NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: One - Administration
POLICY NAME: Compliance Plan
EFFECTIVE DATE: May 1, 2021

PURPOSE:

It is the policy of North Country Community Health (NCCMH) to provide quality, cost-effective medically necessary services in an ethical and legal manner. This policy describes our plan for the prevention, detection, and reporting of fraud, waste, and abuse. The Compliance Policy helps employees and contract providers understand and follow state and federal laws governing the delivery of services.

APPLICATION:

All North Country Community Mental Health programs

DEFINITIONS:

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical 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 of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative.

CMHSP: Community Mental Health Services Program. North Country Community Mental Health is a CMHP.

Disclosing Entity: A Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Exclusion: Items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fiscal Agent: A contractor that processes or pays vendor claims on behalf of a Medicaid provider.

Fraud: (Federal False Claims Act) An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act (42 CFR § 455.2). Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person "should have been aware that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge." But errors or mistakes do not constitute "knowing" conduct necessary to establish Medicaid fraud, unless the person's "course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present."

Managed Care Entity: A managed care organization (MCO), PIHP, PAHP, PCCMs, and HIO Subcontractor

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or

render covered services related to the state's contract with the Northern Michigan Regional Entity (NMRE) or its member CMHSP.

Subcontractor: An individual, agency, or organization to which NCCMH has contracted or delegated some of its management functions or responsibilities of providing care to its clients; or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Waste: Overutilization of services or other practices that, directly or indirectly, results in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources or inefficient practices.

STANDRDS, POLICIES and PROCEDURES:

NCCMH has written policies, procedures, and standards of conduct in place that articulate our commitment to comply with all applicable requirements under the PIHP-CMHSP Contract, MDHHS-CMHPS Contract, federal, and state requirements. Policy and procedures are maintained in accordance with the Administrative Manual Procedure. NCCMH maintains a Code of Ethics Policy, Code of Conduct Policy, and Conflict of Interest Policy, made avaibale online to employees and contract providers. The Code of Ethics, Code of Conduct, and Code of Ethics are incorporated into the employee handbook, the NCCMH Provider Manual, and annual compliance training for board members, employees, and contract providers.

COMPLIANCE PROGRAM ADMINISTRATION

The designated Compliance Officer and has primary responsibility of developing and implementing policies, procedures, and practices designed to ensure compliance with the PIHP-CMHSP Contract, MDHHS-CMHPS Contract, federal, and state requirements. The Compliance Officer reports directly to the Chief Executive Officer and shall report to the Board as needed but not less than annually.

The NCCMH Compliance Officer is a member of the NMRE Regional Compliance and Quality Committee whose membership includes the NMRE Compliance Officer and Compliance Officers representing each Region 2 CMHSP. Activities include:

- Meeting a minimum of once each quarter
- Assessing region-wide staff training requirements (Exhibit A – Training Grid)
- Determining overall strategies for promoting compliance and detecting violations
- Reviewing Compliance Plans annually
- Reviewing content/information from state-wide meetings
- Monitoring and auditing
- Analyzing, monitoring, and reviewing high-risk compliance areas

SCREENING AND EVALUATION OF EMPLOYEES, PHYSICIANS, VENDORS AND OTHER AGENTS

All prospective employees, interns, and volunteers are required to undergo a pre-employment background check prior to employment with NCCMH. The pre-employment background check includes:

- SSN Trace
- Criminal and public records history
- Driver's Record
- Healthcare Sanctions Search
- ICHAT
- LEIE – OIG
- Sanctioned Provider List
- Public Sex Offender List

NCCMH shall comply with all requirements to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions. NCCMH shall ensure that all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided with federal and State healthcare funds are compliant with applicable federal and state regulations.

Disclosure of Ownership, 42 CFR 455.104 - A Disclosure of Ownership and Control Form will be obtained from all Disclosing Entities, Fiscal Agents, and Managed Care Entities prior to contract or contract renewal.

NCCMH will require a disclosure of ownership from any NCCMH Subcontractor receiving more than $25,000 per year.

