Northern Lakes Community Mental Health Authority
FY 2021 Regulatory Compliance Plan

1.0 Introduction

It is the policy of Northern Lakes Community Mental Health Authority (NLCMHA), to obey the law and to follow ethical business practices. NLCMHA has a commitment to ensure employees and contract providers are fully informed about applicable laws and regulations so that they do not inadvertently engage in conduct that may raise compliance issues. The legal requirements relating to the quantitative and qualitative documentation of professional services, fee billing, and reimbursement are primary concerns. NLCMHA recognizes that its business relationships with other providers, vendors, and clients are subject to legal requirements and accountability standards.

2.0 Purpose

To ensure, to the fullest extent possible, compliance with laws and regulations; that ethical business practices are followed; and that contractual and legal requirements are met. Further, to provide the highest quality of service in accordance with applicable regulations through service provision, documentation of the service provided, and reimbursement for the service.

To further the organization's commitment to compliance and to protect its employees and contract providers, emphasis is placed on this compliance plan to address those regulatory issues likely to be of most consequence to its operations.

Compliance is accurately following the government's rules on Medicaid billing system requirements and other regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities. The compliance program and plan described in this document is intended to establish a framework for legal compliance by employees and contract providers. It is not intended to set forth all the substantive programs and practices that are designed to achieve compliance.

3.0 Application

Northern Lakes is a Community Mental Health Services Program covering Leelanau, Grand Traverse, Wexford, Crawford, Roscommon, and Missaukee counties. Affiliated with 4 other CMH boards to comprise the Northern Michigan Regional Entity (NMRE). It is the intent of NLCMHA that the scope of all compliance policies and procedures should promote integrity, support objectivity, and foster trust within the NMRE as well.

This Plan shall apply to all NLCMHA operational activities and administrative actions and includes those activities that come within federal and state regulations relating to health care providers. Of particular concern to NLCMHA, is compliance with respect to human resources practices and training, under or over utilization of services, quality of care, data collection and submission processes, appropriate service authorization and documentation, and proper medical coding.

The primary provider network for NLCMHA covers the six counties, offering services for adults and children with mental illness, intellectual/developmental disabilities, and co-occurring mental health and substance abuse disorders. All employees of NLCMHA are subject to the requirements of this

Plan as a condition of employment. All aspects of this Plan that address "provider organizations" shall also apply to the participating provider network.

4.0 General Overview

It is acknowledged that efforts to maintain compliance must be organization-wide and must be ongoing. In order to assure that these efforts are sustained, compliance activities are developed from a performance improvement perspective. Northern Lakes Community Mental Health Authority believes that for services to be of the highest quality, they must be provided, documented, and reimbursed in accordance with applicable regulations. Assuring this compliance, both prospectively and retrospectively, is best done through a focus on improvement, utilizing objective data, systems analysis, participant input, and continuous feedback.

The compliance plan has the following key features:

- Designation of NLCMHA officials responsible for directing the effort to enhance compliance, including implementation of the Plan;
- Incorporation of standards and policies that guide personnel and others involved with operational practices and administrative guidelines;
- Identification of legal issues that may apply to business relationships;
- Development of compliance initiatives/requirements at the unit level;
- Coordinated training of clinical and administrative staff and contract providers concerning applicable compliance requirements and policies;
- A uniform mechanism for employees and contract providers to raise questions and receive appropriate guidance concerning operational compliance issues;
- Regular review and audit to assess compliance, to identify issues requiring further education, and to identify potential problems;
- A process for employees and contract providers to report possible compliance issues and for such reports to be fully and independently reviewed;
- Enforcement of standards through well publicized disciplinary guidelines and development of policies addressing dealings with sanctioned individuals;
- Formulation of corrective action plans to address any compliance problems that are identified;
- Regular reviews of the overall compliance effort to ensure that operational practices reflect current requirements and that other adjustments are made to improve operations.

5.0 Administrative Responsibilities

Primary responsibility for implementing and managing NLCMHA's compliance effort shall be assigned to the Director of Quality Improvement and Compliance. The position of Director of Quality

Improvement and Compliance will directly report to the NLCMHA CEO and indirectly, as required, to the governing body of NMRE. As appropriate, compliance program findings will be reported to the Performance Measurement & Quality Improvement, and the Executive Team Committees. The Director of Quality Improvement and Compliance will, with oversight of the NLCMHA CEO, engage the assistance of legal counsel and the NMRE where appropriate, and perform the following activities:

- Review and amend, as necessary, the Code of Conduct that includes a code of ethics and ethical standards.

- Assist in the review, revision, and formulation of appropriate policies to guide any and all activities and functions that involve issues of compliance.

