Community Behavioral Health

Compliance Matters

Spring 2016

In this issue:

Donna's Desk

This issue marks the fourth edition of Compliance Matters. Thanks to everyone for the positive feedback and ideas for future topics. The spring edition features articles that highlight the importance of an agency's compliance plan – the foundation of your compliance program. An effective compliance plan should be designed, implemented, and enforced with the goal of prevention, detection, and resolution. Consider your compliance plan a "living" dynamic document that articulates your agency's commitment to quality assurance and compliance processes. We hope that you continue to find our features informative and as always, please feel free to reach out to us.

Sincerely,

Donna E.M. Bailey
Chief of Staff & Compliance Officer

¡POP QUIZ!

Winter Issue Answer:

The Federal False Claims Act dates to the Civil War and the Lincoln Administration. In fact, it is often referred to as the "Lincoln Law." After an extended period of relative dormancy because of changes to the act, Congress dusted off the Act during the 1980's in order to combat a new round of perceived fraud by military contractors during the Cold War. The 2010 passing of the Affordable Care Act brought revisions related specifically to healthcare compliance.

Spring Issue Question:

What are the three exclusion lists that CBH providers are required to check monthly?

**Answer will appear in the Summer 2016 issue.

Staff Roster Requests

Earlier this year, the Network Provider Analysis Unit (NPAU) forwarded an e-mail and staff roster template for providers to complete and return. The due date for the completed staff rosters was March 25, 2016. If your agency has not yet returned a completed staff roster, you may have already received a call from your Provider Relations Representative and/or Compliance staff requesting its prompt submission. Some providers have raised questions as to why this is necessary; particularly given that NPAU staff comes out regularly to review staff files and rosters. There are several reasons why this process is important (and will be repeated).

While NPAU staff do attempt to check-in with every provider at regular intervals, the reality is that some providers may go for extended periods of time without having a review of their delegated credentialing responsibilities. This makes it impossible to provide basic analytics of provider capacity, needs, and strengths related to staffing for any point in time.

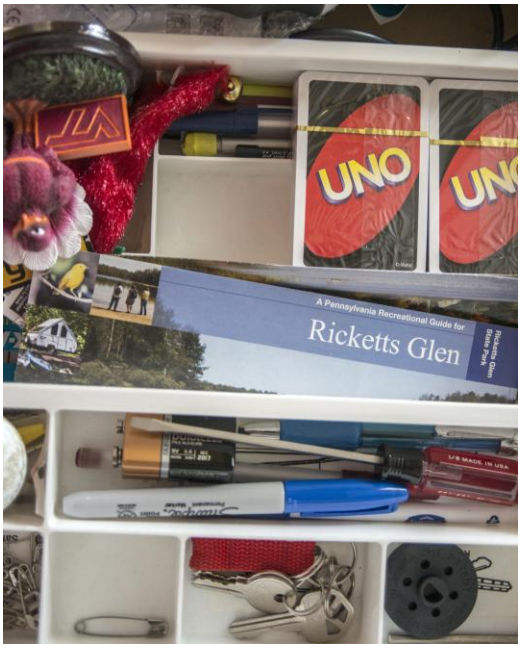
The need to quickly assess network capacity is critical when providers leave the network and when agencies are closed to new admissions. In order to effectively steer our members to agencies that are able to absorb new clients, we need to be able to quickly assess provider's overall staffing levels.

Finally, while we take our responsibility to provide Compliance education seriously, another undeniable role that we must play as stewards of public funding, is to ensure that potential 'bad actors' are identified and investigated. Without a snapshot of where staff are employed in the network, makes this task quite difficult. Having a listing of all staff utilized in the network, at a given point of time, provides us a starting point to quickly investigate these potential bad actors at all of their places of employment. Hopefully, this will also mitigate financial impacts to our providers - the faster we are able to identify and deal with these individuals, the less likely an agency's billing will be impacted.

For more information on the staff roster request, please visit the DBHIDS website and

MRPFF Madness!

