North Sound Behavioral Health
Administrative Services Organization

Board of Directors

Meeting Agenda

October 12th, 2023

Board of Directors Members Present in Person:

Members Present via Zoom:

North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO) Staff Present:

Guests Present:

1. **Call to Order and Introductions** – Chair

2. **Tribal Acknowledgement** – Chair
   Tribal Behavioral Health | North Sound BH-ASO (nsbhaso.org)

3. **Revisions to the Agenda** – Chair

4. **Approval of the September 14th, 2023, Minutes, Motion #23-55**
   Chair..... Attachment

5. **Comments & Announcements from the Chair**

6. **Reports from Members**

7. **Comments from the Public**

8. **Annual Compliance Training**.....Attachments
   Charles DeElena, Compliance Officer, NS BH-ASO

9. **Report from the Advisory Board** (Available at Meeting) ..... Attachment

10. **Report from the Finance Officer** (Available at Meeting) ..... Attachments

11. **Report from the Governance Operations Committee**

All matters listed with the Consent Agenda have been distributed to each Member for reading and study, are considered to be routine, and will be enacted by one action of the Board of Directors with no separate discussion. If separate discussion is desired, the item may be removed from the Consent Agenda and placed on the Regular Agenda by request of a Member.

Consent Agenda (Available at Meeting) .....Attachment

Motion #23-56

- To review and approve the North Sound Behavioral Health Administrative Services Organization claims paid from September 1st, 2023, through September 30th, 2023, in the amount of $4,35,222.06. Payroll for the month of September in the amount of $179,489.75 and associated employer benefits in the amount of $84,994.48.

12. Action Items

For Board Approval

Health Care Authority (HCA)

This is the continuing contract for Projects for Assistance in Transition from Homelessness (PATH). This is an outreach program targeting individuals with a serious mental illness who are unhoused. The annual funding for this service is $219,026.

The continuing contract for Peer Pathfinder Homeless Outreach Programs. Funding is used to support outreach and engagement services for those who are, or who are at risk of homelessness and have or are suspected to have an Opiate Use Disorder and/or stimulant use disorder. The annual funding for these services is $117, 207.

Motion #23-57

- HCA-North Sound BH-ASO-PATH-23 for the purpose of funding PATH services in Snohomish County. The contract term is October 1, 2023, through September 30, 2024.

Motion #23-58

- HCA-North Sound BH-ASO-K6453-23 for the purpose of providing peer pathfinder services in Whatcom County. The term of the contract is September 30, 2023, through September 29, 2024.

***

The following two contracts are the downstream contracts for PATH and Peer Pathfinder services.

Bridgeways

Bridgeways is the provider of PATH services in Snohomish County. The annual funding amount is $219,026 of grant funding and $73,000 in State funds for case management services for a total of $292,034.

Motion #23-59

- North Sound BH-ASO-Bridegeways-PATH-23 for the purpose of providing PATH outreach and case management services in Snohomish County. The term of this agreement is October 1, 2023, through September 30, 2024, based on continued compliance with the terms of the contract.

***

Lifeline Connections
Lifeline Connections is the provider of Peer Pathfinder Services. The annual funding for this contract is $117, 207.

Motion #23-60

- NS BH-ASO-Lifeline Connections-FBG-23 Amendment 1 to provide funding to the Peer Path Finder services under this contract. The contract term is January 1, 2023, through December 31, 2023, with an automatic one-year renewal on January 1, 2024, based on continued compliance with the terms of the contract.

***

North Sound BH-ASO Administrative Budget Amendment
These are the factors requiring a budget amendment-

- Skagit County will not pay our warrants if our budget revenues and expenses are not balanced.
- Significant expenses, such as IT servers, repayment of 650K+ of Recovery Navigator Program (RNP) funds to HCA and professional services for recruitment and a needs assessment are major factors.
- We also received new revenue in the amount of $550K, from the Department of Commerce (DOC) Grant which needs to be noted in the budget.
- The ASO has the funds to cover the expenses, we only need to amend our budget to show the Skagit County Treasurer the funds are available to pay our bills. We are requesting $2M to be moved from reserves, $650K of restricted funds from the RNP, $550K from new revenue (DOC) and $800K from unrestricted reserves.

Motion #23-61

- To approve the transfer of $2,000,000.00 from reserves, $650,000.00 from RNP restricted reserves, $550,000.00 from Department of Commerce revenue and $800,000.00 from unrestricted reserves.

***

North Sound BH-ASO Investment Agreement
The Skagit County Investment Pool (the SKIP) is an investment pool consisting of public funds offered by the Skagit County Treasurer and authorized under RCW's 36.29.020, 36.29.022 and 36.29.024. Participants of the investment pool may include, but not limited to, county departments, and Junior taxing districts. North Sound BH-ASO has been a member of the pool for several years. The county has changed its investment firm and has updated the operating agreement which requires Board action for our continued participation.

The Skagit County Treasurer's office charges pool participants a fee representing administration and recovery costs associated with the operation of the pool. In accordance with RCW 36.29.024, this fee is intended to reflect the Skagit County Treasurer's actual direct expense and out-of-pocket cost of administering the pool.

- Skagit County Treasurer requires a Board resolution/motion to state the following:
  - North Sound BH-ASO Board of Directors hereby authorizes the contribution and withdrawal of North Sound BH-ASO monies in the SKIP in a manner prescribed by law, rule and the SKIP Operating Terms and Conditions; and
  - North Sound BH-ASO Board of Directors shall appoint investment officers, identified as

follows:

- Kimberly Nakatani, Accountant (Primary)
- Shari Downing, Accounting Specialist (Secondary)

Motion#23-62

- To authorize North Sound BH-ASO to enter into an agreement with SKIP for investments of North Sound BH-ASO public funds.

Motion#23-63

- To authorize the appointment of a primary and secondary Investment officer for the purpose of SKIP.

13. Introduction Items

Recovery Cafés

North Sound has set aside American Rescue Plan Act (ARPA) funding for the region's Recovery Cafés. The funding is our ARPA Substance Abuse Block Grant and is a one-time funding allotment. The funding will be used for operational costs at all the cafés.
Below are the allocations:

- New Earth Recovery-Recovery Café Skagit $154,836
- San Juan County
  - Lopez Island Heart and Soul $25,777
  - San Juan Joyce L Sobel Family Resource Center/New Day Recovery Café $52,646
- Everett Recovery Café $121, 739

Motion#
North Sound BH-ASO-New Earth Recovery-PSC-23 to provide funding for the Recovery Café in Mount Vernon. The term of this agreement is October 1, 2023, through September 30, 2024, based on continued compliance with the terms of the contract.

Motion#
North Sound BH-ASO-Lopez Island Heart and Soul-PSC-23 to provide funding for the Recovery Café in Mount Vernon. The term of this agreement is October 1, 2023, through September 30, 2024, based on continued compliance with the terms of the contract.

Motion #
North Sound BH-ASO-Joyce L Sobel Family Resource Center-PSC-23 to provide funding for the Recovery Café in Mount Vernon. The term of this agreement is October 1, 2023, through September 30, 2024, based on continued compliance with the terms of the contract.

Motion #
North Sound BH-ASO-Everett Recovery Café-PSC-23 to provide funding for the Recovery Café in Mount Vernon. The term of this agreement is October 1, 2023, through September 30, 2024, based on continued compliance with the terms of the contract.

