North Sound Mental Health Administration

BOARD OF DIRECTORS MEETING
June 29, 2004
NSMHA Conference Room
117 N First Street, Suite 8
Mount Vernon
1:30 PM
Agenda

1. Call to Order; Introductions – Chair
2. Revisions to Agenda – Chair
3. Approval of May Minutes – Chair
4. Comments & Announcements from the Chair
5. Reports from Board Members
6. Comments from Public
7. Report from Advisory Board – Marie Jubie, Chair
8. Report from Executive/Personnel Committee – Dave Gossett, Chair
9. Report from QMOC – Jim Teverbaugh, Chair
   - Clinical Guidelines
   - Regional Training Plan
   - Quality Management Plan Amendments
10. Report from Planning Committee – Dave Gossett, Chair
    - Transition Plan to comply with new Medicaid Regulations
    - Snohomish County Crisis Services
11. Report from Executive Director – Chuck Benjamin, Executive Director
12. Report from Finance Officer – Bill Whitlock
13. Report from Finance Committee – Mike Shelton
14. Consent Agenda – Chair

    Motion # 04-022 – To review and approve NSMHA claims paid from April 1, 2004 to April 30, 2004 in the amount of *$3,889,167.34*. Payroll for the month of April in the amount of *$68,263.56* and associated employer paid benefits in the amount of *$31,041.37*.

Motion # 04-025 – To review and approve NSMHA claims paid from May 1, 2004 to May 31, 2004 in the amount of *$3,650,557.53.* Payroll for the month of May in the amount of *$60,040.73* and associated employer paid benefits in the amount of *$21,091.31.*

Motion # 04-024 – To introduce the following line item transfer in the NSMHA 2003 Operating Budget:
Move $2,000 from Professional Services to Machinery and Equipment. Budget is overdue to capital expenses of Machinery and Equipment for the IS Department.

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

15. Action Items –

Motion #04-023 – The Quality Management Oversight Committee recommends an amendment to the NSMHA Quality Management Plan for 2004 – 2005, removing the requirement to conduct the Supervised Living Review and Jail Review.

Motion # 04-025 – To review and approve NSMHA claims paid from May 1, 2004 to May 31, 2004 in the amount of *$3,650,557.53.* Payroll for the month of May in the amount of *$60,040.73* and associated employer paid benefits in the amount of *$21,091.31.*

16. Action Items not yet reviewed by the Advisory Board

Motion # 04-027 – To approve North Sound Mental Health Administration's revised Complaint, Grievance, Appeal and Fair Hearing Policy. We have revised our current Complaint, Grievance, Appeal and Fair Hearing Policy to comply with the new BBA standards.

Motion #04-028 – To approve the North Sound Mental Health Administration's proposed Compliance Plan. The purpose of this plan is to outline and define the scope, responsibilities, operational guidelines, controls and activities employed by NSMHA to ensure that we maintain an environment that facilitates ethical decision making and that we act in accordance with the laws and regulations that govern us. The plan establishes the NSMHA Finance Committee as the Compliance Committee and charges it with developing and implementing the program. Note: Includes a 10 minute presentation on the Compliance Plan

Motion #04-029 – To approve the revised job description for Quality Specialist. The Quality Specialist supports the NSMHA's quality management oversight functions such as risk management, quality assurance, quality improvement and utilization management. Responsibilities include the monitoring of clinical services to assure minimum quality assurance and continuous quality improvement. Quality Specialists also support NSMHA planning activities. To assure quality of services to children, older adults, and underserved populations, Quality Specialists with special training, experience, and expertise are assigned to these areas.

17. Introduction Items

    Motion # IN-014 – To introduce the North Sound Mental Health Administrations contract # NSMHA-APN-04-05, amendment 1. This amendment will replace the current pages 1-55 with revised language and replace Attachment XXVII with a new Attachment XXVII. The purpose of the amendment is to bring the contract into compliance with BBA regulatory requirements and to adopt changes imposed by CMS through the State Medicaid Plan Waiver approval process. The amended language also adds a structure for a transition planning process to result in future contract amendments that will be approved by the NSMHA Board of Directors.

18. Emergency Action Items – Chair

19. Items for Discussion

20. Executive Session – Chair

21. Reconvene – Chair

22. Adjournment – Chair

NOTE: The next Board of Directors meeting will be Thursday, August 12, 2004, at 1:30 p.m. in the NSMHA Conference Room at 117 N First Street Suite 8, Mount Vernon.