- Develop methods to ensure that employees are aware of the Code of Conduct and Code of Ethics Policy and understand the importance of compliance.

- Develop methods to ensure that provider organization Code of Conduct and compliance standards are on par with NLCMHA and staff understand the importance of compliance.

- Assist in developing and delivering educational and training programs.

- Coordinate compliance reviews and audits, as required.

- Receive and investigate instances of suspected compliance issues, as set forth in this Plan.

- Develop appropriate corrective actions, as set forth in this Plan.

- Prepare Annual Compliance Review, as set forth in this Plan.

- Prepare Annual Compliance Work Plan, as set forth in this Plan.

- Prepare proposed revisions to the Compliance Plan as needed, with a review at least annually.

- Provide other assistance as directed by the CEO.

6.0 Compliance Oversight and Structure

The designated Director of Quality Improvement and Compliance has primary responsibility for oversight and implementation of this Plan. The Director of Quality Improvement and Compliance is given sufficient authority to promote and enforce compliance program issues, and

The Director of Quality Improvement and Compliance will work with the Regional Compliance Committee as established by the NMRE, and may include, but not be limited to, the following representatives:

- Compliance Leader from each Member Board
- Human Resources
- Information Systems
- Quality Assurance/improvement
- Finance/Reimbursement

The committee activities will include the following:

- Assist in implementation of the compliance program within the boundaries of the NMRE
- Analyze the external business environment
- Conduct risk analysis and assessment for the NMRE
- Determine overall strategy or approach to promoting compliance and/or detecting violations of regulation
- Develop, approve, and evaluate compliance policy and guidance
- Participate in compliance training
- Audit Compliance Plan

The Director of Quality Improvement and Compliance will review NLCMHA's system of recordkeeping (either manual or electronic) for each employee's participation in this Plan and maintain documentation of participation for submission to the NMRE. This record will include documentation of related training, acknowledgment of receipt of pertinent documents, details of any non-compliance and the actions taken, and evidence of participation in compliance related activities.

Participation in, and acceptance of, this Plan is a condition of employment for NLCMHA. For providers contracted with the PIHP participation in, and acceptance of, this Plan is required. Each employee and agent bears responsibility for compliance. This responsibility includes:

A. Read the Compliance Plan

B. Be familiar with, and use, the compliance requirements

C. Pay attention to correspondence, both by paper and by electronic mail, and return "acknowledgement statements" promptly when required

D. Participate in training sessions

E. Utilize the Compliance Access System as needed

F. Review, periodically, this Compliance Plan

G. Report immediately when and if made aware of any violation of this Compliance Plan, or related policies and procedures. Reports can be made to the Director of Quality Improvement and Compliance (See attachment A). Failure to report a violation is itself, is a violation and therefore subject to disciplinary action.

H. Cooperate with all compliance related efforts

I. Submit any suggestions for improvement of this Plan

J. Refer ALL inquiries relating to compliance efforts and results to the NLCMHA's Director of Quality Improvement and Compliance, or Chief Executive Officer

K. Submit evidence of compliance attestation annually, acknowledging that all potential non-compliance issues have been reported. (see Attachment B)

7.0 Policy Guidelines

Policies specific to NLCMHA's operational practices will be reviewed on an annual basis and revised as necessary. The Code of Conduct will guide in all business activity. This Code reflects good common sense and ethical behavior. All new hires receive and acknowledge the Code of Conduct as a requirement of employment. The Code is reviewed and acknowledged annually thereafter.

8.0 Clinical and Administrative Plans

NLCMHA will be responsible for the development and implementation of a plan to address compliance efforts. These plans shall, at a minimum, include the following features:

A. Written policies and procedures for operational activities undertaken by organization personnel, including any specialty specific standards that may be relevant to regulatory compliance;

B. Educational and training programs to address operational issues of particular importance to the organization;

C. A program for ensuring and documenting that all new personnel receive training regarding operational compliance issues;

D. A program for routine "spot checks" of compliance activities, sharing the results of such reviews with the NMRE's Compliance Coordinator;

E. A system that tracks operational compliance issues within NLCMHA that have been raised within the organization and the resolution of those issues; and

F. An annual review of the existing compliance plan in order to identify the need for changes and to identify specific compliance objectives during the succeeding year.

9.0 Communication, Education and Training

A compliance plan cannot be successful as a static, written document. It requires a dynamic implementation process that provides ongoing communication, education and training to all participants. This includes the NLCMHA governing body, direct employees, and contract agents. The plan is intended to be "the way we do business" and, as such, be second nature to all employees and agents. This same rigor will apply to the external provider network.