14. **Report from the Executive Director**..... Attachment

15. Adjourn

Next Meeting: November 9th, 2023

North Sound Behavioral Health
Administrative Services Organization

Board of Directors

Meeting Minutes

September 14th, 2023

Board of Directors Members Present in Person:

- **Barry Buchanan,** County Council; Whatcom County
- **George Kosovich,** Public Health**,** Skagit County; designated alternate for Peter Browning, Commissioner

Members Present via Zoom:

- **Darcy Cheesman,** Legislative Aid, Snohomish County; designated alternate for Sam Low, County Council
- **Pat O'Maley Lanphear,** North Sound BH-ASO Advisory Board Chair
- **Jami Mitchell,** Human Services Manager, San Juan County; designated alternate for Jane Fuller, County Council
- **Nicole Gorle,** Legislative Analyst, Snohomish County; designated alternate for Nate Nehring, County Council
- **Perry Mowery,** Behavioral Health Supervisor, designated alternate for Satpal Sidhu, County Executive; Whatcom County
- **Cammy Hart-Anderson**, Human Services, designated alternate for Dave Somers County Executive, Snohomish County
- **Lynda Austin,** Human Services, designated alternate for Jill Johnson Commissioner, Island County
- **Sam Low,** County Executive; Snohomish County

North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO) Staff Present:

- **Darrell Heiner**, Senior Accountant, North Sound BH-ASO
- **Margaret Rojas,** Assistant Executive Director, North Sound BH-ASO
- **Michael McAuley,** Clinical Director, North Sound BH-ASO

- **Maria Arreola,** Senior Administrative Assistant, North Sound BH-ASO
- **Joanie Wenzl**, Administrative Manager/Clerk of the Board, North Sound BH-ASO

Guests Present:
JanRose Ottaway Martin

Call to Order and Introductions – Chair
The Vice-Chair called the meeting to order and initiated introductions.

Tribal Acknowledgement – Chair
Tribal Behavioral Health | North Sound BH-ASO (nsbhaso.org)
The Vice-Chair read the Tribal Acknowledgement

Revisions to the Agenda – Chair
The Vice-Chair asked if there were any revisions to the agenda. There were none mentioned.

Approval of the August 10th, 2023, Minutes, Motion #23-46 – Chair
George Kosovich moved the motion for approval (with the addition of Jane Fuller's name added to the August Minutes as an attendee via Zoom) Perry Mowery seconded the motion, all in favor no abstentions, motion #23-46 approved.

Comments & Announcements from the Chair
The Vice-Chair noted that he is anticipating JanRose beginning work at the ASO next week in the Executive Director capacity.

Reports from Members
Updates were given from the respective counties regarding the latest happenings around behavioral health and substance use disorder happenings.

Comments from the Public
No members of the public were present

Report from the Advisory Board
Pat O'Maley Lanphear gave the Report from the Advisory Board. Topics of discussion included the anticipated coordination and advocacy of the Advisory Board in the Opioid Abatement Council decisions regarding spending the settlement funds. Snohomish shared some opportunities for AB Member involvement.

Diversity, Racial Equity, and Inclusion (DREI) was also included in the AB Brief. Nominations for the 2024 AB Officers will be open in October. The Report from the Executive Director was also part of the AB meeting for September.

Report from the Finance Officer

Margaret gave the Report from the Finance Officer. She spoke about the Budget Amendment. She covered the other topics listed on the Finance Officer Report.

Report from the Governance Operations Committee

Motion approved to recommend payment of the August bills.

All matters listed with the Consent Agenda have been distributed to each Member for reading and study, are considered to be routine, and will be enacted by one action of the Board of Directors with no separate discussion. If separate discussion is desired, the item may be removed from the Consent Agenda and placed on the Regular Agenda by request of a Member.

Consent Agenda

Motion #23-47

To review and approve the North Sound Behavioral Health Administrative Services Organization claims paid from August 1st, 2023, through August 31st, 2023, in the amount of $2,636,795.93.

Payroll for the month of August in the amount of $174,526.10 and associated employer benefits in the amount of $84,827.32.

Cammy Hart-Anderson moved the motion, George Kosovich seconded, all in favor, none opposed, no abstentions. Motion #23-47 carried.

Action Items

For Board Approval

Conquer

Conquer was the successful bidder for the Assisted Outpatient Treatment (AOT) Request for Proposals (RFP) in the North Sound Region. Conquer will provide AOT services in Snohomish County. The annual funding is $902,994.

Motion #23-48

North Sound BH-ASO-Conquer Addiction-ICN-23 to provide AOT services in Snohomish County. The contract term is August 1, 2023, through July 31, 2024, with an automatic one-year renewal on August 1, 2024, based on continued compliance with the terms of the contract.

Cammy Hart-Anderson moved the motion for approval, George Kosovich seconded, no discussion, all in favor, no abstentions, none opposed, motion #23-48 carried.

***

Touchstone Behavioral Health

Touchstone Behavioral Health is a provider of youth services in Whatcom County. This contract is for youth outpatient services. The contract is a Fee for Service Contract.

Motion #23-49

North Sound BH-ASO-Touchstone Behavioral Health-ICN-23 to provide youth outpatient services in Whatcom County. The contract term is September 1, 2023, through August 31, 2024, with an automatic one-year renewal on September 1, 2024, based on continued compliance with the terms of the contract.

Barry Buchanan moved the motion, Perry Mowery seconded, all in favor, none opposed, all in favor, motion #23-49 carried.

***

Evergreen Recovery Centers
ERC is requesting funding to start up Substance Use and Mental Health Outpatient services in Skagit County. The request for one-time startup funds in the amount of $42,000.

Motion #23-50
North Sound BH-ASO-ERC-ICN-23 Amendment 2 for the purpose of providing $42,000 in one-time start-up funds for establishing outpatient services in Skagit County. The contract term is January 1, 2023, through December 31, 2023, with an automatic one-year renewal on January 1, 2024, based on continued compliance with the terms of the contract.
George Kosovich moved the motion, Perry Mowery seconded, no discussion, none opposed, all in favor, no abstentions, Motion #23-50 carried.

***

Professional Service Contracts
The following contracts are being presented for approval. These contracts are being renewed on a Federal Grant from Health Resources and Services Administration (HRSA) an agency of U.S. Department of Health and Human Services. The services provided are Medication Assisted Treatment and Opioid outreach to east and west Skagit County.

Mount Baker Presbyterian Church (MBPC)
The MBPC has been a partner in our opioid outreach program and our Federal Health Resources and Services Administration (HRSA) grant for Medication Assisted Treatment in east Skagit County. MBPC conducts outreach and engagement in the Concrete area and will be expanding into Sedro Woolley. The annual budget total is $125,000, $30,000 of HRSA grant funds and an increase of $95,000 in Federal Block Grant Funds.

Motion #23-51
North Sound BH-ASO-MBPC-PSC-23 to provide outreach and engagement to individuals struggling with their substance use and/or mental health. The contract term is September 1, 2023, through August 31, 2024, based on continued compliance with the terms of the contract.
George Kosovich moved the motion for approval, Jami Mitchell seconded, all in favor, no discussion, no abstentions, motion #23-51 carried.

***

Lifeline Connections
Lifeline provides Medication Assisted Treatment (MAT) and Nurse Care Managers. The annual funding for this contract is $89,500.

Motion #23-52
North Sound BH-ASO-Lifeline Connections-PSC-23 for the purpose of providing MAT services in east and west Skagit County. The contract term is September 1, 2023, through August 31, 2024, based on continued compliance with the terms of the contract.
Barry Buchanan moved the motion for approval, Cammy Hart-Anderson seconded, no discussion, all in favor, no abstentions, Motion #23-52 carried.

***

NW ESD 189
The NW ESD provides a prevention specialist in the Coupeville School District. The annual funding for this contract is $87,734.

Motion #23-53
North Sound BH-ASO-NW ESD 189-PSC-23 for the purpose of providing a prevention specialist in the Coupeville School District. The contract term is September 1, 2023, through August 31, 2024, based on continued compliance with the terms of the contract.
Lynda Austin moved the motion for approval, Perry Mowery seconded, all in favor, no abstentions, none opposed, motion #23-53 carried.

***

Compass Health
Compass Health provides a Mental Health Professional as a co-responder with the Skagit Sheriff's Department in east Skagit County. The annual for funding for this contract is $178,000, $89,000 in HRSA funds and $89,000 in Federal Block Grant Funds.

Motion #23-54
North Sound BH-ASO-Compass Health-PSC-23 for the purpose of providing a mental health professional as a co-responder with the Sheriff's Department in east Skagit County. The contract term is September 1, 2023, through August 31, 2024, based on continued compliance with the terms of the contract.
Jami Mitchell moved the motion, George Kosovich seconded, all in favor, none opposed, no abstentions, Motion #23-54 carried.