North Sound Mental Health Administration

BOARD OF DIRECTORS MEETING
May 13, 2004
NSMHA Conference Room
117 N First Street, Suite 8
Mount Vernon
1:30 PM

MINUTES

Members Present:
Mike Shelton, Island County Commissioner
Andy Byrne, designated alternate for Whatcom County Executive Pete Kremen
Marie Jubie, Chair NSMHA Advisory Board
Jim Teverbaugh, designated alternate for Snohomish County Executive Aaron Reardon
June LaMarr, The Tulalip Tribes
Kirke Sievers, Snohomish County Council
Barbara LaBrash, designated alternate for San Juan County Commissioner Rhea Miller
Dave Gossett, Snohomish County Council
Sharie Freemantle, designated alternate for Snohomish County Council John Koster
Maile Acoba, designated alternate for Skagit County Commissioner Ken Dahlstedt
Sharon Roy, designated alternate for Whatcom County Council Ward Nelson

Staff Present:
Chuck Benjamin, Annette Calder, Wendy Klamp, Gary Williams, Rebecca Pate, Bill Whitlock, Deirdre Ridgway, Chuck Davis, Shirley Conger, Greg Long

Guests Present:
Linda Ford, Sheryl Fryberg, Brad Furlong, Tom Sebastian

1. Call to Order; Introductions
Mike Shelton called the meeting to order at 1:35 pm.

2. Revisions to Agenda
None.

3. Approval of April Minutes
On page 4 of item 12, Jim Teverbaugh requested change "our" to "out". Motion to approve, seconded, all in favor, **motion carried.**

4. Comments & Announcements from the Chair
None.

5. Reports from Board Members

None.

6. Comments from Public

Tom Sebastian announced Compass Health's Art Show tonight (5/13/04) in downtown Everett starting at 5:30 pm with proceeds going to the Compass Health art program.

7. Ombuds Semi-Annual Report – Chuck Davis

Chuck stated the Ombuds Report has been changed to a semi-annual report. If anyone has any requests/changes for improvements, please let Chuck know. He distributed a handout and presented a comprehensive PowerPoint presentation. See Attachment A for more information. Chuck stated Ombuds have been working with a lot of different organizations including a long-term care Ombuds and do a lot of outreach presentations. A question and answer period followed and Chuck was thanked for his presentation.

8. Report from Advisory Board – Marie Jubie, Chair

Marie Jubie said the Advisory Board had a pre-meeting presentation from Chuck Benjamin on CMS challenge. The Advisory Board recommended that ten people on Medicaid be eligible to go to the Behavioral Health Conference paid for by the Advisory Board and applications were distributed. Marie did voter registration training through the TASLE group. She announced that the Advisory Board would probably have a retreat in mid July and discuss how they can fill all vacancies on the Advisory Board. Marie talked to Aaron Reardon, Snohomish County Executive, about doing some advocacy in the legislature and he gave his blessing to proceed. Marie stated the Advisory Board is looking at restructuring their committees. The Advisory Board received a semi-annual Ombuds report. There was no public comment. She said Tom Sebastian informed the board about the Compass Health art show and also heard that the NSMHA Tribal Conference went well.

9. Report from Executive/Personnel Committee – Dave Gossett, Chair

Dave Gossett said the Personnel Committee is recommending approval of the Accounting Specialist job description. He noted this was not an increase in FTE's as the Accounting Specialist job is a new position and the committee is recommending abolishing an accounting specialist/support analyst position. See Attachment B for more information. There was a motion to approve the new job description, seconded, all in favor, **motion carried.**

Dave brought forward an informational item concerning Quality Management staffing. He said NSMHA wanted all to be aware of the problems so there would be no surprises. Wendy Klamp said there are conflicts of interest provisions in the Balanced Budget Act that preclude people who are providing direct services or care management from doing the resource/utilization management or participating in grievance work field. NSMHA is being forced through the BBA to morph into a health plan with staff designated to certain departments. NSMHA has too many staff cross-trained in various tasks, therein lies the problem. We have been waiting for months for guidance on how these regulations are going to be interpreted and just received it last week. Chuck Benjamin said

that NSMHA has met with Snohomish County to work out staffing issues and become compliant. The NSMHA will come before the Board with a plan that will end the temporary plan.

10. Report from QMOC – Andy Byrne, Chair

Andy Byrne stated QMOC now has a full roster. QMOC discussed several different items on the agenda:

1. Diana Striplin presented a six-month Critical Incident report. The Critical Incident Review Committee reviews all reports to note any patterns, trends, recommend follow-up, etc.
2. Terry McDonough presented a report on documentation re-review for Compass North. Wendy stated Compass North seems to have a sincere, open, and honest commitment to making the necessary changes.
3. Linda Benoit presented a report on the Utilization Management (UM) Subcommittee. UM is a check to see:
   - Are consumers receiving the services needed and eligible to receive?
   - Are consumers receiving the right amount of service at the right time services are needed?

