

NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY REGULATORY COMPLIANCE PLAN

2.0 Purpose

Northeast Michigan Community Mental Health Authority (NeMCMHA) established a Compliance Program to assure compliance with all laws, rules and regulations relating to federal and state health care programs. The Compliance Program is an integral part of NeMCMHA and its Provider Network. NeMCMHA is dedicated to adhering to the highest ethical standards and recognizes the importance of full compliance. NeMCMHA is committed to detect and prevent fraud, waste and abuse. This policy is intended to address matters relating to the Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statute, the Health Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act (1996) [now known as the Managed Care Rules], the Deficit Reduction Act [Medicaid Integrity Program] (2006), as well as any other circumstances in which the potential for or actual occurrence of Medicaid fraud, waste and abuse is involved.

Element 1 – Standards, Policies and Procedures

NeMCMHA is obligated to conduct itself in accordance with the Standards of Conduct outlined in the Ethics and Unprofessional Conduct policies.

Element 2 – Compliance Program Administration

NeMCMHA has a designated Compliance Officer charged with the responsibility for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract. The Compliance Officer reports directly to NeMCMHA's Director.

Management Team will assist the Compliance Officer conducting risk assessments, developing policies and procedures and reviewing the annual Regulatory Compliance Plan.

The Compliance Officer will conduct an annual evaluation of the Regulatory Compliance Plan to determine whether the required elements have been implemented. Methods that can be used to assess and evaluate the Plan include:

- Work with the provider network to coordinate Regulator compliance activities;
- An analysis of reports generated as part of the Medicaid Encounter Verification reviews and other processes to identify trends;
- An analysis of all allegations of abuse and/or fraud and reporting requirements/process to provide notification to MDHHS/Office of Inspector General (OIG);
- A review analysis of compliance activities and provider agencies via the ongoing and annual contract monitoring process.

NeMCMHA's Compliance Officer will be a member of the PIHP's Regional Compliance Committee membership. Meetings are planned at least quarterly. Activities of this Committee may include:

- Assess region-wide trainings and staff training requirements
- Determine overall strategy or approach to promoting compliance and/or detecting violations or regulation
- Review Compliance Plans annually
- Review statewide meetings
- Monitoring and auditing
- Analyze, review and identify high-risk compliance areas.

Element 3 – Screening and Evaluation

Disclosure of Ownership – see NeMCMHA Disclosure of Ownership Policy/Procedure NeMCMHA shall comply with all requirements to obtain, maintain, disclose and furnish required information about ownership and control interests, business transactions and criminal convictions.

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NeMCMHA shall ensure 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.

NeMCMHA will require disclosure statements for all Medicaid providers and fiscal agents and any subcontractor who receives \$25,000 or more per year. NeMCMHA requires each provider, fiscal agent and applicable contractor to identify all owners and others with an ownership or controlling interest, and the identity of managers and others in a position of influence or authority. The Agency defines their managing employees as Executive Director and Finance Director. NeMCMHA Board Members will also be required to submit disclosure statements to the Executive Director's office.

All disclosure of ownership forms will be maintained in accordance with Disclosure of Ownership Policy/Procedure. Information will only be shared as indicated in the current PIHP Contract terms and applicable federal/State laws.

Excluded Person or Entity

NeMCMHA confirms the importance of compliance with 42 U.S.C. 1320a-7(b), which imposes penalties for "arranging or knowing (by employment or otherwise) with an individual or entity the person knows, or should know, is excluded from participation in a Federal healthcare program for the provision of items or services for which payment may be made under such a program. Accordingly, prior to employing or contracting with any provider or appointment of an individual to the Board of Directors, NeMCMHA will take appropriate steps to confirm the provider has not been excluded. Thereafter, the PIHP will conduct excluded provider checks every thirty days and share results of all searches with NeMCMHA's Compliance Officer. NeMCMHA's Compliance Officer will ensure the PIHP has updated information to accurately conduct these database checks each month.

Element 4 – Communication, Education and Training

NeMCMHA and its Provider Network is committed to open communication as an essential component or proper implementation of its Compliance Program. The Compliance Officer shall be available to communicate compliance topics/complaints/issues received by NeMCMHA employees and/or its Provider Network and will protect the anonymity of complainants and protect callers from retaliation.