***

Introduction Items

Health Care Authority (HCA)
This is the continuing contract for Projects for Assistance in Transition from Homelessness (PATH). This is an outreach program targeting individuals with a serious mental illness who are unhoused. The annual funding for this service is $219,026.
The continuing contract for Peer Pathfinder Homeless Outreach Programs. Funding is used to support outreach and engagement services for those who are, or who are risk of homelessness and have or are suspected to have an Opiate Use Disorder and/or stimulant use disorder. The annual funding for these services is $117, 207.

Motion #XX-XX (introduction)
HCA-North Sound BH-ASO-PATH-23 for the purpose of funding PATH services in Snohomish County. The contract term is October 1, 2023, through September 30, 2024.

Motion #XX-XX (introduction)
HCA-North Sound BH-ASO-K6453-23 for the purpose of providing peer pathfinder services in Whatcom County. The term of the contract is September 30, 2023, through September 29, 2024.

***

The following two contracts are the downstream contracts for PATH and Peer Pathfinder services.

Bridgeways
Bridgeways is the provider of PATH services in Snohomish County. The annual funding amount is $219,026 of grant funding and $73,000 in State funds for case management services for a total of $292,034.

Motion #XX-XX (introduction)
North Sound BH-ASO-Bridegeways-PATH-23 for the purpose of providing PATH outreach and case management services in Snohomish County. The term of this agreement is October 1, 2023, through September 30, 2024, based on continued compliance with the terms of the contract.

Lifeline Connections

Lifeline Connections is the provider of Peer Pathfinder Services. The annual funding for this contract is $117, 207.

Motion #XX-XX (introduction)

NS BH-ASO-Lifeline Connections-FBG-23 Amendment 1 to provide funding to the Peer Path Finder services under this contract. The contract term is January 1, 2023, through December 31, 2023, with an automatic one-year renewal on January 1, 2024, based on continued compliance with the terms of the contract.

***

North Sound BH-ASO Administrative Budget Amendment

These are the factors requiring a budget amendment-

- Skagit County will not pay our warrants if our budget revenues and expenses do not balance.
- Significant expenses, such as IT servers, repayment of 650K+ of Recovery Navigator Program (RNP) funds to HCA and professional services for recruitment and a needs assessment are major factors.
- We also received new revenue in the amount of $550K, from the Department of Commerce (DOC) Grant which needs to be noted in the budget.
- The ASO has the funds to cover the expenses, we only need to amend our budget to show the Skagit County Treasurer the funds are available to pay our bills. We are requesting $2M to be moved from reserves, $650K of restricted funds from the RNP, $550K from new revenue (DOC) and $800K from unrestricted reserves.

Motion #XX-XX (introduction)

To approve the transfer of $2,000,000.00 from reserves, $650,000.00 from RNP restricted reserves, $550,000.00 from Department of Commerce revenue and $800,000.00 from unrestricted reserves.

The Introduction Items above were reviewed. It was noted that the items will come to the BOD for approval during the October Board Meeting.

Report from the Executive Director

- Annual BOD Member Response/RCW 43.160.040/Conflicts of Interest—Code of Ethics

Margaret Rojas noted that the ASO's Clerk of the Board will be sending out the annual Conflict of Interest/Code of Conduct Attestation Notices soon.
Members were encouraged to look for them in their email, fill out the brief questions and return them to Joanie.

The Report from the Executive Director was given by Margaret Rojas.
Topics included:

- Health Care Authority (HCA) Team Monitoring
- Opioid Abatement Council
- Western State Hospital & the Pechman Ruling Update
- Touchstone Behavioral Health
- ASO Funding
- 988/Regional Crisis Lines (RCL) Alignment
- Audits (HCA Fiscal Audit, State Auditor Audit)

Adjourn: 2:18 p.m.

Next Meeting: October 12th, 2023

North Sound BH-ASO
2021 E. College Way, Suite 101, Mt. Vernon, WA 98273
Phone: (360) 416-7013 Fax: (360) 899-4754
www.nsbhaso.org

10/2/2023

Re: Required Centers for Medicare & Medicaid Services (CMS) Trainings

Dear North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO) Board of Directors,

As stipulated in North Sound BH-ASO contracts with the five (5) managed care organizations (MCOs), all members of the North Sound BH-ASO Board of Directors and their alternates are required to complete the following Medicaid Fraud, Waste and Abuse training:

- Combatting Medicare Parts C and D Fraud, Waste and Abuse Training

North Sound BH-ASO will provide information on how to access the approved web-based training provided by Centers for Medicare & Medicaid Services (CMS). A pdf of the training will also be provided to all board members and their alternates as an alternative format. The deadline for completion is December 1, 2023.

Each individual will need to complete an attestation form attesting to the fact they completed the required training. Completed attestations may be submitted via email to compliance_officer@nsbhaso.org.

We thank you in advance for your attention to this matter. If you have any questions about the request, please contact me at compliance_officer@nsbhaso.org or by calling 360-416-7013.

Sincerely,

Charles DeElena MBA, MHA, CHC, PMP, CPHQ
North Sound BH-ASO Business Improvement Manager/Compliance Officer

Combating Medicare Parts C & D Fraud, Waste, & Abuse

Synopsis

In this 30-minute course, learn about fraud, waste, and abuse (FWA) laws and regulations, potential violation consequences and penalties, and how Medicare Part C and Part D employees can recognize and prevent FWA.

* Introduction
* Lesson 1: What's Fraud, Waste, & Abuse?
* Lesson 2: Your Role in the Fight Against Fraud, Waste, & Abuse
* Assessment

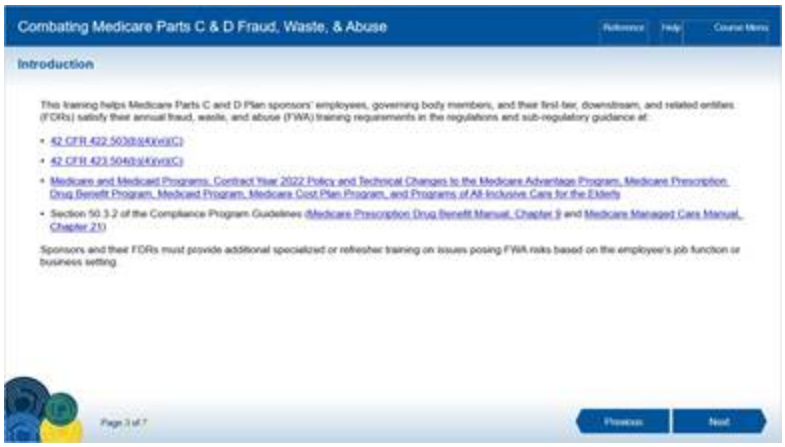
Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

* Health Equity Technical Assistance Program
* Disparities Impact Statement

The Combating Medicare Parts C & D Fraud, Waste, and Abuse course is brought to you by the Medicare Learning Network®

The Medicare Learning Network® (MLN) offers free educational materials for health care professionals on CMS programs, policies, and initiatives. Get quick access to the information you need.

* MLN Publications & Multimedia
* MLN Events & Training
* MLN Newsletters & Social Media



This training helps Medicare Parts C and D plan sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) satisfy their annual fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:

* 42 CFR 422.503(b)(4)(vi)(C)
* 42 CFR 423.504(b)(4)(vi)(C)
* Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly
* Section 50.3.2 of the Compliance Program Guidelines (Medicare Prescription Drug Benefit Manual, Chapter 9 and Medicare Managed Care Manual, Chapter 21)

Sponsors and their FDRs must provide additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

Why Do I Need Training?

Each year, billions of dollars are improperly spent because of FWA. It affects everyone—including you. This training will help you detect, correct, and prevent FWA. You're part of the solution.

Combating FWA is everyone’s responsibility. As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

Training Requirements: Plan Employees, Governing Body Members, & First-Tier, Downstream, or Related Entity Employees

Certain training requirements apply to people involved in Medicare Parts C and D administration. All Medicare Advantage Organization (MAO) and Medicare Drug Plan (Part D) (collectively referred to in this course as sponsors) employees must get training to prevent, detect, and correct FWA.