   The committee is developing tools to help identify problem areas so they can hone in on these to see what can be done to correct these problems.
4. Wendy Klamp presented the NSMHA Regional Training Plan (RTP) for the next two years. The QMOC felt this is an excellent RTP based on a very detailed needs assessment. One recommendation was to present RTP to Board of Directors and Andy failed to bring it with him but will present it next month. Gary Williams said that Wendy's RTP article is in the current issue of Behavioral Health.

11. Report from Planning Committee – Dave Gossett, Chair

Dave Gossett apprised the Board last fall that Snohomish County's providing service for involuntary treatment and other related services was costing more than the RSN was providing funding for and requested additional funding. At that time a process was begun to take a look at other options. Where we are at with the Planning Committee is we believe we have reached a conclusion significant savings can be had by combining the involuntary and voluntary features under one program with Snohomish County taking the lead. At this point, there needs to be some discussion with Snohomish County staff, Compass Health staff, and Volunteers of America on how to integrate and exactly what pieces should fit where. The Planning Committee believes that information will be available at the July Planning Committee meeting and will be brought to the Board in August.

The NSMHA Strategic Plan runs out this year. Snohomish County recommends we extend the current plan until June 30, 2005, to allow time to make necessary changes and get them implemented. A subcommittee will be established to work on the changes that the Planning Committee will have to put into that plan as part of the new Medicaid rules, etc.

12. Report from Executive Director – Chuck Benjamin, Executive Director

Chuck Benjamin informed the Board on CMS. He distributed a handout and gave a comprehensive PowerPoint presentation. Medicaid funds can only be used for Medicaid eligible consumers and

services. Our concern is that non-Medicaid consumers will have some difficulty obtaining services. The biggest hit will be in our flex funds. Chuck hopes to present more information on CMS with better numbers next month. The Board has some very critical decisions to make soon concerning this issue. Discussion followed on the transition plan. Consumers have to be enrollee eligible to qualify. More information will be presented at the June 2004 Board of Directors meeting.

13. Executive Session

Chair Shelton stated the Board would go into Executive Session to discuss potential litigation for approximately ½ hour. Executive Session began at 2:55 pm.

14. Reconvene

Chair Shelton reconvened the meeting at 3:35 pm.

Chair Shelton stated that two motions were being brought forward. A motion was made to extend the current Strategic Plan to June 30, 2005, to allow time to assess and plan more accordingly. Moved, seconded, all in favor, **motion carried.**

A motion was made to authorize NSMHA Executive Director to form a non-Medicaid transition plan committee, seconded, all in favor, **motion carried.**

Motion was made to authorize the Executive Committee to authorize legal counsel to take the appropriate steps to implement the legal program that was discussed, seconded, all in favor, **motion carried.**

15. Report from Finance Officer – Bill Whitlock

Bill Whitlock stated there are funding issues with the State. The State is still planning on taking back additional State funds because federal match rate changed. The State is still in negotiations with CMS about the actuarial rates. When they complete these negotiations they will amend our contract and take back funds.

16. Report from Finance Committee – Mike Shelton

Mike Shelton stated the committee met and he recommended a motion to move #04-017. Motion was made by Dave Gossett to approve the consent agenda, seconded by Andy Byrne, all in favor, **motion carried.**

17. Consent Agenda – Chair

Motion # 04-017 To review and approve NSMHA claims paid from March 1, 2004 to March 31, 2004 in the amount of *$3,417,972.81.* Payroll for the month of March in the amount of *$72,580.87,* and associated employer paid benefits in the amount of *$21,917.89.*

All matters listed with the Consent Agenda have been distributed to each Board Member for reading and study, are considered to be routine, and will be enacted by one motion of the Board of Directors with no separate discussion. If separate discussion is desired, that item may

be removed from the Consent Agenda and placed on the Regular Agenda by request of a Board Member.

18. Action Items–

None.

19. Introduction Items

Motion # IN-012 – To introduce contract # NSRSN-APN-DDD-Crisis-02, Amendment 4. This amendment will:

1. Under Terms and Conditions add a new subsection L to read as follows:
All references to Associated Provider Network and CONTRACTOR shall mean Associated Provider Network and its member organization Compass Health.

