AuSable Valley Community Mental Health Authority

Compliance Plan

This document is made part of the AVCMHA Quality Department Manual.

Table of Contents

Elements 1 through 7 4

Investigation, Resolution, and Documentation 8

Compliance Investigation Form 11

COMPLIANCE PLAN

AVCMHA Quality Department Policy

1.0 Purpose

AuSable Valley Community Mental Health Authority (AVCMHA) established a Compliance Program to assure compliance with all rules and regulations relating to federal and state health care programs. The purpose of this Compliance Plan is to provide the framework for AVCMHA to comply with applicable laws, regulations, and program requirements.
The Compliance Program is an integral part of AVCMHA and its Provider Network.

It is the policy of AVCMHA to ensure compliance with all state and federal regulatory agency standards and applicable laws and regulations including, but not limited to, the following:
State Laws and Rules

- Michigan Mental Health Code and Administrative Rules
- Other requirements as identified in the MDHHS contract
- Medicaid State Plan
- Medical Services Administration (MSA) Policy Bulletins
- Michigan Whistleblowers Act, 469 of 1980
- Michigan State Laws and Rules

Federal Medicaid Law, Regulations and Related Items

- Social Security Act, Title XIX (Medicaid)
- Balanced Budget Act of 1997
- Deficit Reduction Act/Medicaid Integrity Program of 2005
- Code of Federal Regulations
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- False Claims Act
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse

COMPLIANCE PLAN

AVCMHA Quality Department Policy

Element 1 – Standards, Policies and Procedures

AVCMHA is obligated to conduct itself in accordance with the Employee Handbook, Administrative Manual, AVCMHA Compliance Plan, the NMRE Compliance Plan, and the Regulatory Compliance Training video outlining the Code of Ethics and Standards of Conduct.

Element 2 – Compliance Program Administration

AVCMHA 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 and is responsible for the oversight and monitoring of all aspects of the Compliance Plan. The Compliance Officer reports directly to AVCMHA's Chief Executive Officer.

The Quality Team will assist with reviewing and monitoring other areas of the Compliance Plan.

The Compliance Officer will conduct an annual evaluation of the 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 compliance activities;
- Analyze reports generated as part of the Medicaid Encounter Verification reviews and other processes to identify trends;
- Analyze all allegations of abuse and/or fraud;
- Utilize reporting requirements and processes to provide notification to MDHHS/Office of Inspector General (OIG);
- Analyze compliance activities and provider agencies via the ongoing and annual contract monitoring process.

AVCMHA's Compliance Officer will be a member of the PIHP's (Northern Michigan Regional Entity or NMRE) Quality and Compliance Committee. 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
- Review Compliance Plans annually
- Review statewide meeting minutes
- Monitor and audit as needed
- Analyze, review, and identify high-risk compliance areas

Element 3 – Screening and Evaluation

Disclosure of Ownership

AVCMHA shall comply with all requirements to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions and criminal convictions.

AVCMHA 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.

AVCMHA will require disclosure statements for all Medicaid providers and fiscal agents and any contracted provider who receives $25,000 or more per year. AVCMHA 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.

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 NMRE Contract terms and applicable federal/State laws.

Excluded Person or Entity

AVCMHA 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, AVCMHA will take appropriate steps to confirm the provider has not been excluded by searching the OIG exclusionary database. Thereafter, the NMRE will conduct excluded provider checks every thirty days and share results of all searches with AVCMHA's Compliance Officer or designee. AVCMHA's Compliance Officer or designee will ensure the NMRE has updated information to accurately conduct these database checks each month.

Element 4 – Communication, Education and Training

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

COMPLIANCE PLAN

AVCMHA Quality Department Policy

Telephone	989-747-3003
Email	compliance@avcmh.org
Mail or in person	1199 W. Harris Ave, P.O. Box 310, Tawas City, MI 48764

All staff are expected and required to report any conduct they, in good faith, reasonably believe may be fraudulent or erroneous. It is our expectation that any instances reported will 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 AVCMHA Compliance Officer, senior management and employees for the Federal and State standards and requirements under the contract. AVCMHA personnel will receive initial compliance training at orientation and annually using a web-based system. Staff compliance training must be documented and reported via attestation.