FWA training must happen within 90 days of initial hire and at least annually thereafter.

Compliance Training, Education & Outreach for Medicare Parts C & D Programs webpage has more information.
Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare patients. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to patients who enroll in an MA plan.

MA plans must cover all services Medicare covers (with the exception of hospice care). They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to patients enrolled in Part A and or Part B who enroll in a Part D or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to individuals living in a plan’s service area.

Navigating & Completing the Course

This WBT has course content, reference documents, review questions, and an assessment. You must score 70% or higher to successfully complete this course.

This course uses cues, like hyperlinks, buttons, rollovers, and pop-up windows to give more information. For more information on these cues, select Help. The Reference button includes resource documents and a glossary of defined terms. You may print these materials at any time.

After you successfully complete the course, you'll get instructions on how to get your certificate.

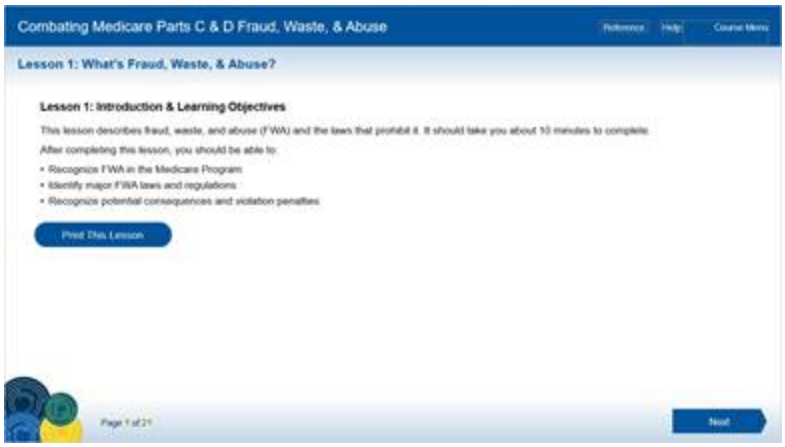
Welcome to the Combating Medicare Parts C & D Fraud, Waste, & Abuse Course

Course Objectives

After completing this course, you should be able to:

* Recognize FWA in the Medicare Program
* Identify major FWA laws and regulations
* Recognize potential consequences and violation penalties
* Identify methods to prevent FWA
* Identify how to report FWA
* Recognize how to correct FWA

Select Continue to return to the Course Menu. Then, select Lesson 1: What's Fraud, Waste, & Abuse?

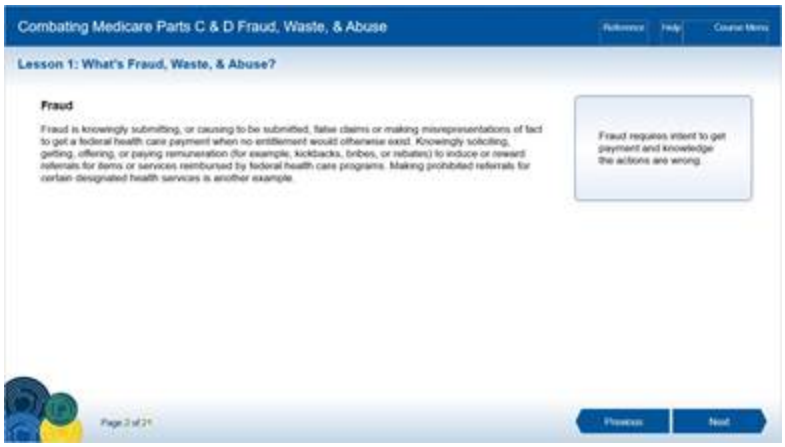


Lesson 1: Introduction & Learning Objectives

This lesson describes fraud, waste, and abuse (FWA) and the laws that prohibit it. It should take you about 10 minutes to complete.

After completing this lesson, you should be able to:

* Recognize FWA in the Medicare Program
* Identify major FWA laws and regulations
* Recognize potential consequences and violation penalties



Fraud

Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment when no entitlement would otherwise exist. Knowingly soliciting, getting, offering, or paying remuneration (for example, kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health care programs. Making prohibited referrals for certain designated health services is another example.

Fraud requires intent to get payment and knowledge the actions are wrong.

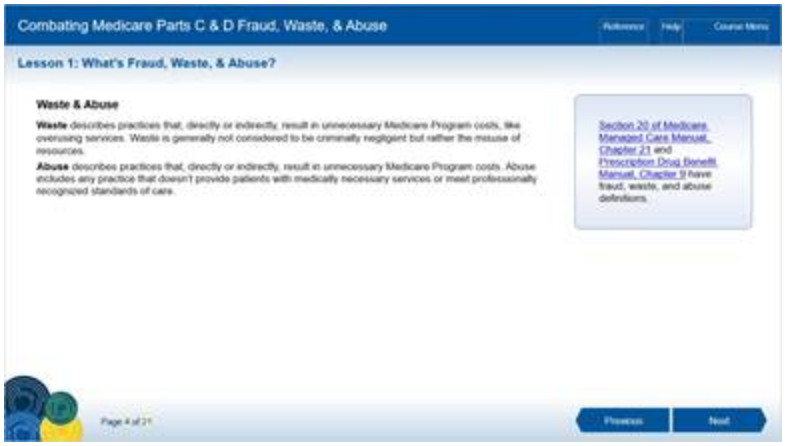
Fraud (continued)

The Criminal Health Care Fraud Statute (18 United States Code (USC) 1347) 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 up to 10 years. It's also subject to criminal fines up to $250,000. The statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:

* Defraud any health care benefit program
* Get (by means of false or fraudulent pretenses, representations, or promises) money or property owned by, or controlled by, any health care benefit program

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary power wheelchair claims.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.



Waste & Abuse

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program costs, like overusing services. Waste is generally not considered to be criminally negligent but rather the misuse of resources.

Abuse describes practices that, directly or indirectly, result in unnecessary Medicare Program costs. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards of care.

Section 20 of Medicare Managed Care Manual, Chapter 21 and Prescription Drug Benefit Manual, Chapter 9 have fraud, waste, and abuse definitions.

Fraud, Waste, & Abuse Examples

Medicare fraud examples:

* Knowingly billing for services of higher complexity than services actually provided or documented in patient medical records
* Knowingly billing for services or supplies not provided, including falsifying records to show item delivery
* Knowingly ordering medically unnecessary patient items or services
* Paying for federal health care program patient referrals
* Billing Medicare for appointments patients don’t keep

Medicare waste examples:

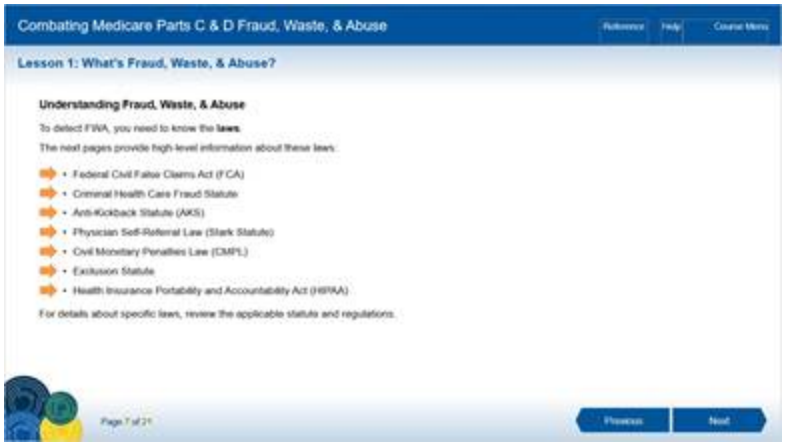
* Conducting excessive office visits or writing excessive prescriptions
* Prescribing more medications than necessary for treating a specific condition
* Ordering excessive lab tests

Medicare abuse examples:

* Billing unnecessary medical services
* Charging excessively for services or supplies
* Misusing codes on a claim, like upcoding (assigning an inaccurate medical procedure or treatment billing code to increase payment) or unbundling codes

Fraud, Waste, & Abuse Differences

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to get payment and knowledge the actions are wrong. Waste and abuse may involve getting an improper payment or creating unnecessary Medicare Program costs but don't require the same intent and knowledge.