From the Junk Drawer…



Where did I put that deck of Uno cards? Do we have batteries for the flashlights? Aw, come on we have rubber bands somewhere, right?

Where do you put important things that just don't seem to have a logical storage place? For most people, they end up in a drawer somewhere in the kitchen. Though, to be fair, sometimes they may occupy multiple drawers in multiple rooms depending on your reluctance to part with things. That is for a hoarding article in a clinical newsletter though.

Beginning with this edition, Compliance Matters will feature a recurring column where we will highlight shorter articles, updates, or summaries of important happenings in the world of CBH Compliance. If, at any point, you would like a longer article or additional information on a junk drawer item, please let us know!

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IOP Claims Edit

CBH Provider Bulletin 16-02 informed our providers that a new claim edit was being implemented as of March 14, 2016 related to Intensive Outpatient (IOP) services. The claim edit would cap the number of billable hours per week, per recipient at 9.75. Any claim(s) attempting to bill for over 9.75 hours per week will reject. For additional information on the new claims edit, please refer to the Bulletin on the DBHIDS website (under the CBH Provider Bulletins tab).

Changes to CBH Compliance Practice – Provider Notice

On March 9, 2016, a Provider Notice was published that highlighted two important changes in the standard practices of CBH Compliance related to audits. The first is a reduction in time that providers have to submit missing documentation. CBH audit teams will leave a list of all missing documents with the provider at the conclusion of each audit day. Historically, providers have been given until 5PM the following day to submit missing documentation. Effective April 8, 2016, providers will have until 10AM of the day following the audit to submit missing documentation.

The second change relates to the submission of new claims for errors related to incorrect date or incorrect service type/level of care. Historically, providers have been able to submit corrected paper claims for these error types. Effective April 8, 2016, this will no longer be allowed.

For additional information on these changes, please refer to the March 9, 2016 Provider Notice available on the DBHIDS website (under the CBH Provider Notices page)

CBH Compliance Staff Shine

CBH Compliance Team Leader Gretchen Murchison recently sat for and passed her Certified in Healthcare Compliance (CHC) exam. Gretchen, who had already had MBA and LCSW designations in her signature, now adds the CHC in her quest to have every letter represented in her signature!

Compliance Analyst Nary Kith successfully defended her thesis and completed her Doctorate in October, 2015. Shortly after that, newly minted Dr. Kith won a DBHIDS-wide cook-off with her Banana Egg Rolls and Ice Cream creation.

Former Compliance Operations Specialist Kate "KFox" Fox accepted a promotion to join CBH's Performance Evaluation, Analytics, and Research (PEAR) team. Kate, our self-appointed Editor in Chief, has been the prime force behind making Compliance Matters a reality. We plan to lure KFox back to Compliance Matters for editorial consultation. In fact, if you are reading this and the columns are lined up, we were successful in our first attempt.

CONFIDENTIALLY REPORT FRAUD, WASTE, and ABUSE.
1-800-229-3050 or
CBH.ComplianceHotline@phila.gov

It's Elementary…

Compliance Matters will use this column to publish an article each quarter regarding one of the seven core elements of a successful compliance program, as outlined by provisions in the Patient Protection and Affordable Care Act 42 U.S.C. § 18001 (2010)

Murder She Wrote just happens to be one of my all time favorite shows. I can't get enough of retired school teacher, turned mystery writer, turned super sleuth and heroine, J.B. Fletcher. I have DVDs of the first 6 seasons and mocked though I am by family and friends, I jump at the chance to watch a Saturday afternoon marathon. Maybe it's her keen attention to detail, or perhaps her uncanny way of picking up on the most nuanced clues, Jessica Fletcher always gets to the bottom of the mystery, saving some poor innocent from an inept or overzealous sheriff, constable, or lieutenant depending on the locale.

Like J.B., you may be faced with the same kind of conundrums when it comes to your agency's compliance program. Where do you start? Who's Involved? What does it all mean? In the last issue of *Compliance Matters*, we introduced the first of the seven essential components of a compliance plan – Standards and Procedures. Think of these as your blueprints that help frame your agency's quality standards, ethical boundaries, and organizational culture, or in the world of Hallmark Mysteries, clues that help guide and inform your sleuthing.