2. Under Terms and Conditions add a new subsection M to read as follows:
Contract Performance/Enforcement. NSRSN shall be vested with the rights of a third party beneficiary, including the "cut through" right to enforce performance should CONTRACTOR be unwilling or unable to enforce action on the part of its network and subcontractors. In the event that CONTRACTOR dissolves or otherwise discontinues operations, NSRSN may, at its sole option, assume the right to enforce the terms and conditions of this Agreement directly with CONTRACTOR's service network and subcontractors. CONTRACTOR shall include this clause in its contracts with its subcontractors. In the event of the dissolution of CONTRACTOR, NSRSN's rights in indemnification shall survive.

20. Items Not Yet Reviewed By The Advisory Board– Chair

None.

21. Items for Discussion

None.

22. Adjournment – Chair

The meeting adjourned at 3:41 pm.

Respectfully submitted,

Rebecca Pate
Administrative Secretary

NOTE: The next Board of Directors meeting will be Tuesday, June 29, 2004, at 1:30 p.m. in the NSMHA Conference Room at 117 N First Street Suite 8, Mount Vernon.

Agenda Item: System Change Recommendations by Medicaid Policy Changes

Presenter: Greg Long

Committee Action: **Action Item** ☒ **FYI & Discussion** ☐ **FYI Only** ☐

Significant Points or Executive Summary:

The NSMHA and providers have been dilengently working to develop plans to shift Outpatient Services in the North Sound Region to be compliant with the new CMS/Medicaid Policies. These policy changes include:

1. Medicaid Funds can only be used for Medicaid eligible consumers.
2.. Medicaid Funds can only be spent on State-Plan Billing Codes approved by CMS.
3. Medicaid consumers can only be served in residential facilities with a maximum capacity of 16 beds.
4. Medicaid rates will be reset by an acturial study every two years.

A major planning meeting was conducted on 6/15/2004 to develop recommended changes for the North Sound Mental Health System. These changes significantly affect access to service for individuals who are not Medicaid eligible, dramatically restructure residential services, discontinue or limit a number of hospital alternative programs, and allow providers to charge for Protective Payee Services. Attached is a summary sheet documenting eleven (11) major changes and the proposals from the providers and approved by the Transition Workgroup.

These eleven (11) proposals were reviewed and approved by the NSMHA Planning Committee on 6/18/2004.

Conclusions/Recommendations:

Concensus approval was obtained on all eleven (11) of the recommendations. The proposal regarding funding of services when consumers are on Medicaid Spend-Downs was deferred.

Timelines:

Implementation for these proposals is July 1 or as rapidly as possible. Some proposals will have to be phased in overtime.

Attachments:

Summary Sheet, and Proposal Worksheets

Recommended Medicaid Transition Plans

June 21, 2004

The public mental health system in the State of Washington has to change many of its approaches to the delivery of mental health services due to recent policy changes by the Center for Medicaid and Medicare Services. These policy changes include the following:

- Medicaid funds can only be used to serve Medicaid-enrolled individuals.
- Medicaid funds can only be used to provide State-Plan Services approved by Medicaid.
- Individuals with Medicaid can only be served in Residential facilities of 16 or fewer beds.
- An actuarial study will be done every two years to determine mental health service payment rates.

Providers indicate the services will be enhanced in the following areas in this transition to focusing all Medicaid funding on Medicaid-eligible enrollees and on State Plan approved services:

- Reductions in caseload size leading to more intensive and responsive services for consumers.
- Increased availability of High-Intensity Treatment Services.
- Decreased size of residential facilities.
- Continuation of plans to develop trauma services for high utilizers of hospital services in three (3) counties.
- Continued development of Dialectical Behavioral Treatment Services (DBT) for adults and children.

No.	Recommendations on Issues Requiring Change	Transition Workgroup Recommen-dation	Planning Committee Recommen-dation
	In this table, "yes" means that the issue was reviewed by the Transition Workgroup and the Workgroup recommends this change to the NSMHA Planning Committee		
1.	Close admissions for outpatient and residential services to all non-Medicaid en-rolled consumers who do not have an alternate source of funding (e.g. United Way, insurance, private pay) effective July 1, 2004. People on less restrictive orders without Medicaid will continue to be served pending further review.	Yes	Yes
2.	Begin discharging current non-Medicaid enrolled consumers as soon as is clinically feasible, in a manner that avoids abandonment of care situations, until all non-Medicaid consumers receiving outpatient or residential services with	Yes	Yes