The compliance plan provides an internal process to clarify, educate, and train staff in contractual and regulatory requirements, and appropriate use of the CMH Prepaid Medicaid dollars. This section describes the communication, education and training efforts utilized to achieve this goal.

A. Communication - The success of this Plan is largely dependent upon the ability of NLCMHA to sustain the efforts identified within this Plan. As with any improvement effort, sustaining this Plan will require regular communication to employees and agents. This includes communication regarding applicable laws and regulations; monitoring efforts; training efforts; improvement activities; and achievements. The Director of Quality Improvement and Compliance, as well as the administrative team and all supervisors, are responsible for this communication.

B. Education and Training – The compliance plan identifies three categories of education/training to meet all state and federal requirements. They are as follows:

   1. *Initial Training* - NLCMHA is responsible for developing and assuring that initial training is provided to all employees during their orientations. This training will address the substantive legal standards and the processes identified in this manual. Completion of this training will be documented.

      Each employee will receive a Regulatory Compliance Plan at orientation, along with a Compliance Plan Acknowledgement Form (Attachment C) and the Compliance Attestation

Form (Attachment B). Each employee, upon receipt of this Plan, will have one week to read the Plan and acknowledge acceptance of its principles and obligation to report fraud, abuse or waste of public funding, as evidenced by signing the Acknowledgement Form and the Attestation Form. Evidence of acknowledgement and attestation must be submitted to the PIHP at least annually.

Employees are encouraged to actively participate in this training process and to ask questions. It is essential that all employees understand these requirements and processes. It is the responsibility of the employee to assure that he or she understands this Plan.

2. *Focus Training* - In addition to the initial training for all employees, specialized training will be developed for targeted positions and functions. The NLCMHA Director of Quality Improvement and Compliance, in coordination with the Network Management team, will identify those positions requiring additional, targeted training due to the particular tasks for which they are responsible. This would include, but not be limited to; NLCMHA CEO, CFO, Director of IT and IT staff. NLCMHA is responsible for providing compliance training to the CMH Board of Directors, as well.

3. *Ongoing Training* - The Director of Quality Improvement and Compliance and Network Management team will routinely review available data to identify emerging trends and training needs relating to compliance issues and this Plan. Data sources include, but are not limited to: performance indicator report, question/answer or reporting via *e-mail/voicemail/website/mail (*access systems),* record audit results (see Ongoing Monitoring and Reporting), MDHHS report, and staff activity reports, as required.

   - As training opportunities and needs are identified, either for targeted staff or all staff, the Director of Quality Improvement and Compliance will develop and implement appropriate training. Training may be provided by NLCMHA staff or be arranged through outside sources.

   - Compliance training will be incorporated in the organization's annual training requirements. This annual training will have three objectives: (1) provide detailed information regarding false claims recovery under the federal and State False Claims Act, various protections under the Whistleblower Protections Act and other regulations as they apply, (2) review the Compliance Plan and efforts, and (3) address emerging needs as determined through monitoring and data analysis.

   - All ongoing training, whether annual or targeted, will be documented.

   - Ongoing training occurs as well through correspondence and communication from the Director of Quality Improvement and Compliance. The question/answer and hotline reporting system *will be utilized* as a tool for identifying, and promptly responding to, staff questions and requests.

C. <u>Training Personnel</u> - All staff providing training relating to compliance issues, will be required to certify, in writing, that he or she has never been convicted of any crimes (other than traffic related offenses); has never had a professional license revoked or suspended, and has never been sanctioned, whether personally or through an entity, by the Medicare or Medicaid programs. Compliance and DRA training is mandated to be completed by all NLCMHA staff annually. The Director of Quality Improvement and Compliance will also review the content information for compliance training done via webinars or e-learning systems.

10. Ongoing Monitoring and Reporting

Compliance activities are developed from a performance improvement (PI) perspective. This approach uses the objective of providing high quality services. To meet the objective of high quality services in accordance with applicable regulations, the service must be provided, documented, and be reimbursable. Assuring compliance is best done through a PI focus on improvement, utilizing objective data, systems analysis, participant input, and continuous feedback.

Errors in compliance may be rooted in a number of causes. Frequently, the source of difficulty may be traced to deficiencies in the systemic processes used by staff. When compliance errors or lapses are determined to be rooted in individual behavior, the quality improvement process will likely not be appropriate. Such errors may be the result of insufficient information and training, individual carelessness, or willful acts. Each of these causes requires a different response. It is essential that the Director of Quality Improvement and Compliance conduct an investigation to determine the source and cause of errors prior to determining the response.

The monitoring and reporting processes are designed to facilitate continuous improvement and to identify errors and wrongdoing. This is accomplished through routine review of records and through input from staff.