In compliance with 42 CFR 455.105, all contracts between NCCMH and Disclosing Entities, Fiscal Agents, and Managed Care Entities will require the entity provide ownership statements upon request for any Subcontractor with whom the entity has had business transactions totaling more than $25,000 during the 12- month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

NCCMH submits disclosure statements to the NMRE. NCCMH defines their managing employees as: CEO, COO and CFO. NCCMH Board Members are required to submit disclosure statements.

Excluded Person - NCCMH and contract providers will comply with 42U.S.C.1320a-7(b), which imposes penalties for arranging or knowing (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program…for the provision of items or services for which payment may be made under such a program.

Prior to employment or contract with any individual or entity, NCCMH will check to confirm that the individual, entity, and person with ownership or control interest in the entity, has not been excluded from participation. Every individual, entity, or person with ownership or control interest in the entity, will be checked for exclusion each month thereafter while employed or under contract with NCCMH. Evidence of these checks will be maintained according to the Retention and Destruction of Records Procedure located in Chapter 1 of the Administrative Manual.

If NCCMH learns that any of its current providers (either as entities, employees, or contractors) has been proposed for exclusion or excluded, it will remove such individuals from any involvement in or responsibility for federal health insurance programs until such time that NCCMH has confirmed that the matter has been resolved. If NCCMH learns that one of its Board Members has been proposed for exclusion or excluded, it will ask that the Board Member step down from any responsibility relating to federally funded programs until the matter is resolved.

If an individual has been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; had a professional license revoked or suspended, or has been sanctioned, whether personally or through an entity, by the Medicare or Medicaid programs after being hired, contracted or appointed, they must report such to the NCCMH CEO within 3 (three) business days of such action. Failure to provide such notification will result in disciplinary action, up to and including immediate termination of employment, contract, or appointment.

COMMUNICATION, EDUCATION, AND TRAINING ON COMPLIANCE ISSUES

Employees and contract providers have been informed through their training that they are required, in good faith, to report any conduct reasonably believed to be fraudulent or erroneous. NCCMH will maintain anonymity of the reporting party if requested and will strictly enforce protections under state and federal whistleblower statutes. The NCCMH Compliant Form (Exhibit B) shall be made readily available and may be used for reporting compliance issues. Employees and contract providers have been informed that they may report in good faith suspected fraud, waste, abuse, or overpayment via any one of the following methods:

NCCMH Compliance Officer
Brian Babbitt
Email: bbabbitt@norcocm.org
Phone: 231-439-1240
By mail or in person at 1420 Plaza Drive, Petoskey, MI 49770

NMRE Compliance Office
Email: compliancesupport@nmre.org
Phone: 886-789-5774
Website: NMRE.org/Compliance/Report Compliance Issues
By mail or in person at 1999 Walden Drive, Gaylord, MI 49735

Michigan Department of Health and Human Services
Website: Michigan.gov/MDHHS/Assistance Programs/Healthcare Coverage

To ensure effective communication, the NCCMH Compliance Officer will participate in the NMRE regional Compliance and Quality Committee and work in conjunction with the NMRE Compliance Officer on all Fraud, Waste and Abuse investigations. There is on-going communication between the Compliance Officer, the Chief Quality Officer, and Reimbursement Supervisor on matters relating to integrity of the medical record, claims, and compliance standards.

The Staff Development Committee will review and recommend changes to the Annual Training Plan (Exhibit A -Training Grid) to ensure compliance with Federal, State, Regional, and accreditation standards. Training is considered a condition of employment and/or contract and failure to comply will result in disciplinary action up to and including termination. Supervisors have the responsibility to ensure all employees complete training in a timely manner. Each contract provider is contractually obligated to monitor their employees and ensure adherence to the identified training requirements.

The Compliance Officer and Human Resources are responsible for coordinating compliance training activities. All NCCMH employees shall be trained on compliance during new hire orientation and at least annually thereafter. Trainings are offered through instructor led classes and on-line training modules. Additional training may be required for parties involved in specific areas of risk or as new regulations are issued. Training is documented and reported via signed attestation at the end of the course. To meet regulatory contractual requirements, NCCMH will require 100% of staff are trained.