	Medicaid funds are discharged. Providers are to submit a time schedule to the NSMHA for this process.		
3.	Find a source of funds to serve people who are on Medicaid spend-downs	Deferred	Deferred
4.	Residential Services—*bridgeways* proposes shifting the 32 consumers in their residential facility to independent living and providing them intensive community treatment. Madison House would be closed as a residential facility and become a treatment center	Yes	Yes
5.	Residential—Compass Health (Snohomish County) proposes downsizing both Green House and Aurora House from 20 beds to 16 beds to comply with the IMD rule. They would transfer as many slots to Haven House as HUD will allow given the requirements surrounding Haven House.	Yes	Yes
6.	Residential—Lake Whatcom Residential Treatment Center (LWRTC) proposes downsizing their facility from 67 beds to 16 to comply with the IMD rule and treating the remaining 52 consumers in intensive case management in apartments. LWRTC is looking to find apartments to buy to house these consumers.	Yes	Yes
7.	Residential—Compass Health (Skagit County) proposes reducing the census at Ovenell's through attrition and development of intensive outpatient services (including case management in the living situation) for those consumers now there. The contract with Ovenell's would be terminated and replaced with intensive outpatient services (including case management in the living situation) to consumers who would otherwise be admitted to Ovenell's in the future.	Yes	Yes
8.	Crisis Respite—Compass Health proposes to downsize the Crisis Respite Bed Program at the Bailey Center from 25 beds to 16 beds. They would increase the Skagit Behavioral Triage Program from 6 beds to 12 beds.	Yes	Yes
9.	Children's Hospital Diversion Programs—Compass (Skagit) proposes continuing their children's crisis team at its current level for it has been effective at diverting children from the hospital, absorbing part of the fund reduction in other programs.	Yes	Yes
10.	Children's Hospital Diversion Programs—Compass (Snohomish) proposes discontinuing their intensive short-term treatment team program, but they will continue to better utilize their treatment aides and respite resources, as well as, continue the intense focus on manager oversight prior to and after requests for hospital certification.	Yes	Yes
11.	Children's Hospital Diversion Programs—Catholic Community	Yes	Yes

	Services proposes will keep one Hospital Diversion Intensive Family Services Case Manager, 8-10 hours/month of psychiatric services for hospital diversion, and for now they will continue their full-time Community Stabilization Counselor. Flex funds and planned respite care of kids at risk of being hospitalized will be terminated.		

	Issues pending Review At future Transition Work Group Meetings		
12.	Serving non-Medicaid consumers who are on LRS, both new admissions and current consumers.		
13.	Assisting consumers to get on Medicaid without using Medicaid Funding to cover staff time—NSMHA agreed to arrange a regional meeting with DSHS officials.		
14.	Serving consumers who temporarily lose Medicaid eligibility due to Spend-Downs.		
15.	Providing financial management of Medicaid Personal Care—NSMHA will arrange a technical workgroup.		
16.	Reviewing Room and Board Costs for the E & Ts Reviewing the E & Ts so they serve only Medicaid Eligible individuals.		
17.	Tracking Medicaid-eligibility and billing for crisis services.		
18.	Assuring the maximum possible availability of employment services, given that Medicaid funds can only be used for limited types of employment related services.		
19.	Advocating for increased funding for non-Medicaid eligible consumers and for non-Medicaid covered services.		
20.	Flex Funds—How will the need for specialized expenditures for client services be met and managed which are no eligible for Medicaid re-imbursement?		
21.	Other issues identified by the group.		

Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: Plan for Services to Non-Medicaid Consumers

Date of Work Sheet: 6/14/04 **Contact Person:** Tom Sebastian, Chair, APN SAM Committee

Dean Wight

Statement of Issue: *(In one or two sentences)* Recent CMS regulations have defined that Medicaid dollars must only be spent on Medicaid consumers. Where APN had provided services to non-Medicaid level 3 consumers, this service will no longer be allowed.

Why is this an issue now? CMS rules have made it very clear that Medicaid funding is limited to those consumers with Medicaid coverage. Future audits could result in paybacks or possibly legal penalties, should dollars be used in such a manner that does not follow that strict rule. As a result, our system must be modified to discontinue the use of Medicaid funds to serve non-Medicaid consumers.

Number of current consumers affected: Outpatient: Approximately 7.2% of 11,861 consumers served in outpatient services in 2002-03 were not on Medicaid at any time during the year, or 859 consumers. 34% of those were served using Federal Block Grant funds. United Way funds paid for an estimated 15% of these consumers as well (based on Compass Health experience). Accordingly, an estimated 3.7% of outpatients were non-Medicaid served with Medicaid funds, or about 439 consumers. These numbers do not include consumers were on "spend-down" part of the year, but eligible for Medicaid during other times in the year.
Residential: included in the 439 is an estimated 6-8 non-Medicaid consumers received residential treatment services in 2002-03.