- TELEPHONE 989-358-7741
- TOLL FREE 800-968-1964, EXT. 7741
- HOTLINE 989-358-7777
- EMAIL jwalburn@nemcmh.org
- MAIL or in PERSON 400 Johnson Street, Alpena, MI 49707

All staff are expected and required to report any conduct they, in good faith, reasonably believe may be fraudulent or erroneous. It is NeMCMHA's expectation instances such as this be reported and NeMCMHA shall assure anonymity with no retribution. Staff making a good faith report of potential violations are protected by State and federal Whistleblower laws under the False Claims Act.

Education/Training

The Agency will establish and maintain a system for training and education for the NeMCMHA Compliance Officer, senior management and employees for the Federal and State standards and requirements under the contract. NeMCMHA personnel will receive initial compliance training at orientation with the Human Resources Department and, thereafter, annually using a web-based system. Staff compliance training must be documented and reported via attestation to NeMCMHA's Compliance Officer. CMHSPs can submit a copy of the Inspector General "Certification of Compliance" letter to the PIHP's Compliance Director annually. Subcontractors should track and keep all trainings on-site, monitored by NeMCMHA's Contract Manager. NeMCMHA and its Provider Network must be 100% compliant, which is reported to MDHHS-OIG annually; section 6032 of the Deficit Reduction Act (DRA) of

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2005, pursuant to section 1902 (a) (68) of the Social Security Act training which includes but is not limited to:

- Written policies regarding the laws of False Claims Act including administrative remedies, criminal penalties and whistleblower protection/non-retaliation
- Written policies for detecting and preventing fraud, waste and abuse
- Code of Conduct/Conflict of Interest

Network Providers are expected to provide compliance training at orientation, annually and as needed to all staff and agents working on their behalf. Compliance training is considered a condition of employment and failure to comply will result in disciplinary action as deemed appropriate by supervisors/Director.

Element 5 – Monitoring & Auditing

Monitoring and auditing of compliance risk, prompt response to investigation of potential compliance problem as identified during self-evaluations and audits, correction of such problems to reduce the potential for recurrence and ongoing compliance with requirements under the contract. All NeMCMHA personnel are responsible for monitoring compliance activities and operations within NeMCMHA and they must report.

The Agency conducts a variety of monitoring and auditing techniques which may include:

- Periodic questionnaires, surveys and interviews with staff and subcontracted providers regarding their perceived levels of compliance, effectiveness or training/education within their departments or areas of responsibilities
- Periodic audits complying with federal and State law, regulations, rules and guidelines
- Input from PIHP Compliance Director and regional CMHSP Compliance Leaders
- Internal/External Audit results for specific compliance guidelines
- Information from past investigations for noncompliance
- Information from exit interviews

NeMCMHA's Compliance Officer will report at least annually to NeMCMHA's Board of Directors on the following (if applicable):

- Tips/grievances received
- Data mining and analysis of paid claims, including audits performed based on the results
- Audits performed
- Overpayments collected
- Identification and investigation of fraud, waste and abuse
- Corrective action plans implemented
- Provider disenrollment
- Contract terminations

Element 6 – Discipline for Non-Compliance

All non-compliant reports shall be reviewed by the Compliance Officer within three business days of receipt. If the evidence gathered during investigation confirms non-compliance, a corrective action plan will be initiated and disciplinary action will be taken (based on the circumstances). Disciplinary action may include any of the following:

1. Written warning, if applicable
2. Suspension without pay, if applicable
3. Termination of employment or contract

Documentation will be kept for all reported issues.

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Element 7 – Investigations and Remedial Measures

Healthcare fraud and abuse affects all of us. Healthcare fraud significantly impacts the Medicaid and non-Medicaid programs by using up valuable public funds needed to help vulnerable children and adults access health care. Everyone can take responsibility by reporting fraud and abuse. Together we can make sure taxpayer money is used for people who really need help.

Detection of non-compliance may occur through already established reviews, including audit of claims data and clinical documentation, record reviews and complaints made by staff, individuals receiving services, subcontract providers or others. Findings of any of the non-compliance examples could result in discipline, corrective action, larger samples of claim review and possible payback of inappropriate payments and reporting to the MDHHS-OIG.

