Compliance Training NCCMH Contract Providers

May 1, 2019

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What is Compliance?

- What does this look like in an 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.

- What does this look like in INDIVIDUAL BEHAVIOR?
  - Following laws and rules that govern healthcare;
  - Being honest, responsible, and ethical;
  - Preventing, detecting, and reporting unethical and illegal conduct;
  - Preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA) of Federal and/or State funds;
  - Auditing and Monitoring to make sure funds are being used correctly.

OIG's 7 elements for effective compliance

- **ELEMENT 1** Code of Conduct Standards, Policies and Procedures
- **ELEMENT 2** Compliance Program Administration
- **ELEMENT 3** Training and Education
- **ELEMENT 4** Open Lines of Communication
- **ELEMENT 5** Monitoring, Auditing, and Internal Reporting
- **ELEMENT 6** Investigations
- **ELEMENT 7** Discipline and Documentation Process

NCCMH Standards of Conduct

Code of Conduct

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

Ethics

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

What are the laws we need to follow?

- 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.
- 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.
- Established new audit procedures for Medicaid services by 3rd party companies called Recovery Audit Contractors (RAC).
- 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.
- About preventing and detecting Fraud, Waste, and Abuse in the Federal health care programs.

Fraud, Waste, and Abuse

- **Fraud** - An intentional deception or misrepresentation by a person with the knowledge the deception could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.

- **Waste** - Overutilization of services, or other practices, that result in unnecessary costs. Generally not considered caused by criminally negligent actions, but rather the misuse of resources.

- **Abuse** - Practices that are inconsistent with sound fiscal, business or medical practices & result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare.

Improper payments

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

Federal False Claims Act

- Covers fraud involving any federally funded contract or program, including the Medicaid program.
- Includes whistleblower provisions that rewards citizens who report offenders (known as Qui Tam).
- 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.
- 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.

Michigan False Claims Act

- Amended in 2009 to add provisions that mirror federal False Claim Act.
- Imposes liability on persons who knowingly submit false/fraudulent claims to Michigan's Medicaid Program.
- Made it illegal to pay or receive bribes or incentives for medical referrals.
- If convicted under the Act, fines include $5,000 to $10,000 each violation.

Federal Whistleblower's Act

- Provides protection to employees who report a violation of law.
- States that an employer shall not discharge, threaten, or discriminate against an employees who reports a violation.
- Law requires a person to bring civil action within 90 days after any employer action.

Michigan False Claims Act

- Authorizes State Attorney General to investigate alleged violations and recover funds from fraudulent conduct.
- Also protects whistleblowers from retaliation by their employers.
- Whistleblowers recover 15-25% of recovered amounts if state intervenes and 25-30% if the state does not intervene.

Affordable Care Act

- The program integrity requirements include:
  - Increased screening and enrolling of providers.
  - If a provider is terminated from Medicare program, they are also terminated from Medicaid.
  - States can suspend payments of any provider under investigation of credible allegations of fraud.
  - Expanded Recovery Audit Contractors to audit Medicaid services.

What are examples of a false claim?

- Reporting two encounters when only one was provided.
- Reporting services not rendered (if there is no documentation, the service wasn't provided).
- Billing for medically unnecessary services (not authorized in the plan of service).
- Unbundling or billing separately for services that should be billed as one (reporting nursing services same day as physician's office visit).
- Failing to report and refund overpayments.

Other Applicable Laws

- Anti-Kickback Statute - Health care providers and suppliers 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. The information collected on Provider Disclosures, including SS#s is used by NCCMH to verify eligibility for participation.
- Civil Monetary Penalties Law - Allows the Office of the Inspector General (OIG) to impose civil penalties for violations of the Anti-Kickback Statute and other violations including submitting false claims and making false statements on applications or contracts.
- Criminal Health Care Fraud Statute - Makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment of up to 10 years, and fines of up to $250,000. Specific intent is not required for conviction.

INTERNAL
Reporting and Investigation

All suspected violations, misconduct and fraud and abuse are required to be reported to the NCCMH/NMRE Compliance Officer

If it is suspected that Compliance Officer has a conflict of interest in the matter being reported, then the report is made to the Chief Executive Officer

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

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

EXTERNAL
Reporting and investigation

The NMRE Compliance Officer will annually report all suspected fraud and abuse to the MDHHS Office of Health Services Inspector General and report quarterly to the OIG

When an investigation substantiates a violation, corrective action will be required that can include restitution of overpayment amounts, notifying government agencies, a corrective action plan and implementing system changes

If I suspect fraud or abuse, what should I do?

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NMRE Compliance Office

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- Website: nmre.org\Resources\Compliance\ Report Compliance Issues, enter summary of your issue.

Request an e-copy at providerrelations@norcocmh.org