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DIVISION OF MENTAL HEALTH SERVICES

ADMINISTRATIVE BULLETIN TRANSMITTAL MEMORANDUM

DATE ISSUED: September 2, 2008 EFFECTIVE DATE September 15, 2008

SUBJECT: Administrative Bulletin 7:23
Federal Deficit Reduction Act of 2005, Section 6032 – Policy on Compliance

The attached Administrative Bulletin is being forwarded for your review, action if necessary, and distribution to staff as appropriate. Please be advised that each recipient of this Bulletin is responsible for being familiar with the content and ensuring that all affected personnel adhere to it. Also attached is a revised Administrative Bulletin Index for your Manual.

Kevin Martone
Assistant Commissioner

KM:pjt
Attachment

DIVISION OF MENTAL HEALTH SERVICES

ADMINISTRATIVE BULLETIN 7:23

DATE ISSUED: September 2, 2008 **EFFECTIVE DATE: September 15, 2008**

I. **TITLE: Federal Deficit Reduction Act of 2005, Section 6032 Policy on Compliance**

II. **PURPOSE:** The purpose of this Administrative Bulletin is to establish policies and procedures for all employees and contractors or agents in regard to the Deficit Reduction Act of 2005 and to provide detailed information about compliance with the requirements of the act.

III. **SCOPE:** This Bulletin applies to the Division Mental Health Services' (Division) state regional psychiatric hospitals participating in the Medicaid program and contractors or agents that provide Medicaid health care items or services to the hospitals.

IV. **POLICY:** Section 6032 of the federal Deficit Reduction Act of 2005 (Public Law 109-171) that requires certain governmental, for-profit and non-profit providers and other entities that receive Medicaid funding to take actions that will address fraud, waste and abuse in health care programs that receive federal funds. It is the policy of the Division of Mental Health Services (DMHS) to be in compliance with the federal and state laws and regulations related to the Deficit Reduction Act, the federal False Claims Act, and the New Jersey Conscientious Employee Protection Act. (See Administrative Bulletin 7:22, Deficit Reduction Act of 2005, Policy on Fraud, Waste and Abuse.)

V. **DEFINITIONS**

1. Chief Compliance Officer- the fiscal officer of the Division of Mental Health Services will function as the chief compliance officer for purposes of this Bulletin.

2. Claim- for purposes of this Bulletin means any request or demand for money that is submitted to the federal government or to its contractors under the Medicaid program.

3. Compliance Committee- the committee in conjunction with the chief compliance officer charged with the implementation of the policies in this Bulletin. The committee is a Division level group with representatives from each of the regional hospitals that are the subject of this Bulletin.

4. Compliance Liaison – regional hospital representative that is a member of the compliance committee.

5. Contractors or Agents – providers that contract with the Division of Mental Health Services to provide health care services or medical equipment or supplies for the regional hospitals as defined in this Bulletin.

6. Department- means Department of Human Services.

7. Division of Mental Health Services – referred to in this Bulletin as Division.

8. Hospital – for purposes of this Bulletin, means the regional psychiatric hospital defined in this section.

9. Regional psychiatric hospitals – means those state psychiatric hospitals listed in N.J.S.A. 30:1-7 which are being utilized by the Division to treat adult psychiatric patient within designated regions of the State. These facilities are Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital, Trenton Psychiatric Hospital and Senator Garrett Hagedorn Psychiatric Hospital.

VI. GENERAL STANDARDS:

A. Compliance Monitoring Elements:

The compliance program for the Division contains the following elements:

1. This Administrative Bulletin (AB) as well as AB 7:22 constitute the written procedures that define the Division's compliance policies. These Bulletins and the established Treasury and Division audit procedures incorporated within address specific areas of potential fraud and financial relationships with physicians and other health care professionals.

2. The chief fiscal officer of the Division is appointed as the compliance officer charged with the responsibility of operating and monitoring the compliance program in conjunction with a Division compliance committee. The Chief Compliance Officer will report directly to the Assistant Commissioner.

3. The development and implementation of regular, effective education and training programs for all affected employees.

4. The utilization of the existing DMAHS hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

5. The enhancement of the existing internal control policies described in section VI, B number 4 of this Bulletin to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.

6. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area.

7. The investigation and remediation of identified systemic problems and the non-employment or retention of sanctioned employees.

B. Compliance Program Areas:

This Bulletin and AB 7:22 define the procedures for monitoring, auditing, reporting and resolving potential and actual claims of Medicaid fraud, waste and abuse. This Bulletin confirms established internal control processes required by OMB/Treasury and the Department.