Contracted Providers should track and keep all training records and attestations on-site. AVCMHA and its Provider Network must be 100% compliant, which is reported to MDHHS-OIG annually; section 6032 of the Deficit Reduction Act, 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 including non-retaliation
- Written policies for detecting and preventing fraud, waste, and abuse
- Code of Conduct and 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 the Compliance Officer.

Element 5 – Monitoring & Auditing

Monitoring and auditing of compliance risk will include prompt responses to investigations of potential compliance problems 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 employees are responsible for monitoring compliance activities and operations within AVCMHA and they must report any suspected or actual risks.

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

- Periodic audits complying with Federal and State laws, regulations, rules, and guidelines
- Input from the NMRE Compliance Director and regional CMHSP Compliance Leaders
- Internal and External Audit results for specific compliance guidelines
- Information from past investigations for noncompliance
- Internal Auditors have been designated to:
    - Review documentation and billing codes
    - Review internal reports for compliance
    - Regularly conduct internal audits for AVCMHA clinical programs

AVCMHA's Compliance Officer will report at least annually to the Chief Executive Officer 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.

Element 7 – Investigations and Remedial Measures

Detection of non-compliance may occur through already established reviews including:

- audits of claims data and clinical documentation,
- record reviews or complaints made by staff,
- individuals receiving services,
- contracted providers or others.

Findings of any of the non-compliance examples could result in discipline, corrective action,

larger samples of claims review, 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 the leadership team for follow up action.
- If it is determined the matter requires further investigation, the Compliance Officer will report the issue to the NMRE's Compliance Director, who will then review the information and assess if immediate reporting to the MDHHS-OIG should take place.

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

AVCMHA'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-assign duties of individuals allegedly involved

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

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

II. RESOLUTION

Following the investigation, the NMRE Compliance Director will document and report the findings of the investigation to AVCMHA's CEO and/or the Compliance Officer. In cases where actions of the AVCMHA's CEO are investigated, the report of findings will be made to AVCMHA's Board of Directors and the NMRE's CEO. If the occurrence involved an AVCMHA employee, disciplinary action will be taken in accordance with the Agency's policies and procedures.

- If the occurrence involved a contracted provider within the NMRE/AVCMHA/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 NMRE/AVCMHA/SUD Provider Compliance Director will notify the NMRE/AVCMHA/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 NMRE's CEO will seek legal counsel or other resource prior to taking action.

III. DOCUMENTATION

A record will be maintained by the NMRE/AVCMHA/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.

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, 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."

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.

Compliance Investigation Report Form

Source of the Complaint (Name/Agency): ____________________

Date of Complaint: ____________________

Medicaid ID Number (if applicable): ____________________

Provider (if applicable): ____________________

Describe Reported Issue: (Provide specific information – dates of events, actions taken, estimated dollar amount. Attach additional documentation, if needed.)

____
____
____
____
____
____
____
____
____
____

Findings/Outcome of the Investigation: (Include description of disclosures, the investigative process followed and conclusion/findings/outcome of the investigation.)

____
____
____
____
____
____
____
____

Recommendations and Plan of Correction (if necessary) (Include any plan of action needed based on the outcome of the investigation.)

____
____
____
____
____
____
____
____
____

Does this investigation need to be reported to: NMRE: Yes ☐ No ☐ MDHHS-OIG: Yes ☐ No ☐
If Yes, date reported issue to NMRE/MDHHS-OIG: ____________ Reported By: ____________________
Name and title of the individual completing the investigation: ____________________
Signature of Investigator: ____________________ Date investigation completed: ____________

COMPLIANCE PLAN

AVCMHA Quality Department Policy

APPROVED: 02102021

REVISED:

02102021

Diane C. Pelts, MA
Chief Executive Officer
AuSable Valley CMHA

Date