Number of hours of service: Outpatient**:** An estimated 6,588 hours of service were provided to non-Medicaid consumers with Medicaid funds in 2002-03. Residential: An estimated 2092 bed-days of residential treatment services were provided to non-Medicaid consumers in 2002-03.

Number of new consumers affected by this change per year: Assuming 10% of the 439 non-Medicaid level 3 consumers leave service each year, then this change would affect approximately 44 new consumers each year.

Funds expended during the last year on this program: About 3.7% of outpatient funds, or $856,000, represents Medicaid funds spent on outpatient services to consumers not on Medicaid during 2002-03.

Proposed Change: Close admissions for outpatient and residential services to all non-Medicaid consumers who do not have an alternate source of funding (e.g. United Way, FBG, insurance) except consumers on "Less Restrictive Alternative" orders, effective July 1, 2004. Begin discharging current non-Medicaid consumers without alternative funding as soon as is possible clinically feasible, in a manner that avoids abandonment of care situations, until all there are no non-Medicaid

consumers receiving outpatient or residential services with Medicaid funds. The target date for completing discharge of all non-Medicaid consumers without alternative funding is August 31, 2004. Exceptions will be allowed with Clinical-Director-level approval at each agency.

Recommendations
1 & 2

Potential Benefits of this Change: *(Please describe)* The Region and its providers will reduce the risk of CMs audit findings and recoupment actions. Consumers will potentially benefit from reduced caseloads (see "Outpatient Enhancement" Transition Plan Worksheet. Using FBG $ for "spend-down" consumers will assure that these consumers will be Medicaid-eligible part of each year and kept out of the hospital (where spend-down amounts would be met quickly and then shift more inpatients costs to the Medicaid side of the ledger).

Potential Negative Impacts of this Change: *(Please describe)* An estimated 439 non-Medicaid consumers will no longer receive outpatient or residential services; if FBG funds are earmarked for spend-down, then some portion of the 292 additional non-Medicaid consumers now served with FBG funds will also not be served. Because these are all Level 3 consumers, many will be re-hospitalized or potentially end up in the criminal justice system. There will be increased pressure on use of State Hospital beds.

Are there Alternative Options? ***(Please describe)*** None without additional state-only funding from DSHS / MHD to serve non-Medicaid priority consumers.

NSMHA Staff Review Comments:

Final Recommendation of Workgroup:

Recommendations
1 & 2

NORTH SOUND MENTAL HEALTH ADMINISTRATION/*bridgeways*

Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: 16 Bed limit on Residential Treatment Facilities. Everett Madison House

Date of Work Sheet: 6/15/04 **Contact Person:** Chuck Roxin

Why is this an issue now?
This is a recent clarification of CMS rules. Implementation of the IMD exclusion rule requires reduction from 48 to 16 beds at EMH. The facility is not financially viable at 16 beds. Therefore implementation requires closing EMH.

Number of current consumers affected:
48 residents capacity; current census at 32. Annualized between 40 and 50.
Without a center to deliver programs the remaining clients [between 60 and 90] would experience a diminishment of services.
Total current client capacity through outpatient services is 108-150

Number of new consumers affected by this change per year:
Unknown

Proposed Change:

1. Assess clients regarding appropriate living situation
2. Move clients into renovated Bridgeways Place
3. Renovate Emerald Apts and move clients into that location.
4. Move remaining clients into other appropriate housing.
5. Implement enhanced community based clinical services with intensive case management.
6. Provide community based services while using EMH as clinic and location for socialization and group activities.
7. Renovate Van fleet to assure transport of consumers to group and socialization activities if they are unable to use the bus.

Evaluation:

1. **Formative evaluation** to document program implementation and achievement of detailed objectives.
2. **Summative evaluation** [annual] to document program outcomes and program efficiencies.
3. **Longitudinal Studies**: tracking a sample of consumers to document long-term impacts of services.

Recommendation
4

Enhanced Clinical Services

bridgeways **is proposing to provide enhanced clinical services to address the shift in programmatic core from residential to non-residential, i.e. from boarding home to community-based, mental health services. With said shift, the support services of residential specialists disappear, but client needs do not decrease. Staff number itself will decrease by 9 FTE's. Consequently,** ***bridgeways*** **will need to alter and add clinical services;** ***bridgeways*** **will need to add clinical staff members who meet the requirements set by the Center for Medicare & Medicaid Services (CMS) and the Washington State Plan. Ideally and eventually,** ***bridgeways*** **would be able to address the full range of needs. From the start, the Recovery Model forms the spine of our services; from assessment through to providing employment. Faced with the exigencies of federal funding negative impact,** ***bridgeways*** **would deploy a multi-phase enhancement of clinical services, beginning with Phase I.**

Phase I service modalities are as follows.