Understanding Fraud, Waste, & Abuse

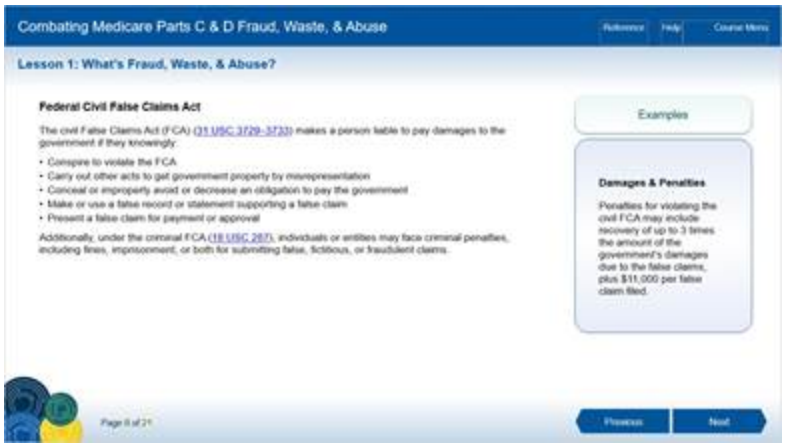
To detect FWA, you need to know the law.

The next pages provide high-level information about these laws:

* Federal Civil False Claims Act (FCA)
* Criminal Health Care Fraud Statute
* Anti-Kickback Statute (AKS)
* Physician Self-Referral Law (Stark Statute)
* Civil Monetary Penalties Law (CMPL)
* Exclusion Statute

* Health Insurance Portability and Accountability Act (HIPAA)

For details about specific laws, review the applicable statute and regulations.



Federal Civil False Claims Act

The civil False Claims Act (FCA) (31 USC 3729–3733) makes a person liable to pay damages to the government if they knowingly:

* Conspire to violate the FCA
* Carry out other acts to get government property by misrepresentation
* Conceal or improperly avoid or decrease an obligation to pay the government
* Make or use a false record or statement supporting a false claim
* Present a false claim for payment or approval

Additionally, under the criminal FCA (18 USC 287), individuals or entities may face criminal penalties, including fines, imprisonment, or both for submitting false, fictitious, or fraudulent claims.

Examples:

A Florida Medicare Part C plan:

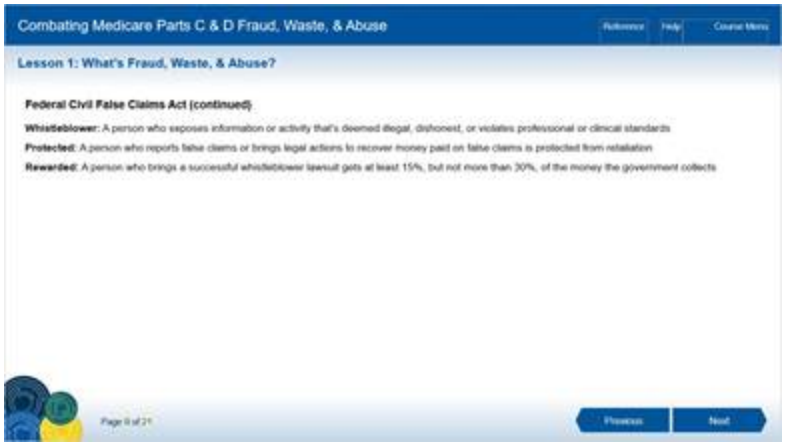
* Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase CMS risk capitation payments
* Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported
* Failed to report the unsupported diagnosis codes to Medicare
* Agreed to pay $22.6 million to settle FCA allegations

The owner-operator of a California medical clinic:

* Used marketers to recruit individuals for medically unnecessary office visits
* Promised free, medically unnecessary equipment or free food to entice individuals
* Charged Medicare more than $1.7 million for the scheme
* Was sentenced to 37 months in prison

Damages & Penalties

Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus $11,000 per false claim filed.



Federal Civil False Claims Act (continued)

Whistleblower: A person who exposes information or activity that's deemed illegal, dishonest, or violates professional or clinical standards
Protected: A person who reports false claims or brings legal actions to recover money paid on false claims is protected from retaliation
Rewarded: A person who brings a successful whistleblower lawsuit gets at least 15%, but not more than 30%, of the money the government collects

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 USC 1346–1349) states, “Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program or obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both.”

Conviction under the statute doesn’t require proof the violator knew the law or had specific intent to violate it.

Examples:

A Pennsylvania pharmacist:

* Submitted Medicare Part D claims for non-existent prescriptions and drugs not dispensed
* Pleaded guilty to health care fraud
* Got a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan

The owner of multiple New York Durable Medical Equipment (DME) companies:

* Falsely represented themselves as 1 of a nonprofit health maintenance organization’s (that administered a Medicare Advantage plan) authorized vendors
* Didn’t provide DME to any patients as claimed
* Submitted almost $1 million in false claims to the nonprofit; was paid $300,000
* Pleaded guilty to 1 count of conspiracy to commit health care fraud

Criminal Health Care Fraud Statute (continued)

Persons who knowingly make a false claim may be subject to:

* Criminal fines up to $250,000
* Imprisonment for up to 20 years

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

18 USC 1347 has more information.

Anti-Kickback Statute

The Anti-Kickback Statute (AKS) (42 USC 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or get any remuneration directly or indirectly to induce or reward patient referrals or business generation involving any item or service payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they

violate the AKS.

The safe harbor regulations (42 CFR 1001.952) describe various payment and business practices that, although they potentially implicate the AKS, aren't treated as AKS offenses if they meet certain regulatory requirements. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses.

Comparison of the Anti-Kickback Statute and Stark Law handout has more information.

Example:

A physician operating a Rhode Island pain management practice:

* Conspired to solicit and get kickbacks for prescribing a highly addictive version of the opioid Fentanyl
* Reported patients had breakthrough cancer pain to secure insurance payments
* Got $188,000 in speaker fee kickbacks from the drug manufacturer
* Admitted the kickback scheme cost Medicare and other payers more than $750,000

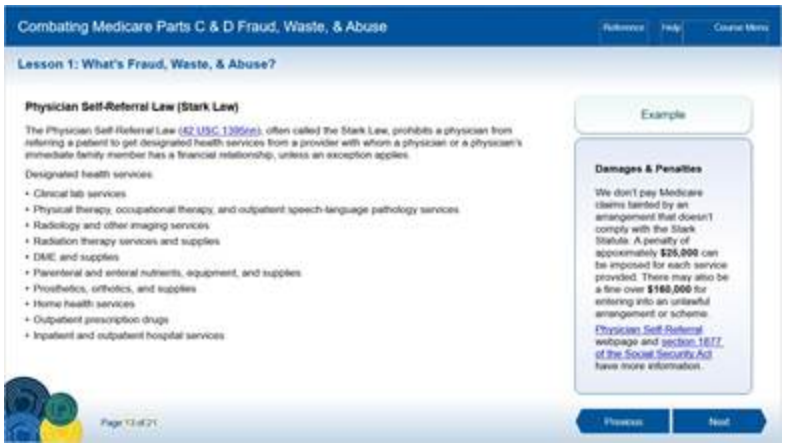
The physician was required to pay more than $750,000 in restitution.

Damages & Penalties

Violations are punishable by:

* A fine up to $25,000
* Imprisonment up to 5 years, or both

Section 1128B(b) of the Social Security Act has more information.



Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (42 USC 1395nn), often called the Stark Law, prohibits a physician from referring a patient to get designated health services from a provider with whom a physician or a physician's immediate family member has a financial relationship, unless an

exception applies.