A. Audits – The Director of Quality Improvement and Compliance may conduct audits of the compliance plan. This includes, but is not limited to:

1. Clinical record audits
2. Reviewing the sufficiency and completeness of training
3. Reviewing staff training records
4. Auditing the response to employee/agent questions or comments to the Question and Answers or reports through the access system
5. Reviewing the response to any finding during the past quarter
6. Review of adherence to policies and procedures relating to contracting, and
7. Monthly verification that no employee/agent of NLCMHA is listed on any federal or state sanctioned providers list.

Annually, the Director of Quality Improvement and Compliance will review this Plan and the activities carried out pursuant to this Plan. The review will be designed to assess the effectiveness and current applicability of each aspect of the Compliance Plan and will incorporate input from appropriate NLCMHA Committees. Appropriate changes will be made and submitted to the Board for review. Upon Board approval, the changes will be distributed to all employees and agents. Changes to the Regulatory Compliance Plan will be included in the annual compliance training and employees will be required to sign an Acknowledgement Form.

B. Reporting - This Plan addresses two types of reporting. The first involves the obligation to and avenues for, employees and agents reporting noncompliance. The second involves the regular reporting of data and information pertinent to the compliance activities.

1. *Reporting by Employee and Agents* - If an employee or agent becomes aware of any wrongdoing under this Plan, whether intentional or unintentional, by that employee or another employee, he or she must report the wrongdoing to the Director of Quality Improvement and Compliance through one of the methods described below (*e-mail/voicemail/website/mail - access system)*. Individuals reporting anonymously must

follow-up within a few days via voice mail or e-mail to answer follow-up questions. Specific elements to include in a report are addressed in "Non-compliance Reporting" (See Attachment A).

a. ***Hotline*** - Reporting can be done by e-mail or voicemail or postal or interagency mail, and via web based reporting.

b. ***Postal or Interagency mail*** – This method of reporting is to be directed to the Compliance Coordinator/Leader, and marked "Confidential – Personal".

c. **Anonymous Reporting -** If an employee or provider chooses to submit a report anonymously, he or she may do so. In this case, the time and date must be clearly stated on the report, as this information will be used to identify follow-up questions.

d. The Director of Quality Improvement and Compliance will check each reporting system (*e-mail/voicemail/mail)* each business day. Upon receiving a call or e-mail, the Director of Quality Improvement and Compliance will ask questions, listen to (or read e-mail) the report, and complete a written report of the call.

e. If further investigation is warranted, the Director of Quality Improvement and Compliance shall conduct the investigation. As appropriate, consult with the CEO or legal counsel.

f. As needed, questions will be asked of the employee making the report. If the individual chooses to make the report anonymously, the Director of Quality Improvement and Compliance shall make arrangements for the individual to call back at specified times, or e-mail, for follow-up questions or communication.

g. The employee must answer those follow-up questions via electronic mail or voice mail. Anonymity may be maintained to the limits of the law.

h. Whatever the method of reporting, when the Director of Quality Improvement and Compliance receives a report alleging wrongdoing, he or she shall take the following response steps:

   - Initiate an inquiry within three (3) business days after receiving any report alleging wrongdoing.

   - Determine whether the alleged wrongdoing is a violation of federal or state law, contract requirements, this Compliance Plan, or other organizational standard or policy, or in some way jeopardizes, or puts at risk, the organization's operations or reputation. As necessary, the Director of Quality Improvement and Compliance shall access legal counsel, consult the CEO, or seek other appropriate guidance.

   - If the alleged wrongdoing is a violation, action shall be taken commensurate with the gravity of the allegation. As appropriate, the Director of Quality Improvement and Compliance shall consult with the CEO, and/or legal counsel.

   - If, upon investigation, the allegation is proven by the preponderance of evidence to be true, the Director of Quality Improvement and Compliance shall immediately

report this to the CEO, with recommendations regarding appropriate disciplinary and corrective action.

- If the situation constitutes a potential payback of reported services, the Director of Quality Improvement and Compliance, CEO and CFO shall consult with legal counsel to determine the appropriate course of action, if any. Payback of reported services must be completed within 60 days after discovery.

- A full and complete written report of the allegation, investigation, determination, and actions shall be written by the Director of Quality Improvement and Compliance. This report is to be submitted to the CEO, the NMRE Compliance Coordinator, and maintained in a secure location.

- If systemic corrections are indicated, the Director of Quality Improvement and Compliance shall submit appropriate information (*Appropriate information includes that necessary to institute a quality action team process while protecting the confidentiality of the people involved to the extent appropriate and necessary*.) to the appropriate quality improvement body. The Committee will conduct the review consistent with PDCA (Plan, Do, Check, Act) model, make final recommendations, and communicate recommendations to the Director of Quality Improvement and Compliance, as appropriate.