- Group Treatment Services
- Individual Treatment Services
- Day Support Treatment Services
- Intake Evaluation
- Medication Management
- Medication Monitoring
- Psychiatric Evaluation
- Rehabilitation Case Management
- Special population evaluation
- Therapeutic psycho-education

The current client population totals 90 clients. Providing the minimum necessary services as outlined above, ***bridgeways*** projects minimum Phase I staffing needs are as follows.

- 6 FTE clinicians
- Clinical Director
- Psychiatrist, 8 hrs per month
- Advanced Registered Nurse Practitioner, 6 hrs per week

It is also reasonable to project an increase in mileage costs.

This level of staffing represents a decrease in case loads, increases in intensity of services, and , we believe , can be provided for the funds now used for housing services.

Although the modalities are standard, the enhancement comes in three ways:

- Reduced case load

- Increase in staff qualifications
- Increased frequency and intensity of services

Recommendation 4

Potential Benefits of this Change [primary]:

- Consumers will not loose services.
- Consumers will receive a higher level of service.
- Deterioration of client functioning for those who loose housing and a protected environment will be will be reduced.

Potential Negative Impacts of this Change:

Disruption of clients' lives and sense of security during the move.
Difficulty for some of adjusting to life in a non-secure environment.

Recommendation 4

bridgeways

Memorandum

To: Greg Long
From: Chuck Roxin
Date: June 17th, 2004
Re: Everett Madison House Move Out Schedule

Greg,

Here is our updated move out schedule to bring EMH first into compliance with the IMD exclusion rule and then to close for financial reasons.

Month	Number	Comment
Before June 15	2	
June	9	This group is confirmed as to location and date of move. They are fairly high functioning.
July	8	We will implement a housing Learning Lab in a vacant apartment so clients for the July-August move out will have a chance to learn how to clean, cook, make beds, etc. prior to move out.
August	10	Most of August and September clients are those who are hard to place for a variety of reasons.
September	3	We believe that the goals for August and September may not be met depending on client progress and

1220 – 75th Street SW ♦ Everett, WA 98203 (425) 513-8213 fax; (425) 513-0534

Recommendation 4

North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

117 North First Street, Suite 8 • Mount Vernon, WA 98273 • 360.416.7013
800.684-3555 • Fax 360.416.7017 • TTY 360.419.9008 • Email nsrsn@nsrsn.org

Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: How to restructure services for those in Compass Health owned residential facilities, which may be considered IMD's.

Date of Work Sheet: 6/8/2004 **Contact Person**: Carole Kosturn & Dean Wight

Statement of Issue: Consumers otherwise eligible for Medicaid will not be covered by Medicaid if they reside in facilities considered by CMS to be institutions for the Mentally Diseased (IMD), defined as a facility that is larger than 16 beds where more than 50% of its residents are there for treatment of a mental illness.

Why is this an issue now?
Compass has been providing residential services to Medicaid-eligible consumers in two facilities in Snohomish County, which may in future audits, be determined to be IMD's:

Number of current consumers affected: Greenhouse – None; Aurora House – None.

Number of new consumers affected by this change per year: 20% of the number of consumers admitted in a typical year to each facility: probably 1-2 clients per year in each facility.

Funds Expended during the last year on this program: Greenhouse - $576,730; Aurora House - $439,536.

Proposed Change:
Reduce Greenhouse and Aurora House to 16 beds each; transfer as many as possible to Haven House, where vacancies now exist but permission has been requested from HUD to expand the age range to serve all adults; provide intensive outpatient services (including case management in the living situation) to consumers who would otherwise be admitted.

Early decision-making on this issue would allow providers to begin the process of making plans for consumers which could take some time, and consumers would be best served by being given a smooth transition process.

Potential Benefits of this Change:
This will bring Compass into compliance with CMS rules. Continuation of the bed capacity over the standard could well result in paybacks and sanctions that would not benefit the RSN or

providers. Providers have begun to explore creative means to meet the needs of their consumers without residential beds, through the new modalities in the state Medicaid plan.

Recommendation 5

Potential Negative Impacts of this Change:

Because of current low census, no consumers will need to be transitioned out of their current residential placements. In some cases, consumers have been in these facilities for many years. It will be difficult for consumers to make such a transition, despite good clinical planning and creative alternatives. The change will reduce the number of beds in Snohomish County by 8 beds.