1. **Standards of Conduct** – The standards in this Bulletin apply to all Division and regional psychiatric hospital employees and include applicable providers.

2. **Risk Areas** – Each hospital has their own established policies and procedures to ensure that the following objectives are achieved. These policies and procedures take into consideration the regulatory exposure of each function or unit of the facility, such as:

   a. Billing for items or services not actually rendered;
   b. Providing medically unnecessary services;
   c. Duplicate billing;
   d. Accurate records to prevent the preparation of false cost reports;
   e. Unbundling of billing claims;
   f. Patient's freedom of choice;
   g. Financial arrangements between facilities and providers that violate the anti-kickback statute or other similar Federal or State statute or regulation;
   h. Joint ventures; and
   i. Knowing failure to provide covered services or necessary care to patients.

3. **Additional Risk Areas** – These should be assessed as well by facilities and incorporated into written policies and procedures and training elements developed as part of their compliance programs.

   a. Claim development and submission process;
   b. Cost Reports and underlying documentation;
   c. Medical necessity – reasonable and necessary services;
   d. Anti-kickback and self referral concerns;

e. Bad debts;
f. Credit balances;
g. Retention of records; and
h. Compliance as an element of a performance plan.

4. **Internal Control Policies and Certification Process**

The system of internal accounting and administrative control of the Division provide the following monitoring functions through the structure described in this section:

- A clear organizational structure, with delineation of levels of authority and accountability and assigned responsibilities;
- Personnel who enforce supervision and review procedures, with timely measurement of results;
- Ongoing evaluation of organizational performance;
- Review to confirm that obligations and purchases are in compliance with applicable law;
- Monitoring to ensure that funds, property and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation;
- Monitoring of the Division's funds and other assets to confirm proper management, accounting and safeguarding against waste, loss, unauthorized use, or misappropriation in accordance with applicable Federal and State laws, regulations, policies and procedures;
- Monitoring of revenues and expenditures applicable to agency operations to ensure that funds are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the assets;

Treasury Circular Letter 03-08 delineates the requirements for each Department's annual Certification of Internal Controls. The purpose of this circular is to require an annual self-assessment of internal controls by State executive branch agencies. This self-assessment helps managers evaluate internal controls and identify possible deficiencies within their areas of responsibility. Such an effort should lead to the implementation of more effective controls before problems arise.

DMHS Certification

DMHS has an established process for internal controls through the requirement of the certification process in the Treasury Circular. There is a designated Internal Control Coordinator who oversees the completion of the annual Certification. Instructions are issued to the Coordinators at each of the four (4) State regional psychiatric hospitals and the Division's Central Office. The internal control coordinator reports to the chief financial officer of the Division. Each of these components then conducts its own internal controls assessment to identify material weaknesses within its operations.

Part of this assessment is through use of Treasury's annual Questionnaire comprised of over 400 questions. The questionnaire is designed to cover all operational areas of an agency. The Office of Management and Budget (OMB) each year identifies several particularly vulnerable areas of the questionnaire which must be thoroughly evaluated as to the adequacy of controls.

Hospitals are also subject to review from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS). Results and recommendations from these bodies are closely addressed in the timeliest manner possible. These issues are considered as part of each hospital's individual Internal Control Certification process.

The final product of this process, an Internal Control Self-Assessment Report and Certification signed by the hospital Chief Executive Officer, is submitted to the Assistant Commissioner on or about May 31 each year. After consideration of all Reports from Division components, the Assistant Commissioner submits a Division-wide Certification to the Department of Human Services. Finally, the Department's Commissioner submits a Department-wide Certification to the Director of Treasury's Office of Management and Budget on or before July 1, annually.

5. **Audit Monitoring Process**

For any Department or agency, auditors have a direct role in examining the adequacy and effectiveness of internal controls. They also have a responsibility to recommend improvements. For both internal auditors within the Department and external auditors from various agencies, it is essential that agreed upon recommendations for corrective actions be taken as quickly as possible and monitored to ensure effectiveness.

The Division has internal procedures for evaluating and following-up on all Audit Report findings and recommendations. The Division's Central Office is responsible for the regular monitoring of hospital efforts to address audit recommendations. Management reports are periodically prepared to illustrate the status of corrective actions being taken by each hospital. The results of individual

audits are shared with the other hospitals. This allows each facility to evaluate whether certain findings reported elsewhere may be applicable to their own operation. It also enhances the Division's efforts to address recommendations and improve procedures and controls as consistently as possible across the hospital system.

C. Designation of a Compliance Officer and a Compliance Committee

Each regional psychiatric hospital will designate a compliance liaison to serve as the focal point for compliance activities in the hospital. The compliance liaisons will constitute the members of a Division compliance committee to assist in the implementation of the compliance program in this Bulletin.