- If there is any knowledge of potential fraud and or abuse allegations within any program, the Director of Quality Improvement and Compliance must inform the CEO, who will then report allegations directly to the NMRE, who will inform the Michigan Department of Health and Human Services, and the Office of the Health Services Inspector General.

- The Director of Quality Improvement and Compliance will prepare a report at the end of each fiscal year of all suspected fraud and/or abuse reports made to the NMRE. This report will be submitted to the CEO no later than December 31st of each year. In addition to the number of complaints of fraud and abuse made, the report will include the following elements for each complaint:
    - Name of individuals investigated
    - Patient ID number
    - Source of complaint
    - Type of provider
    - Nature of complaint
    - Approximate dollars involved, and
    - Legal and Administrative disposition of the case.

i. Under no circumstances will Northern Lakes Community Mental Health Authority tolerate retribution against any employee or agent simply for making a “good faith” report.

- However, intentionally erroneous reports will be subject to disciplinary action.

- Similarly, if an employee or agent intentionally minimizes their own involvement when making a report, either to protect themselves or a co-worker, appropriate disciplinary action may be taken.

- If any supervisor or employee is determined to be retaliating against an employee for making a report, that supervisor or employee will be subject to disciplinary action.

2. *Reporting Compliance Data and Results* - Accurate and complete monitoring of the compliance plan requires the use of a variety of objective data sources. Information used in this monitoring process will be routinely reported. The NLCMHA Director of Quality Improvement and Compliance will provide information to the NMRE's Compliance Coordinator regarding any reports (of non-compliance) they have received, at least quarterly. A regular reporting schedule will be established which will minimally include:

   - Quarterly reports of record audits
   - Quarterly reports of Hotline access system (*e-mail/voicemail/ website/land-mail)*
   - Annual review of the Compliance Plan
   - Annual summary of Compliance activities, including number of investigations, summary of results of investigations, number of staff trained, and summary of disciplinary actions.

11.0 Responding to Non-compliance

Instances of non-compliance will receive quick and certain responses.

A. When systemic issues are determined to be the cause, in part or in full, the NLCMHA PMQI Committee, will act quickly to address the systems involved.

B. When individual action is determined to be the cause, in part or in full, quick and appropriate disciplinary action will be taken. Intentional non-compliance WILL NOT be tolerated and will be subject to immediate disciplinary action up to and including termination of employment and reporting to federal or state authorities.

C. See Non-compliance Reporting, Attachment A.

12.0 Performance Improvement to Prevent or Correct Non-compliance

Compliance, when possible, should be a proactive process. In other words, the surest way to assure that NLCMHA maintains the highest level of compliance with applicable laws and regulations is to develop systems and processes to facilitate and incorporate compliance from the beginning. This is the essence of performance improvement and the reason for developing this Compliance Plan from a performance improvement perspective.

A. There are a number of sources of data that will be utilized to monitor and improve the systemic processes necessary for compliance. These may include: audit results, MMBPIS reports, Key Indicators, QI Council Indicators, staff activity reports, and employee input processes.

B. The Director of Quality Improvement and Compliance and PMQI committee will review information from these sources cited in 12.0(A) of this Plan on a regular basis. When trends are suspected or identified, they will be discussed with the appropriate groups and additional data will be sought as needed.

1. When such a review is indicated by either objective or sufficient anecdotal information, the Committee will review the issue and make recommendations regarding the process in question.

2. The PMQI will utilize the Plan/Do/Check/Act (Shewart model).

13.0 Annual Regulatory Compliance Review

On or before the end of each fiscal year, the Director of Quality Improvement and Compliance will arrange for a review of the current compliance and regulatory operations. The purpose of the review should include probe samples to ascertain whether the compliance operations are within standards. A written report describing the results of the audit should be prepared on or before December 1.

14.0 Annual Report and Work Plan

On or before December 1, the Director of Quality Improvement and Compliance should prepare and distribute to the CEO and the NLCMHA governing body a report describing the compliance efforts during the preceding fiscal year and a proposed work plan for next fiscal year. The report should include the following elements:

A. A summary of the general compliance activities undertaken during the preceding fiscal year, including any changes made to the Compliance Plan;

B. A copy of the Hotline access system log for the preceding fiscal year;

C. A copy of the preceding fiscal year's Compliance Review;

D. A description of actions taken to ensure the effectiveness of the training and education efforts;

E. A summary of actions to ensure compliance with NLCMHA's policy on dealing with excluded persons;

F. Recommendations for changes in the Plan that might improve the effectiveness of NLCMHA's compliance effort; and

G. A copy of the proposed work plan for the next fiscal year.

15.0 Revisions to this Plan

This Compliance Plan is intended to be flexible and readily adaptable to changes in regulatory requirements and in the health care system as a whole. The Plan should be regularly reviewed to assess whether it is working. The Plan should be changed as experience shows that a certain approach is not effective or suggests a better alternative

16.0 Excluded Persons Policy

Northern Lakes Community Mental Health Authority confirms the importance of compliance 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."