Designated health services:

* Clinical lab services
* Physical therapy, occupational therapy, and outpatient speech-language pathology services
* Radiology and other imaging services
* Radiation therapy services and supplies
* DME and supplies
* Parenteral and enteral nutrients, equipment, and supplies
* Prosthetics, orthotics, and supplies
* Home health services
* Outpatient prescription drugs
* Inpatient and outpatient hospital services

Damages & Penalties

We don’t pay Medicare claims tainted by an arrangement that doesn’t comply with the Stark Statute. A penalty of appoximately $25,000 can be imposed for each service provided. There may also be a fine over $160,000 for entering into an unlawful arrangement or scheme.

Physician Self-Referral webpage and section 1877 of the Social Security Act have more information.

Example:

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) (42 USC 1320a-7a) authorizes the Office of Inspector General (OIG) to seek Civil Monetary Penalties (CMPs) and sometimes exclusions for a variety of health care fraud violations. Violations that may justify CMPs include:

* Arranging for an excluded individual's or entity's services or items
* Failing to grant OIG timely records access
* Filing a claim you know or should know is for an item or service that wasn't provided as claimed or is false or fraudulent
* Filing a claim you know or should know is for an item or service for which we won't make payment
* Violating the AKS
* Violating Medicare assignment provisions
* Violating the Medicare physician agreement
* Providing false or misleading information expected to influence a discharge decision
* Failing to provide an adequate medical screening exam for patients who present to a hospital emergency department with an emergency medical condition or in labor
* Making false statements or misrepresentations on applications or contracts to participate in federal health care programs

Section 1128A(a) of the Social Security Act has more information.

Example:

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated Medicare Part D claims for brand name prescription drugs the pharmacy couldn't have dispensed based on inventory records.

Damages & Penalties

Penalties and assessments vary based on the type of violation. Penalties can be approximately $10,000–$50,000 per violation. CMPs may also include an assessment of up to 3 times the amount claimed for each item or service, or up to 3 times the amount of remuneration offered, paid, solicited, or received.

Exclusion Statute

The Exclusion Statute (42 USC 1320a-7) requires the OIG exclude individuals and entities convicted of these offenses from participating in all federal health care programs:

* Medicare or Medicaid fraud, as well as other offenses related to delivering Medicare or Medicaid items or services
* Patient abuse or neglect
* Felony convictions for other health care-related fraud, theft, or other financial misconduct
* Felony convictions for unlawful manufacture, distribution, prescribing, or dispensing controlled substances

The OIG also maintains the List of Excluded Individuals and Entities (LEIE) website.

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which enables various federal agencies, including the OIG, to take debarment actions.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists aren't the same. 42 CFR 1001.1901 has more information.

Example:

A pharmaceutical company pleaded guilty to 2 felony counts of criminal fraud for not filing required reports with the FDA about oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. When the unconvicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) created greater access to health care insurance, strengthened health care data privacy protection, and promoted health care industry standardization and efficiency.

HIPAA safeguards deter unauthorized access to protected health care information. As someone with access to protected health care information, you must comply with HIPAA.

Example:

A former hospital employee pleaded guilty to criminal HIPAA charges after getting protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

Damages & Penalties

Violations may result in CMPs. In some cases, criminal penalties may apply.

Lesson 1 Summary

There are differences between fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge.

Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment for which no entitlement would otherwise exist.

Waste and abuse may involve getting an improper payment but not the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws include:

* Civil Monetary Penalties
* Civil prosecution
* Criminal conviction, fines, or both
* Exclusion from all federal health care program participation
* Imprisonment
* Loss of professional license

Review Questions

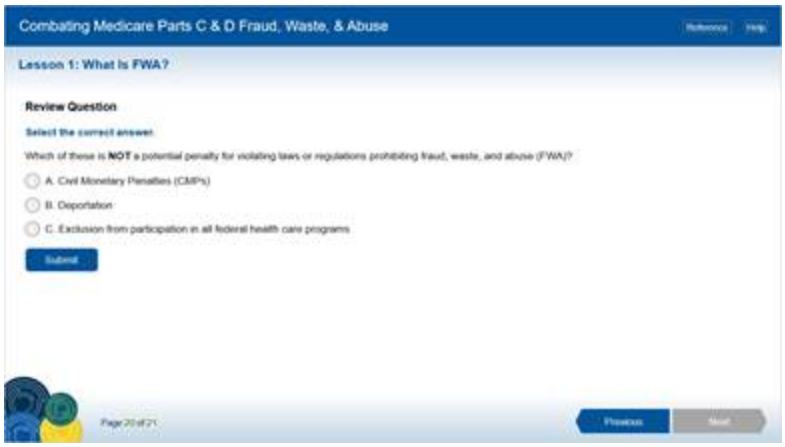
You reviewed the differences between fraud, waste and abuse. The next pages ask review questions to help reinforce this knowledge.

Review Question

Select the correct answer.

Which of these requires intent to get paid and knowing the actions are wrong?

A. Fraud
B. Abuse
C. Waste



Review Question

Select the correct answer.

Which of these is NOT a potential penalty for violating laws or regulations prohibiting fraud, waste, and abuse (FWA)?

A. Civil Monetary Penalties (CMPs)
B. Deportation
C. Exclusion from participation in all federal health care programs

You've completed Lesson 1: What's Fraud, Waste, & Abuse?

Now that you've learned about FWA and the laws and regulations prohibiting it, let's look closer at your role in the fight against FWA.

Select Continue to return to the Course Menu. Then, select Lesson 2: Your Role in the Fight Against Fraud, Waste, & Abuse.

Lesson 2: Introduction & Learning Objectives

This lesson explains your role in the fight against fraud, waste, and abuse (FWA), including your responsibilities to prevent, report, and correct it. It should take you about 10 minutes to complete.
After completing this lesson, you should be able to identify how to prevent, report, and correct FWA.

Where Do I Fit In?

As someone who provides health or administrative services to a Medicare Part C or Part D enrollee, you're likely an employee of a:

* Sponsor: Medicare Advantage Organization (MAO) or a Prescription Drug Plan (PDP)
* First-Tier Entity: Pharmacy Benefit Manager (PBM), hospital or health care facility, provider

group, doctor’s office, clinical lab, customer service provider, claims processing and adjudication company, a company that handles enrollment, disenrollment, and membership functions, and contracted sales agents
* Downstream Entity: Pharmacies, doctors’ offices, firms providing agent or broker services, marketing firms, and call centers
* Related Entity: Entity with common ownership or control of a sponsor, health promotion provider, or SilverSneakers®

Where Do I Fit In? (continued)

A Part C Plan Sponsor is a CMS contractor. Part C Plan Sponsors may enter into contracts with first-tier, downstream, or related entities (FDRs). This stakeholder relationship flow chart shows examples of functions relating to the sponsor’s Medicare Part C contracts. Medicare Part C Plan Sponsor first-tier and related entities may contract with downstream entities to fulfill their contractual obligations to the sponsor.

Examples of first-tier entities may be independent practices, call centers, health services and hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service and hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

A Part D Plan Sponsor is a CMS contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions relating to the sponsor’s Medicare Part D contracts. Medicare Part D Plan Sponsor first-tier and related entities may contract with downstream entities to fulfill their contractual obligations to the sponsor.

Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

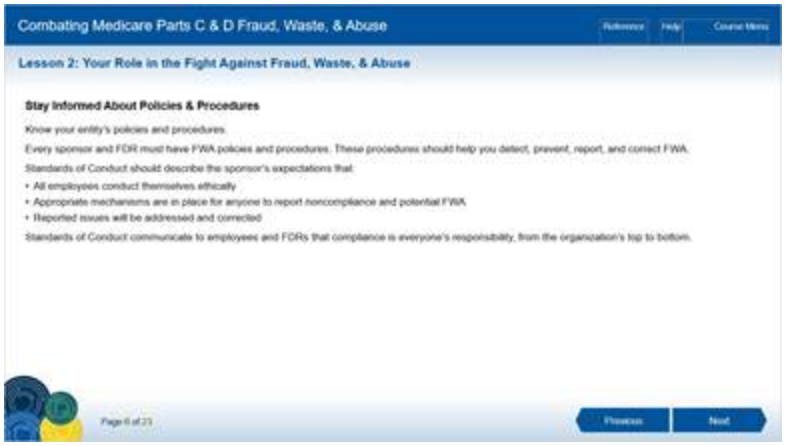
What Are Your Responsibilities?