The Compliance liaison shall have authority to review all documents and other information held by the Division or contracted providers or sub-providers that are relevant to Division compliance activities, including but not limited to: client records, billing records, employee records, contracts, policies and procedures.

1. Compliance Officer - The Division shall appoint its Chief Fiscal Officer as the Compliance Officer whose responsibilities shall include:

    a. Coordinating with the compliance liaisons from each of the hospital facilities.
    b. Overseeing and monitoring the implementation of the compliance program;
    c. Reporting on a regular basis to the Assistant Commissioner and compliance committee on the progress of implementation, and assisting these components in establishing methods to improve the Division's efficiency and quality of services, and to reduce the Division's vulnerability to fraud, abuse and waste;
    d. Assisting the Division's financial management in coordinating internal compliance review and monitoring activities as part of the internal auditing cycle for purposes of certification described in Section B.4. of this Bulletin as required under existing policies;
    e. Working with the quality assurance staff for purposes of initiating investigations and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations (e.g., responding to reports of problems or suspected violations) and any resulting corrective action with all Division components, providers and sub-providers agents and, if appropriate, independent contractors; and
    f. Assisting as needed in the development of policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

2. Compliance Committee: The committee's functions should include:

   a. Analyzing the Division's industry environment, the legal requirements with which it must comply, and specific risk areas;
   b. Assessing existing policies and procedures that address these areas for possible incorporation into the compliance program;
   c. Working with appropriate Division components to develop standards of conduct and policies and procedures to promote compliance with the Division's services;
   d. Recommending and monitoring, in conjunction with the relevant departments, the development of internal systems and controls to carry out the Division's standards, policies and procedures a part of its daily operations;
   e. Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential violations, such as through hotlines and other fraud reporting mechanisms; and
   f. Developing a system to solicit, evaluate and respond to complaints and problems.

3. Compliance Liaisons:

   Each state regional psychiatric hospital through the existing quality assurance staff and the analysts in the fiscal office shall designate a compliance liaison designated to implement new policies and review existing internal control policies in order to promote compliance and to provide oversight for the Medicaid funded services at the Division. The Compliance Liaison shall assist the Division Compliance Officer in:

   a. The implementation of Compliance Program elements and initiatives.
   b. The investigation and correction of compliance related issues.
   c. The communication of the Compliance Program to employees and contractors.

D. Conducting Effective Training and Education

1. Education - Each Division component is required to ensure that employees receive information regarding reporting Medicaid fraud, waste and abuse. Employees shall receive the information contained in Administrative Bulletin 7:22, "Federal Deficit Reduction Act of 2005, Policy on Fraud, Waste and Abuse" and the Division's Standards of Conduct.

   a. New employees shall receive the information contained in the Administrative Bulletin within 30 days of hire.
   b. Employees involved with compliance activities and risk areas may attend relevant training as warranted.

2. Developing Effective Lines of Communication:

   a. Access to Division's Compliance Officer - each employee shall be made aware of the name, address, phone number and email address of the Division's Compliance Office via the educational material.
   b. Hotlines and Other Forms of Communication - each employee shall be made aware of the Department of Human Services Medicaid Fraud Hotline.

3. Enforcing Standards through Disciplinary Guidelines:

   a. Employees who do not comply with the policies and procedures or who have otherwise engaged in wrongdoing shall be subject to disciplinary action as described in DHS Administrative Order 4:08, "Disciplinary Action Policies and Responsibilities".
   b. New employees may be subject to background checks for criminal convictions and/or who are listed as debarred, excluded or otherwise ineligible for participation in Federal health care programs in accordance with these policies.

4. Auditing and Monitoring:

   a. Ongoing evaluation should occur to ensure compliance either via routine audits of the Division's systems or other methods such as the Division's Internal Controls process as described in Administrative Bulletin 9:03 and OMB/Treasury Circular 03-08.
   b. Methods of monitoring may include on-site visits, interviews with staff or contractors, questionnaires, DHS Licensing inspections, reviews of policies and procedures, trend analysis or other methods as deemed appropriate by the Division's Compliance Officer.

5. Responding to Detected Offenses and Developing Corrective Action Initiatives:

   a. Violations and Investigations – A system for receiving reports of alleged offenses and investigation of offenses shall be established by the Division's Compliance Officer.
   b. The Compliance Officer shall initiate steps to investigate the allegations, including but not limited to reporting the allegation to the Department of Human Services or law enforcement, as warranted.

Kevin Martone
Assistant Commissioner

Date 9/2/2008