A. Accordingly, prior to employing or contracting with any provider, NLCMHA will take appropriate steps to confirm that the provider has not been excluded. Those steps will include 1) checking the provider's name against the HHS/OIG Cumulative Sanctions List, 2) the GSA Debarred Bidders List and 3) the State of Michigan Sanctioned Providers List.

B. The Director of Quality Improvement and Compliance will provide training to employees with responsibility for human resources functions about how to access those lists, if required. If NLCMHA learns that a prospective provider (either as an employee or contractor) is excluded, NLCMHA will not hire or use that provider.

C. Additionally, the NMRE will check the OIG List of Excluded Individuals//Entities, the GSA Excluded Party List, the MDHHS Sanctioned Providers (Michigan), every 30 days and provide reports to NLCMHA. This is to assure that no name of any individual hired, under contract, or appointed as a Board Member appears in these databases.

D. If NLCMHA learns that any of its current providers (either as employees or contractors) have 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 it has confirmed that the matter has been resolved. In the event that NLCMHA 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 such time as the matter is resolved.

E. 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 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.

REFERENCES

-- *CMHSP Contract with MDHHS...FY 2020*

- *PIHP Contract with MDCH Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 2020*

- *Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart I, Section 438.700, Subsections (a)(b)(c) and (d), Basis for Imposition of Sanctions*

- *Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart H, Section 438.608, Subsections (a) and (b), Program Integrity Requirements*

- *Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart C, Section 438.106, Subsection (a), (b), and (c), Liability for Payment*

- *Federal Register/Vol. 63, No. 243/Friday, December 18, 1998/Notices – Department of Health and Human Services, Office of Inspector General, "Publications of the OIG Compliance Program Guidance for Third-Party Medical Billing Companies"*

- *Center for Medicare and Medicaid (CMS) State Medicaid Director Letter, June 12, 2008 regarding Medicaid provider requirements for monthly verification of excluded individuals and entities.*

- *Office of Inspector General (OIG) Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs - Issued May 8, 2013*

- *Office of Inspector General (OIG) News Release, April 7, 2013 – "Provider's Self Disclosure Protocols"*

- *Federal Sentencing Guidelines, Section 8 Sentencing of Organizations, as amended November 1, 2011*

- *Centers for Medicare and Medicaid (CMS) State Medicaid Director Letter, September 1, 2010 regarding Additional Medicaid Integrity Program Provisions of the Affordable Care Act 2010, Section 6507*

Northern Lakes Community Mental Health Authority

CMHSP – Mental Health
Regulatory Compliance

REGULATORY NON-COMPLIANCE REPORTING

Purpose: **To provide an internal process for the referral and monitoring of contractual non-compliance, regulatory non-compliance, or inappropriate use of community mental health Prepaid Medicaid service dollars.**

Intent: **To facilitate the reporting on health care waste, questionable practices, or inappropriate use of Medicaid service dollars.**

Who can report: **All individuals affiliated with Northern Lakes Community Mental Health Authority are responsible for compliance with regulations and contracts; this includes Board Members, all staff employed by NLCMHA, as well as sub-contractors.**

Who it is reported to: **Kari Barker, Director of Quality Improvement and Compliance, Northern Lakes Community Mental Health Authority.**

How it is reported: **Regulatory non-compliance reporting can be done by voice mail, email, web access, or in writing. The disclosure can be anonymous.**

Overview

The Office of Inspector General (OIG) in Washington D.C. published a detailed self-disclosure protocol in October 1998 as a part of the pilot voluntary disclosure program. An open letter to Health Care Providers from the OIG, dated March 9, 2000 and March 24, 2009 followed up on various aspects of the October 1998 letter, and notified providers of the responses from providers on self-disclosure.

When fraud is uncovered by the OIG they will look to see whether NLCMHA took appropriate steps to prevent and detect the misconduct and whether there is a likelihood that the same or similar abuse of the Medicaid services will reoccur.

The outcome of any case identified by the OIG will be impacted by NLCMHA's ability to point to tangible, positive outcomes stemming from its own compliance efforts.

Evidence that NLCMHA's regulatory compliance program is operating effectively includes the following:

1. Problematic conduct, such as questionable practices, health care waste, or inappropriate use of Medicaid service dollars, is identified.

