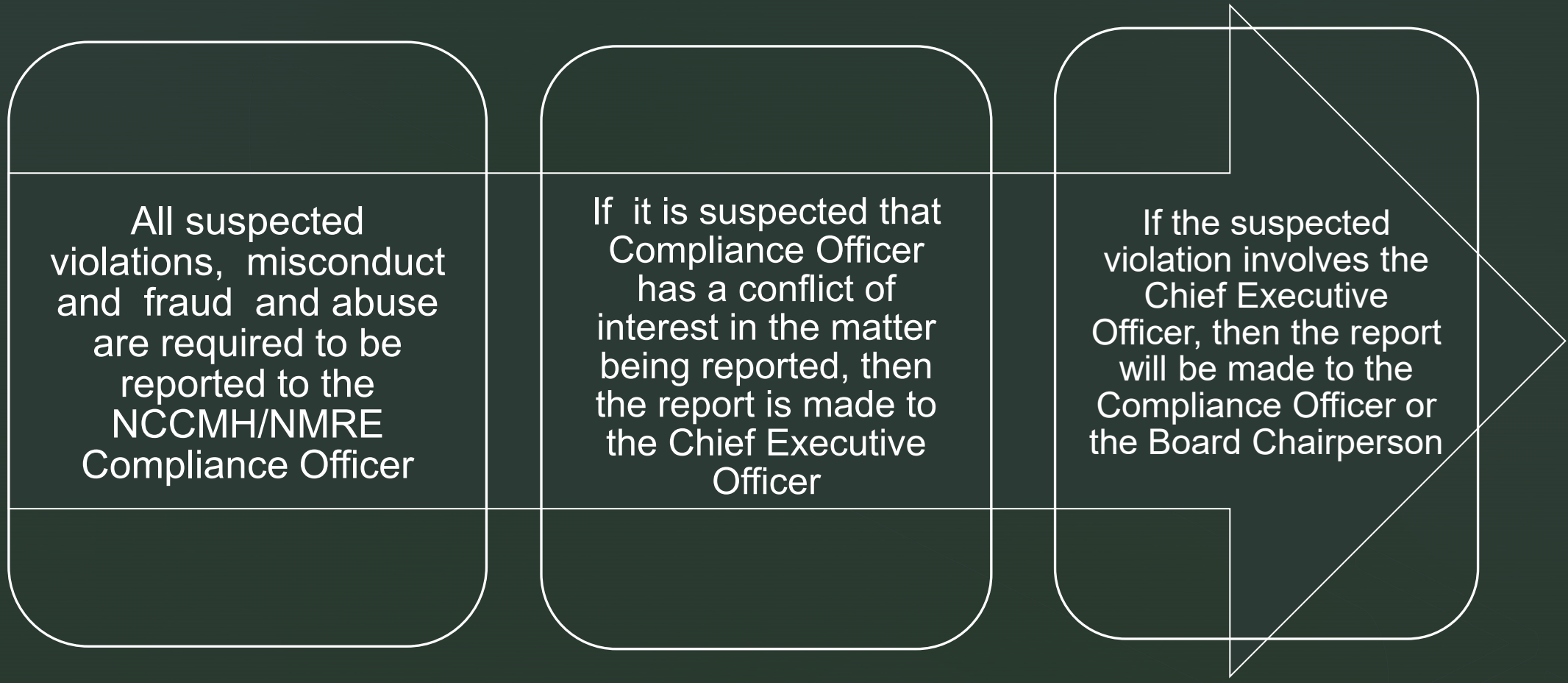
NCCMH Compliance Office

Name: Brian Babbitt
Telephone: 231-439-1240
Email: bbabbitt@norcocmh.org
Mailing: 1420 Plaza Drive , Petoskey, MI 49770

NMRE Compliance Office

Telephone: (231)383-6522
Mailing: 1999 Walden Drive, Gaylord MI 49735
Hotline: 1-866-789-5774
Website: nmre.org\Resources\Compliance\ Report Compliance Issues, enter summary of your issue.

INTERNAL
Reporting and Investigation



All reports of wrongdoing will be investigated promptly and investigations will be kept confidential.

Attestation

- The NCCMH Contract Manager gathers attestations annually.
- You will be asked to attest that:
  - You understand your obligation to report
  - You are not aware of any non-reported issues
  - You have not been convicted of a crime, had a professional license revoked and are not otherwise currently excluded form participation