NORTH COUNTRY CMH COMPLIANCE TRAINING

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Compliance Officer

Overview of Medicaid Program Administration for Behavioral Health Services

FEDERAL
Center for Medicare and Medicaid Services

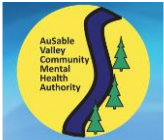
STATE
MDHHS

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

Regional
NMRE (PIHP)

SUD Providers

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



LOCAL
Service Providers

What is *Compliance*?

ORGANIZATION'S BEHAVIOR

- A formal program specifying an organization's **policies, procedures, and actions** within a process to help **prevent and detect violations of laws and regulations**.

INDIVIDUAL BEHAVIOR

- Follow laws and rules that govern healthcare
- Be honest, responsible, and ethical
- Prevent, detect, and report unethical and illegal conduct
- Prevent, detect, and report Fraud, Waste, and Abuse (FWA) of Federal and/or State funds
- Audit and Monitor 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

NCCMH Employee Handbook

The Code of Conduct:

Respect and safeguard personal property of the persons served, visitors, employees, and property owned by the organization.

Do Not:

- Exploit one's position for personal gain or gratification.
- Physically, verbally, or emotionally abuse a person to whom s/he provides direct services.
- Intimately touch or sexual relations with a person to whom s/he provides direct services.
- Use drugs with, provide drugs to, or purchase drugs from a person to whom s/he provides direct services.
- Witness legal documents, e.g., Power of Attorney, Guardianship, or Advance Directives, for service recipients.
- 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.

NCCMH Standards of Conduct

NCCMH Employee Handbook

Ethics

- The principle of beneficence (generous or doing good).
- The principle of non-malfeasance (do no harm to others).
- The principle of autonomy (free from external control or influence).
- The principle of fairness and justice (showing no bias).
- The principle of veracity (conformity to facts; accuracy).
- The principle of informed consent (consent with full knowledge of the possible risks and benefits).
- The principle of privacy and confidentiality (information must be kept safe and private).
- The principle of mandatory reporting (legal requirement to report abuse, neglect, or exploitation).
- The principle of honesty in billing services (only charge for time you've worked).
- The principle of competence (do something successfully or efficiently).
- The principle of consultation (formally consulting or discussing).

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.**

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

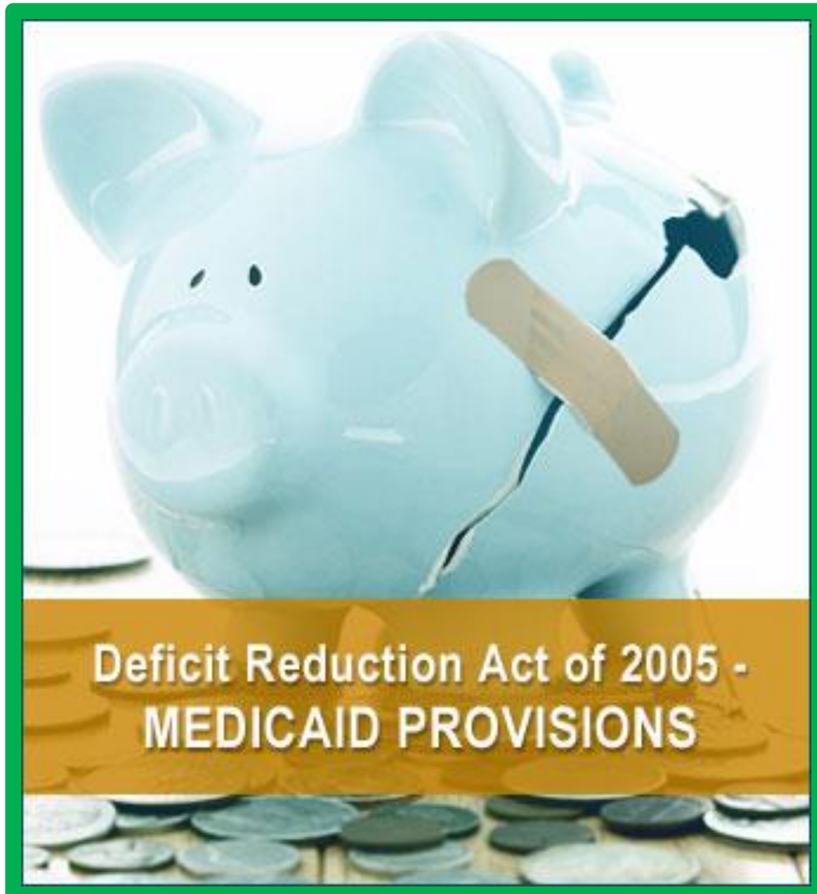
C – **Consult** with supervisor & colleagues about most ethical choice

(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 that employees and providers have not been excluded.

Federal False Claims Act (1863)

QUI TAM LAWSUITS

FALSE CLAIMS ACT (1863)

- grants private citizens the right to file civil lawsuits on behalf of the government
- allows federal officials to investigate claims of fraud in secret
- may come with significant financial rewards for whistleblowers

Enacted in 1863, the False Claims Act extends private citizens the right to pursue stolen federal dollars on the government's behalf. 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 third 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;	Acting in **reckless disregard** of the truth or falsity of the information.	Proof of specific intent to defraud is not 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 <u>or should be aware</u>** 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. <u>Proof of specific intent to defraud is not required</u>.

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.

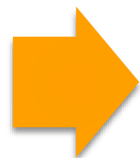
Civil Monetary Penalties Law

- 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 <u>not</u> required for conviction.

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.

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.

What are Examples of False Claims?

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

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 (Kim Rappleyea)

- Telephone: 231-439-1240
- Email: krappleyea@norcocmh.org
- Mailing: 1420 Plaza Drive, Petoskey, MI 49770

NMRE Compliance

- 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.

If the suspected violation involves the Chief Executive Officer, then the report will be made to the NMRE Compliance Officer or the Board Chairperson

QUESTIONS ABOUT COMPLIANCE?