I. INVESTIGATION

Within three business days of receiving a report, the Compliance Officer shall provide a written acknowledgement of receipt to the individual making the report (if known) and conduct an initial assessment to determine whether the report has merit and warrants further investigation.

- If it is determined the matter does not constitute a violation of any applicable laws or regulations and warrants no further action, the issue will be closed following the appropriate documentation and reporting by the Compliance Officer.
- If it is determined the matter does not constitute a violation of any applicable laws or regulations but does identify an area for improvement or raises concern for potential future violations, the matter will be referred to NeMCMHA's Quality Improvement Coordinator for appropriate follow up action.
- If it is determined the matter requires further investigation, the Compliance Officer will report the issue to the PIHP's Compliance Director, who will then review the information and assess if immediate reporting to the OHSIG should take place.

If the PIHP's Compliance Director concludes reporting to a government agency (CMS, OIG, and DOJ) or a third party may be appropriate, the PIHP's CEO and NeMCMHA's Compliance Officer and Executive Director will be informed immediately. The PIHP's Compliance Director shall report the issue to the government agency(ies) within established policies and procedures.

NeMCMHA's Compliance Officer shall take these or any other steps necessary to assure documents or other evidence are not altered or destroyed, as applicable:

- Limiting access of files, computers and other sources of documents by individuals suspected of wrongdoing; and/or
- Temporarily suspend or re-assignment of duties of individuals allegedly involved

No further investigation shall occur until the PIHP's Compliance Director has confirmed with the HSOIG to proceed. However, appropriate steps shall be taken to ensure safety for individuals served by the Agency.

- Once confirmation from the HSOIG is obtained, the PIHP's Compliance Director shall approve further investigation through internal PIHP investigation procedures or notify the NeMCMHA's Compliance Officer to follow internal investigation procedures.
- If HSOIG confirmation is not obtained and/or HSOIG instructs the PIHP to not conduct any further investigation, the PIHP's Compliance Director shall document the HSOIG communication and follow up with the HSOIG within thirty (30) days to obtain an update on the case. The PIHP's Compliance Director will inform the NeMCMHA's Compliance Officer of any change of status or progress with the case.

II. RESOLUTION

Following the investigation, the Provider Compliance Director will document and report the findings of the investigation to NeMCMHA's Executive Director and/or the PIHP's Compliance Director. In cases where

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actions of the NeMCMHA's Executive Director are investigated, the report of findings will be made to NeMCMHA's Board of Directors and the PIHP's CEO. If the occurrence involved a NeMCMHA employee, disciplinary action will be taken in accordance with the Agency's policies and procedures.

- If the occurrence involved a provider within the PIHP/CMHSP/SUD Provider Network, a remedial action plan to address any areas of concern or non-compliance raised during the investigation must be completed, if appropriate
- The PIHP/CMHSP/SUD Provider Compliance Director will notify the PIHP/CMHSP/SUD Provider CEO of any findings requiring sanctioning of a provider or termination of a contact.
- If the situation constitutes a potential pay back or self-disclosure, the PIHP's CEO will seek legal counsel or other resource prior to taking action.

III. DOCUMENTATION

A record will be maintained by the PIHP/CMHSP/SUD Provider Compliance Leader or designee for all reports of potential/alleged violation utilizing the attached *Compliance Investigation Report Form*. The record may also include copies of interview notes and documents reviewed and any other documentation as appropriate.

Records will be maintained in accordance with the "State of Michigan, Department of History, Arts and Libraries – Record Management – Records Retention and Disposal Schedule." (Dated 2007)

Definitions

Abuse – Provider practices are inconsistent with sound fiscal, business or clinical practices resulting in an unnecessary cost to the Medicaid program or in reimbursement for services not medically necessary or failing to meet professionally recognized standards of care. It also includes beneficiary practices resulting in unnecessary costs to the Medicaid program. (42 CFR § 445.2)

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 himself 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) (per Michigan statute and case law interpreting same): 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, aking 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."

Waste – Over utilization 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.

Other Related Policies

Policy 3090 – Code of Ethics
Policy 3040 – Whistleblowers Act
Policy 3610 – Prohibited & Unacceptable Conduct
Policy 2900 – Disclosure of Ownership
Policy 5200 – Consumer Records
PIHP Procedure – NMRE Verification Audit Policy and Procedure