The second essential component, and focus of this month's column, is program oversight. Program oversight is about both structure and accountability. Every agency should have someone, or some organizational body, or combination of both, tasked with implementing and overseeing the compliance plan. There is no one size fits all design when it comes to the structure of compliance governance; this may depend on the size and scope of your organization, staffing constraints, and other organizational considerations. One thing is certain – support and buy-in from the board of directors and senior staff is essential. And, ***someone*** must be responsible for the day in/day out quality assurance and compliance activities related to both your clinical services and your business practices. This gets to the accountability piece.

At CBH, we have a multi-pronged approach. The CBH Compliance Committee reports all provider related activities to the Compliance Committee which is comprised of CBH and DBHIDS senior management. The CBH Compliance Department also works closely with CBH's Privacy Officer, Security Officer, Human Resources and the Ethics Committee to support an aligned and coordinated approach to our overall internal compliance activities. And then there's me – the Compliance Officer. It's only been a year, but I can honestly say it's been fun. *Really!* I review and approve policies and procedures and training curricula (my redlined track changes are not popular); have lots of meetings with our legal eagles; report to our CEO and Board of Directors on our annual compliance work plan; work with all the CBH departments on ways to enhance our internal controls; and monitor the effectiveness of our overall compliance program. And did I mention, work with a top notch Compliance Team (I promised I would work that in somehow). While my days are not full of high intrigue and suspense, (well sometimes they are), I have the awesome responsibility of helping to shape not only our compliance program, but also our culture.

Whether you have a full time staff position dedicated to oversight of your agency's compliance program, or the work is part of a staffer's portfolio of activities, having a point person, ideally with the inquisitiveness and doggedness of J.B. Fletcher, is well worth the investment. Mystery solved.

Donna E.M. Bailey, Chief of Staff & Compliance Officer

The Clock is Ticking:
60 Day Rule

The 2010 passage of the Affordable Care Act (known in its entirety as the Patient Protection and Affordable Care Act), and subsequent Supreme Court decision affirming its legality attracted significant attention from media, political observers, and the general public. While much of the publicized portions of the Act were related to its access provisions (individual mandate, health care exchanges, and Medicaid expansion), it also included language that creates significant impact on the areas of healthcare delivery and finance, affecting healthcare providers and payers in significant ways.

One provision with widespread ramifications included in the Act requires Medicare overpayments to be reported and returned by the later of:

(A) the date which is 60 days after the date on which the overpayment was *identified*; or
(B) the date any corresponding cost report is due, if applicable

This has commonly become referred to as the 60-day rule (42 U.S.C. 1320a-7k). This provision also essentially makes retention of any Medicare overpayments beyond the 60 days a violation of the False Claims Act.

The significant ambiguity in the Act, effectively turning each possible case of overpayment on its face, was how the term "identified" was defined. Following numerous requests for clarification and a whistleblower lawsuit in August 2015 that placed the definition of 'overpayment' squarely at issue in the Southern District Court of New York, the Centers for Medicare and Medicaid Services (CMS), in February 12, 2016, published a final rule, with comments addressing many concerns. The final rule became effective on March 14, 2016.

The final rule articulates that an overpayment is identified when a person "has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment." (Medicare Program: Reporting and Returning of Overpayments, 81 Fed. Reg. 7654, 7684 (Feb. 12, 2016). In order to avoid imposing unreasonable burdens, CMS also restricted the period of time that a provider would have to 'lookback' to find an overpayment to 6 years. To date, this provision applies only to Medicare; however, some believe that it is only a matter of time before the 60-day rule will be extended to the Medicaid program.

This poses a significant stress on any healthcare providers' compliance and quality assurance programs. While only time will tell if CMS will propose additional changes or issue policy clarifications or guidance, one point seems certain: the clock is ticking for providers to review their agency's overall compliance plan and to act proactively to identify and remedy compliance issues, and have a clear process in place to quickly investigate and report potential overpayments.