2. Appropriate steps are taken to remedy and prevent the conduct from recurring.

3. When misconduct appears to be a violation of the law, a full and timely disclosure of the violation of law is made to Medicaid.

4. That matters of overpayment or errors that do not suggest a violation of law, are dealt with promptly by the individuals responsible for claims processing and payment. (The entity accountable and responsible for the Prepaid Health Plan Medicaid dollars.)

5. An internal process for non-compliance reporting is an active part of the Regulatory Compliance Program.

Errors in compliance may be rooted in a number of causes. Frequently, the source of difficulty may be traced to deficiencies in the systemic processes used by staff.

When compliance errors or lapses are determined to be rooted in individual behavior, the quality improvement process will likely not be appropriate. Such errors may be the result of insufficient information and training, individual carelessness, or willful acts. Each of these causes requires a different response. It is essential that sufficient investigation be conducted by NLCMHA's Compliance Program to determine the source and cause of errors prior to determining the response.

The monitoring and reporting processes are designed to facilitate continuous improvement and to identify errors and wrongdoing. This is accomplished through routine review of records and through input and reporting of non-compliance from individuals.

NLCMHA's Compliance Plan addresses two types of non-compliance reporting. The first type of reporting involves the obligation to and avenues for, employees and agents reporting non-compliance. The second type of reporting involves the regular reporting of data and information pertinent to the compliance activities of

- ***Under no circumstances will NLCMHA tolerate retribution*** *against any employee or agent simply for making a "good faith" report to the Compliance Coordinator.*
- However, **intentionally erroneous** reports will be subject to disciplinary action.
- Similarly, if an employee or agent **intentionally minimizes** a wrongdoing when making a report, either to protect themselves or a co-worker, appropriate disciplinary action will be taken.
- If any supervisor or employee is determined to be **retaliating against an employee for making a report**, that supervisor or employee will be subject to harsh disciplinary action.

Health care waste, questionable practices, contractual or regulatory non-compliances, or inappropriate use of the Medicaid Service dollar can be identified in varied aspects of the service delivery process. The following are provided as a point of reference when completing a non-compliance report:

Non-compliance reporting can include:
a. Administrative processes
b. Billing Practices
c. Clinical services
d. Contractual requirements
e. Information system and data collections

Who Reports Non-compliance?

If an employee or agent becomes aware of any wrongdoing, whether intentional or unintentional, by that employee or another employee, he or she must report the wrongdoing to the Compliance Coordinator, or the Compliance Leader at the member CMH Board. Regulatory non-compliance reporting can be done by voice mail, e-mail, web access, or in writing. The disclosure can be anonymous.

How are Non-compliance Issues to be reported?

Non-compliance reporting can be done by voice mail, e-mail, web access, in person or in writing. *The report can be anonymous.*

Compliance Leader at Northern Lakes CMH – Kari Barker

- Voice mail reporting – Call (231)935-3679 and leave a voice message of all required reporting information.
- E-mail all required reporting information to Kari Barker at kari.barker@.org or compliance@nlcmh.org
- Send written non-compliance reports to the attention of Kari Barker at 105 Hall St, Suite A, Traverse City, MI 49684

Compliance for the Northern Michigan Regional Entity – Tema Pefok:

- Voice mail reporting – Call (231) 439-1278 and leave a voice message of all required reporting information.
- E-mail all required reporting information to Tema Pefok at tpefok@nmre.org
- Web Access - Go to nmre.org, click on Compliance Resources, select Report Compliance Issue, enter summary of issue in the text box. To maintain anonymity, use a non-identifying email address (example Hotmail, Gmail or other email account)
- Send written non-compliance reports to the attention of Tema Pefok at 1999 Walden Dr, Gaylord, MI 49735

Responding to Non-compliance

Instances of non-compliance will receive quick and certain responses. When systemic issues are determined to be the cause, in part or in full, the appropriate committee will act quickly to address the systems involved. When individual action is determined to be the cause, in part or in full, quick and appropriate disciplinary action will be taken. Wrongdoing WILL NOT be tolerated and will be subject to immediate disciplinary action up to an including termination of employment and reporting to federal or state authorities.

Definitions

Abuse – 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).

Contractual Non-compliance – Contractual non-compliance is when the provider does not follow specific criteria stated in a contract.

Fraud – 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).

Health Care Waste - Health care waste is providing services longer than medically necessary.

Inappropriate use of Medicaid service dollars – Inappropriate use of Medicaid services dollars is the intentional deception or misrepresentation of deliberate and improper billing. Some examples of fraudulent use are claims submitted for the following:

- Billing amounts greater than usual and customary charges.
- Billing for services not provided or not fully provided.
- Billing higher paying procedures than the ones actually provided.
- Billing multiple procedures rather than comprehensive procedures.
- Billing unnecessary, inappropriate or harmful services.
- Billing non-authorized services, by using an authorized procedure code.