You play an important role in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.

* **First**, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program
* **Second**, you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations you may know
* **Third**, you have a duty to follow your organization's Code of Conduct that describes you and your organization's commitment to standards of conduct and ethical rules of behavior

How Do You Prevent Fraud, Waste, & Abuse?

* Look for suspicious activity
* Conduct yourself ethically
* Ensure accurate and timely data and billing
* Ensure coordination with other payers
* Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
* Verify all information you get



Stay Informed About Policies & Procedures

Know your entity’s policies and procedures.

Every sponsor and FDR must have FWA policies and procedures. These procedures should help you detect, prevent, report, and correct FWA.

Standards of Conduct should describe the sponsor’s expectations that:

* All employees conduct themselves ethically
* Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
* Reported issues will be addressed and corrected

Standards of Conduct communicate to employees and FDRs that compliance is everyone’s responsibility, from the organization’s top to bottom.

Report Fraud, Waste, & Abuse

Everyone must report suspected FWA. Your sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith reporting effort.

Report any potential FWA concerns to your compliance department or your sponsor's compliance department. They will investigate and make the proper determination. Often, sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain a FWA hotline.

Every sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Sponsors must accept anonymous reports and can't retaliate against you for reporting. Review your organization's materials for how to report FWA.

When in doubt, call your compliance department or FWA hotline.

Reporting Fraud, Waste, & Abuse Outside Your Organization

If warranted, sponsors and FDRs must report potentially fraudulent conduct to government authorities, like the Office of Inspector General (OIG), Department of Justice (DOJ), or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid costs and disruptions of a government-directed investigation and civil or administrative litigation.

Details to Include When Reporting Fraud, Waste, & Abuse

When reporting suspected FWA, include:

* Contact information for the information source, suspects, and witnesses
* Alleged FWA details
* Alleged Medicare rules violated
* Suspect's history of compliance, education, training, and communication with your organization or other entities

Where to Report FWA:

Medicare Providers:

HHS Office of Inspector General:
* Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
* Fax: 1-800-223-8164
* Online: OIG.HHS.gov/report-fraud
* Mail:
U.S. Department of Health & Human Services Office of Inspector General
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

Medicare Parts C and D:
* Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

All Other Federal Health Care Programs:
* CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Medicare Patients:
* Online: Help Fight Medicare Fraud

Corrective Action

Once FWA is detected, promptly correct it. Correcting the problem saves the government money and ensures your compliance with CMS requirements.

Develop a plan to correct the issue. Ask your organization’s compliance officer how to develop a corrective action plan. The actual plan varies depending on the circumstances. In general:

* Design the corrective action to fix the underlying problem that results in FWA violations and prevents future noncompliance
* Tailor the corrective action to address the particular FWA problem or identified deficiency; include timeframes for specific actions
* Document corrective actions addressing noncompliance or FWA committed by a sponsor’s or FDR’s employee, and include consequences for failing to satisfactorily complete the corrective action
* Monitor corrective actions continuously to ensure effectiveness

Corrective actions may include:

* Adopting new prepayment edits or document review requirements
* Conducting mandated training
* Providing educational materials
* Revising policies or procedures
* Sending warning letters
* Taking disciplinary action, like marketing, enrollment, or payment suspension
* Terminating an employee or provider

Potential Fraud, Waste, & Abuse Indicators

Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The next pages present potential FWA issues. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a sponsor, pharmacy, or other entity involved in delivering Medicare Parts C and D enrollee benefits.

Key Indicators: Potential Patient Issues

* Does a prescription, medical record, or lab test look altered or possibly forged?
* Does a patient's medical history support requested services?
* Have you filled numerous identical prescriptions for this patient, possibly from different doctors?
* Is the person getting the medical service the actual patient (identity theft)?
* Is the prescription appropriate based on patient's other prescriptions?

Key Indicators: Potential Provider Issues

* Are the provider’s prescriptions appropriate for patient’s health condition (medically necessary)?
* Does the provider bill sponsor for services not provided?
* Does the provider write prescriptions for diverse drugs or primarily controlled substances?
* Does the provider perform medically unnecessary patient services?
* Does the provider prescribe a higher quantity than medically necessary for the condition?
* Does the provider’s prescription include their active and valid National Provider Identifier (NPI)?
* Is the provider’s patient diagnosis supported in the medical record?

Key Indicators: Potential Pharmacy Issues

* Are drugs being diverted (drugs meant for nursing homes, hospices, and other entities being sent somewhere else)?
* Are dispensed drugs expired, fake, diluted, or illegal?
* Are generic drugs provided when prescription requires dispensing brand drugs?

* Are PBMs billed for unfilled or never-picked-up prescriptions?
* Are proper provisions made if entire prescription isn't filled (no additional dispensing fees for split prescriptions)?
* Do you see prescriptions being altered (changing quantities or Dispense As Written)?
* Are Eligibility Facilitations Services (E1s) and their information being used for purposes other than determining patient eligibility?

Key Indicators: Potential Wholesaler Issues

* Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
* Is the wholesaler diverting drugs meant for nursing homes, hospices, or AIDS clinics, marking up prices, and sending to other smaller wholesalers or pharmacies?

Key Indicators: Potential Manufacturer Issues

* Does the manufacturer promote off-label drug use?
* Does the manufacturer knowingly provide samples to entities that then bill federal health care

programs for them?

Key Indicators: Potential Sponsor Issues

* Does the sponsor encourage or support submitting inappropriate risk adjustments?
* Does the sponsor lead patient to believe the benefits cost a certain price, when the actual cost is higher?
* Does the sponsor offer patients cash incentives to join the plan?
* Does the sponsor use unlicensed agents?

Lesson 2 Summary

* As someone providing health or administrative services to a Medicare Part C or D enrollee, you play an important part in preventing fraud, waste, and abuse (FWA). Conduct yourself ethically, stay informed of your organization’s policies and procedures, and keep an eye out for potential FWA indicators
* Report potential FWA. Every sponsor must have a mechanism to report potential FWA.

Sponsors must accept anonymous reports and can't retaliate against you for reporting
* Promptly correct identified FWA with an effective corrective action plan

Lesson 2 Review

You reviewed the role you play in the fight against FWA, including your responsibilities to prevent, report, and correct it. The next pages ask review questions to help reinforce this knowledge.

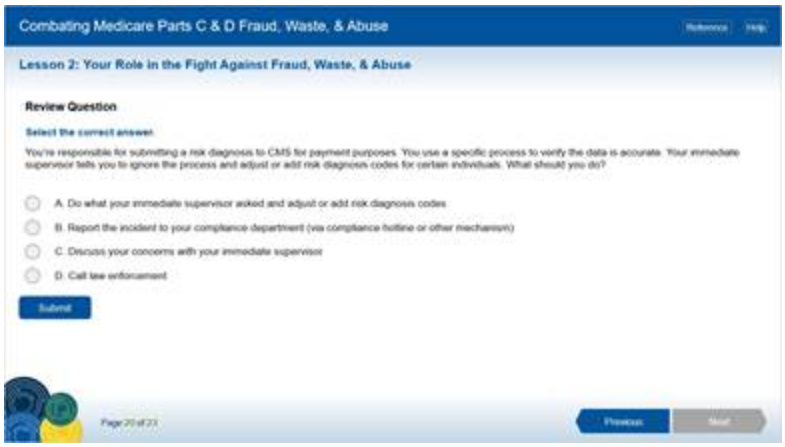
Review Question

Select the correct answer.

A person drops off a prescription for a patient who's a regular pharmacy customer. The prescription is for a controlled substance with a quantity of 160. This patient normally gets a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What's your next step?