The NCCMH Compliance Plan is part of the NCCMH Provider Manual. As a condition of contract, each provider will read the Compliance Plan and acknowledge acceptance of its principles and obligation to report fraud, abuse, or waste of public funding. Acceptance is documented and reported via signed attestation which must be submitted at contract and at least annually thereafter. NCCMH offers instructor led compliance training to providers annually and NCCMH training materials are available online at www.norcocmh.org.

The NMRE CEO shall be notified in writing of any notice to, or inquiry from, investigation by any Federal, State, or local human services, fiscal, regulatory, judicial, or law enforcement agency or protection/advocacy organization regarding the rights, safety, or care of a recipient of Medicaid services

MONITORING, AUDITING, AND INTERNAL REPORTING SYSTEMS

The purpose for monitoring and auditing is to identify compliance risks. Correction of the identified risks reduces the potential for recurrence and promotes ongoing compliance with the MDHHS-PIHP Contract. All NCCMH personnel are responsible for monitoring and reporting compliance activities and operations within NCCMH. NCCMH employs a variety of monitoring and auditing techniques including:

- Periodic Michigan Department of Health and Human Services (MDHHS) reviews
- Periodic Accreditation Reviews
- Annual Delegated Functions Reviews
- Annual Financial and Compliance Audits
- Internal/external audit results for specific compliance guidelines
- Internal/external qualitative chart reviews
- Internal/external claims validations
- Information from past investigations of noncompliance
- Annual attestations from employees and contract providers
- Information from exit interviews
- Input from NMRE Compliance Committee

Reporting/reviewing Compliance Data:

- Quarterly reports of issues (*e-mail/voicemail/ website/-mail)*
- Quarterly results of Medicaid Service Verification
- Annual reviews of the Regulatory Compliance Plan
- Annual summaries of compliance activities, including number of investigations, summaries of results of investigations, and summaries of disciplinary actions
- Annual reports of Medicaid Verification to the NCCMH Chief Executive Officer and NCCMH governing Board
- Annual reports to MDHHS of compliance with annual trainings on the Deficit Reduction Act (DRA)

OIG Submissions to the NMRE:

- Monthly data for excluded provider checks
- Tips/grievances received
- Overpayments collected
- Identification and investigations of fraud, waste, and abuse
- Corrective action plans implemented
- Provider disenrollment
- Contract terminations

DISCIPLINE FOR NON-COMPLIANCE

All reports of non-compliance shall be reviewed. If the review indicates a determination of non-compliance, a corrective action plan will be requested. In cases where disciplinary action is appropriate, the Compliance Officer will work with human resources and relevant supervisor, or in the case of a contracted provider, the Contract Manager and relevant program director. Actions taken will be consistent with OIG recommendations, NCCMH Progressive Discipline Policy and Procedure, and the provider contract.

Documentation of all occurrences shall be retained in accordance with the Document Destruction and Retention Procedure.

INVESTIGATIONS AND REMEDIAL MEASURES

Detection of non-compliance may occur through established review processes including audits, claims data, record reviews, and/or complaints made by personnel, beneficiaries, subcontracted providers, or others.

Internal investigations will reference relevant citations and may include review of data and documents, the absence of data or documentation, interviews, written statements, and observation. (Exhibit C – Compliance Investigation Form) The outcome shall be based on the preponderance of evidence.

Findings of non-compliance could result in disciplinary action, corrective action, a review of additional claims, possible payback of inappropriate payments, and reporting to the NMRE. Prompt reporting of misconduct to the appropriate governmental authority within a reasonable period, after determining credible evidence that a violation occurred, is expected.

Investigations into fraud, waste, and abuse are intended to address matters relating to the Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statue, the Health Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act (1996), the Deficit Reduction Act (Medicaid Integrity Program) (2006), and any other circumstance in which potential or actual violations have occurred.

REFERENCES: Office of the Inspector General, CFR 42 438.608, 42 CFR 455.104, 42 CFR 455.105, Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statue, the Health Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act (1996)/Managed Care Rules, the Deficit Reduction Act/Medicaid Integrity Program (2006), NMRE Compliance Plan.

REVIEWED:

REVISED:

APPROVED BY SIGNATURE:

Chief Executive Officer	Date
NCCMH Board Chair	Date