Non-compliance reporting – reporting of health care waste, questionable practices, or fraudulent use of Medicaid service dollars to the Regulatory Compliance program of the Northern Regional Entity.

Regulatory Non-compliance – Regulatory non-compliance is when a provider does not meet standard stated in Federal Law or State Rule/Regulation

Questionable Practices - Questionable practices are practices inconsistent with generally accepted business or behavioral health care practices and that fail to meet professionally recognized standards for behavioral health care. Some examples of questionable practices (might involve **unintentional** actions by providers, but involve unacceptable practices) are:

- The provision of inappropriate services.
- Providing services that are of inferior quality.
- Inadequate clinical record documentation.
- Poor communication and coordination of treatment/services.

RESOURCES:

CMHSP Contract…FY 2020
Northern Michigan Regional Entity – Northern Regional Entity Compliance Plan

PIHP Contract with MDCH Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 2020

Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart I, Section 438.700, Subsections (a)(b)(c) and (d), Basis for Imposition of Sanctions

Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart H, Section 438.608, Subsections (a) and (b), Program Integrity Requirements

Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart C, Section 438.106, Subsection (a), (b), and (c), Liability for Payment

OIG News Release, April 7, 2013 – "Provider's Self Disclosure Protocols"

Attachment A

Northern Lakes Community Mental Health Authority
Regulatory Compliance Report

Date of reporting: _____ *(Use back of sheet or additional pages as needed.)*

Name of the provider reporting about: _____

If consumer specific, provide name and/or consumer identification number: _____

County where the provider is located: _____

Describe (in detail) the alleged Medicaid fraud, waste, or abuse issue:

_____

_____

_____

_____

_____

Describe any actions that may have been previously done to resolve the issue in question:

_____

_____

_____

_____

_____

Send to Kari Barker, Director of Quality Improvement and Compliance, Northern Lakes Community Mental Health Authority (NLCMHAAA), 105 Hall St., Traverse City, MI 49684, 231.935.3679 or fax 231.935.3082, or attach to email to kari.barker@nlcmh.org or compliance@nlcmh.org

Print Name: _____ **Phone #:** _____

Signature: _____

Note: This report can be submitted anonymously. If reported anonymously, a call or email must be generated within (3) business days of original report for follow-up questions or information by the Compliance Coordinator.

Northern Lakes Community Mental Health Authority
Compliance Attestation
2021

I, _____, as an employee/board member of Northern Lakes Community
(Insert name)
Mental Health Authority or a Contracted Provider, recognize and acknowledge my obligation to report any incidence of fraud, abuse or waste of public funding to the organization.

I understand that this obligation is explained in the Northern Lakes Community Mental Health Authority Regulatory Compliance Plan. This Plan gives guidance on what is reportable, where to direct questions, and how to report.

As of this date, I am not aware of any reportable incident, or I have reported any incidence of non-compliance of which I am aware and it has been objectively reviewed and I have received a response from the organization. Should I become aware that a situation is potentially a violation of the False Claims Act, or an otherwise reportable occurrence, I will report immediately, as specified in the Regulatory Compliance Plan.

Compliance Training Date: _____

My signature below is my certification that I have never been convicted of or had a civil judgment rendered against me 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 destruction of records, making false statements, or receiving stolen property; have never had a professional license revoked or suspended and have never been sanctioned, whether personally or through an entity, by Medicare or Medicaid programs.

I also understand that I am under obligation to report to the CEO, within three (3) business days, any convictions of or civil judgment rendered against me for any of the above offenses.

_____ _____

Attachment C

NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY

2021 Regulatory Compliance Plan

Compliance Plan Acknowledgement Form

On _____ I received orientation and training pertaining to the Regulatory
(Today's Date)
Compliance Plan.

I received a copy of the Regulatory Compliance Plan _____
(Initials)

I understand that I am to read the Regulatory Compliance Plan within one week from today. I contact: Kari Barker, Director of Quality Improvement and Compliance for clarification. She can be reached at: Northern Lakes Community Mental Health Authority, 105 Hall St., Traverse City, MI 49684 Phone: 231-935-3679 or compliance@nlcmh.org or kari.barker@nlcmh.org

_____
(Initials)

Within the next seven (7) days I will return this form signed as my acknowledgement of acceptance with the compliance plan's principles.

I _____ have read and accept the compliance plan principles.
(Print Name)

My signature is acknowledgement of the above: _____
(Signature)

Agency I work for: _____
(Please print clearly)

_____
Date

Evidence of initial training (either manual or electronic version) must be maintained by the employer.