A. Fill prescription for 160
B. Fill prescription for 60
C. Call prescriber to verify the quantity
D. Call sponsor's compliance department
E. Call law enforcement

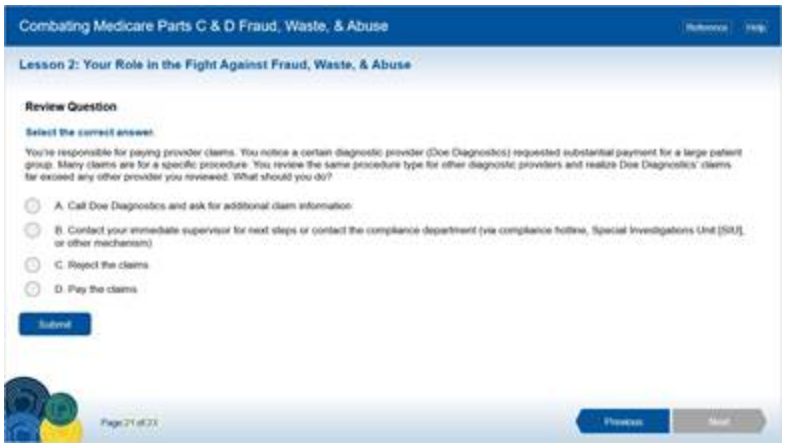


Review Question

Select the correct answer.

You're responsible for submitting a risk diagnosis to CMS for payment purposes. You use a specific process to verify the data is accurate. Your immediate supervisor tells you to ignore the process and adjust or add risk diagnosis codes for certain individuals. What should you do?

A. Do what your immediate supervisor asked and adjust or add risk diagnosis codes
B. Report the incident to your compliance department (via compliance hotline or other mechanism)
C. Discuss your concerns with your immediate supervisor
D. Call law enforcement

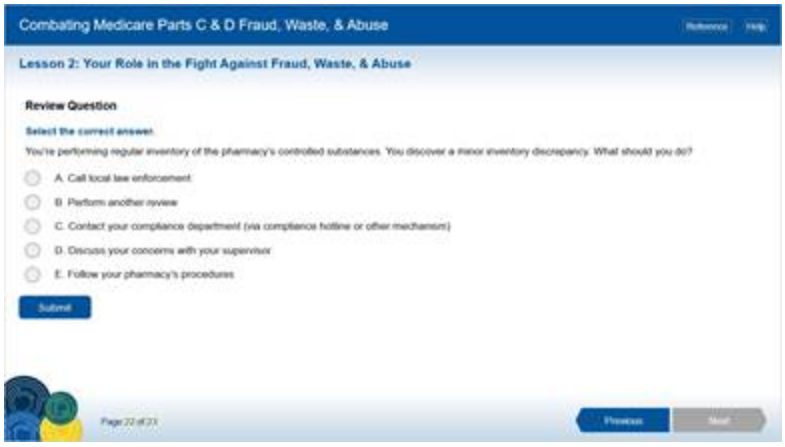


Review Question

Select the correct answer.

You're responsible for paying provider claims. You notice a certain diagnostic provider (Doe Diagnostics) requested substantial payment for a large patient group. Many claims are for a specific procedure. You review the same procedure type for other diagnostic providers and realize Doe Diagnostics' claims far exceed any other provider you reviewed. What should you do?

A. Call Doe Diagnostics and ask for additional claim information
B. Contact your immediate supervisor for next steps or contact the compliance department (via compliance hotline, Special Investigations Unit [SIU], or other mechanism)
C. Reject the claims
D. Pay the claims



Review Question

Select the correct answer.

You’re performing regular inventory of the pharmacy’s controlled substances. You discover a minor inventory discrepancy. What should you do?

A. Call local law enforcement
B. Perform another review
C. Contact your compliance department (via compliance hotline or other mechanism)
D. Discuss your concerns with your supervisor
E. Follow your pharmacy’s procedures

You’ve completed Lesson 2: Your Role in the Fight Against Fraud, Waste, & Abuse

Now that you’ve reviewed common problems plans encounter and how you can help address them, it’s time to assess your knowledge. Select Continue to return to the Course Menu. Then, select Assessment.

North Sound BH-ASO
2021 E. College Way, Suite 101, Mt. Vernon, WA 98273
Phone: (360) 416-7013 Fax: (360) 899-4754
www.nsbhaso.org

COMPLIANCE TRAINING ATTESTATION STATEMENT

Centers for Medicare & Medicaid Services Annual Attestation

I, _____, attest that I have read, acknowledge, and attest to
(printed name)
understanding and abiding by the following North Sound Behavioral Health Administrative Service Organization (BH-ASO) and Centers for Medicare & Medicaid Services policies, procedures, and training:

Centers for Medicare & Medicaid Services (CMS)		
Initials	**Training**	**Date Completed**
	Combatting Medicare Parts C and D Fraud, Waste, and Abuse https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining	

_____ _____
Signature Date

Once completed, please:

1. **Sign, date, and Scan this attestation**
2. **Name scanned attestation: "Last name, first name – Compliance Attestation"**
3. **Email attestation to Compliance_Officer@nsbhaso.org**

Submit Completed Forms to Compliance_Officer@nsbhaso.org

Opioid Abatement Council

North Sound hosted the first meeting of the OAC October 5, 2023, from 1PM-2PM. The OAC laid out the framework for understanding membership, scope and role of the OAC in the region. The role of the OAC includes monitoring distributions for Approved Purposes as outlines in the One WA MOU, Developing and maintaining a centralized public dashboard or other repository for expenditure data, hearing complaints by participating local governments, and identifying additional outcome-related data to evaluate use of Opioid Funds. OAC will meet every other month moving forward.

Western State Hospital, the Pechman Ruling Update, and new Olympic Heritage Facility

Department of Social and Health Services (DSHS) has reopened Cascade Hospital, renaming the facility Olympic Heritage. The secure facility will be dedicated to civilly committed patients. Civil patients have been committed to treatment by the court system and referred to state psychiatric care for treatment and rehabilitation. As of this last week, they indicated they were bringing 54 beds (2 wards) online. When fully operational, the facility will be 137 beds. The rest of the beds are scheduled to open in Spring 2024. It is currently unclear how the Peerbridger/ WSH Liaison programs may work with the facility or if funding/staffing will need to be increased to work with these new beds.

Ituha Facility

Pioneer Human Services (PHS), who holds the operating contract for the Ituha Stabilization Facility in Oak Harbor, has contacted the BHASO and other funders to indicate a budget shortfall projected for 2024. North Sound BH-ASO is working with PHS to identify potential solutions to maintain this necessary, regional 10-bed facility. The facility offers mental health and substance use disorder stabilization services. We have notified HCA and are trying to schedule a meeting with HCA to discuss this issue.

Skagit County Prosecuting Attorney's Office and Involuntary Treatment Act cases

The PR for Skagit County has notified the BHASO of potential staffing issues for lawyers assigned to try ITA cases in Skagit County. North Sound BHASO is working with the PA to identify a path forward.

Update: Touchstone Behavioral Health

A 23-hour youth relief center facility in Whatcom County has been built. The provider, Touchstone, was trying to negotiate with the Managed Care Organizations and North Sound. HCA is calling a meeting of North Sound and MCOs to better understand the services the facility will be offering. The original intent of the facility was a 23 hour facility but the state is not licensing that type of facility for youth at this time which has led to confusion on what the program will be moving forward.

State Auditor's Office (SAO) Final Report Out

The State Auditor's Office has completed their review and is ready to do the final report out to the Board of Directors. There were no findings, but a couple of minor items we need to work on internally. The final report will be presented to the Board in November.

Federal Government Shutdown and Medicaid Unwinding

While the threat of a Federal Government Shutdown has been delayed, this is a reminder that local behavioral health agencies are under multiple pressures right now. The state has indicated that a Federal Government Shutdown would not stall BHASO for multiple months, but did indicate in a meeting that Medicaid payments would potentially be a different situation and could be affected within weeks. Additionally, agencies are managing the Medicaid Unwinding process. As they did not need to do this for multiple years, and the workforce (including administrative and management) such upheaval and turnover, this could be a process they are really struggling with that could create some financial issues for BHAs. North Sound will keep

Board Members up to date on any Federal Government Shutdown information we get from the state, including potential impacts.