Is it time for you to develop or enhance your agency's compliance plan?

Centers for Medicare and Medicaid Services' Ruling, February 2016:

https://federalregister.gov/a/2016-02789

1 + 1 = 10 (Part One)

No, this is not an article on the failings of my West Virginia public education or my admitted lack of math skills. This is the first in a series of articles on the use of Statistically Significant & Random Samples (SSRS) and Extrapolation. For many of our providers who deal with Medicare audits, this is old news. But, for some of our providers, this is a potential game changer. Even for those accustomed to dealing with Recovery Audit Contractors employed by CMS to complete Medicare audits, there are some important distinctions between CBH's planned use of SSRS and extrapolation and its use elsewhere.

In this issue, we will touch briefly on a history of SSRS, why CBH feels that now is the right time to implement its use with Compliance Audits, and a roll-out timetable. Next issue we plan to discuss the nuts and bolts of how we will implement our SSRS and extrapolation audits.

The use of SSRS and extrapolation has been used by CMS since the last century. Granted, the last century was only 16 years ago, but still, this represents 30+ years of experience. Over that time, the use of SSRS and extrapolation has been challenged and repeatedly courts have determined it to be allowed. This includes cases dating to at least 1982 (Illinois Physicians Union v. Miller). In fact, many states, including the Commonwealth of Pennsylvania, utilize SSRS and Random Sampling as do some of our peer Behavioral Health Managed Care Organizations. In a sense, CBH has been late to arrive to the extrapolation party. While most reading likely would prefer we just stay home and watch some 'Nova hoops or Phillies baseball, the time has clearly come to utilize SSRS and extrapolation in our compliance toolkit.

Why now? Partially, an answer is to simply catch up with others. The Commonwealth noted the deficiency related to not having a clear plan to utilize SSRS and extrapolation on our most recent audit (2014). But two other factors are also as important as simply not being the odd BH-MCO out.

First, some providers, unfortunately, seem to have adopted a "Compliance is simply a cost of doing business event". We make this determination based on providers who year after year have elevated error rates and repeat the same basic errors. A portion of any compliance activity must be deterrence of future violations. Clearly, for many, the previous standard was NOT deterring future violations and spurring changes in practice.

Second, a fundamental goal of our Compliance efforts for at least the last 5 years has been to educate our providers about relevant compliance issues, trends, and practices. This newsletter is an example of that effort that had started with in-person meetings with providers following their audits and our extensive use of routine auditing. We do you, our providers, no favor by continuing to not use extrapolation and SSRS. The effort to combat Fraud, Waste and Abuse has taken a more prominent role in Federal and Commonwealth lawmaker's minds. We believe strongly that this trend will continue. Our planned use of SSRS and extrapolation will begin with relatively controlled samples. In doing so, we hope to mitigate the financial impacts of these audits while still exposing and educating our providers about the use of SSRS and extrapolation. For example, we will only utilize SSRS and extrapolation for claims dating back 2 years. To expand that look back period would require prior CBH Compliance Committee approval. The Federal government can look back as far as 6 years.

We plan to issue a formal bulletin to the CBH provider network by May 1, 2016. Implementation would then be planned for June 1, 2016. Implementation would commence for large targeted audits only. Routine audits are NOT subject to SSRS and extrapolation at this time. In the time leading up to the issuance of the draft billeting on May 1, we will be communicating with our providers in a number of forums. In fact, this has already begun. As we move forward, please submit questions, concerns, or thoughts to us through the Compliance Department's e-mail at cbh.compliancecontact@phila.gov

Next issue we will tackle the nuts and bolts of how it works, including our commitment to ensuring that our providers can replicate every phase of the audit from sample selection to file review. Clearly though, now is the time to review your agency's overall compliance plan and self-audit processes.

Ken Inness, Director of Compliance

In the next issue:

- Compliance Training & Education
- 1+1 = 10 (Part TWO!)
- More Junk Drawer
- Puzzling

Suggestions for future Compliance Matters features?

Contact Kenneth Inness at Kenneth.Inness@phila.gov