Are there alternative Options?

No, there are no options to changing the IMD rule. The best option is to develop creative alternatives to meet the consumers' needs with services and housing options.

Recommendation 5

North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

117 North First Street, Suite 8 * Mount Vernon, WA 98273 * 360.416.7013
800.684.3555 * Fax 360.416.7017 * TTY 360.419.9008 * Email nsrsn@nsrsn.org

Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: 16 Bed limit on Residential Treatment Facilities. Lake Whatcom Center

Date of Work Sheet: 6/16/04 **Contact Person:** Mike Watson

Statement of Issue: Consumers otherwise eligible for Medicaid will not be covered by Medicaid if they reside in facilities considered by CMS to be institutions for the Mentally Diseased (IMD), defined as a facility that is larger then 16 beds where more than 50% of its residents are diagnosed with a mental illness.

Why is this an issue now?
Lake Whatcom Center has been providing residential services to Medicaid-eligible consumers throughout the Region in our **67 bed** facility for over 24 years. Now, potential audits from CMS may determine the facility to be an IMD.

Number of current consumers affected: 67

Number of new consumers affected by this change per year: 12 – 20

Funds Expended during the last year on this program: $635,000

Proposed Change:
Reduce the census in the 67 bed facility to 16 utilizing mental health services in residential settings. Move 51 consumers utilizing high intensity treatment to apartments in Bellingham. Provide intensive clinical services as well as meal preparation and housekeeping assistance all requiring additional staff. Purchase a complex large enough to house 51 consumers.

Time would be needed to find and purchase the complex/apartment(s), and do any renovations needed. Consumers would need to transition at individual rates taking as long a 6 to 9 months. Additional staff would be required to begin teaching independent living skills prior to transitioning in the best attempt to help the consumers succeed.

The 16 consumers remaining in the 67-bed facility would receive "bundled" mental health services provided by on site staff.

Potential Benefits of this Change: Bring Lake Whatcom Center into compliance with CMS rules. Consumers will continue to receive services.

Potential Negative Impacts of this Change:
51 consumers will loose what they consider "home" and some may need to be displaced against their wishes. Some of which have lived in the facility for 24 years. Consumers will have an enormous amount of difficulty understanding the displacement, let alone making the required changes to transition to

Recommendation 6

anything less supportive despite all the best clinical planning possible. The cost of providing the necessary services to the consumers will be dramatically increased, as the efficiency of the larger facility is gone. The Region will loose 51 beds, thus reducing available 24-hour residential services.

Are there alternative Options?
We are uncertain, but are continuing to research that issue.

Note: Lake Whatcom Center would need to match or increase current funding in order to provide the above-proposed changes.

Recommendation 6

North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

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Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: How to restructure services for those in Compass Health contracted residential facilities, which may be considered IMD's.

Date of Work Sheet: 6/8/2004 **Contact Person**: Tom Sebastian & Dean Wight

Statement of Issue: Consumers otherwise eligible for Medicaid will not be covered by Medicaid if they reside in facilities considered by CMS to be institutions for the Mentally Diseased (IMD), defined as a facility that is larger than 16 beds where more than 50% of its residents are there for treatment of a mental illness.

Why is this an issue now?
Compass has been providing residential services to Medicaid-eligible consumers in a contracted facility in Skagit County (Ovenell's), which may in future audits, be determined to be IMD's. In addition, because it is a contracted facility, it does not provide the staffing and supervision necessary to meet the requirement of having Mental Health Care Providers primarily involved in implementing its consumer plan of treatment in the facility.

Number of current consumers affected: 14

Number of new consumers affected by this change per year: The number of consumers that equals the turnover rate in each facility, which is relatively low.

Funds Expended during the last year on this program: $216,000/year.

Proposed Change:
Reduce the census at Ovenell's through attrition and development of intensive outpatient services (including case management in the living situation) for those consumers now there. Then terminate the contract with Ovenell's, which is for up to 15 beds; provide intensive outpatient services (including case management in the living situation) to consumers who would otherwise be admitted.

Early decision-making on this issue would allow Compass to begin the process of making plans for consumers which could take some time, and consumers would be best served by being given a smooth transition process.

Potential Benefits of this Change:
This will bring Compass into compliance with CMS rules. Continuing to contract for services in a facility that will not meet state Medicaid plan and IMD rules could well result in paybacks and sanctions that

would not benefit the RSN or providers. Providers have begun to explore creative means to meet the needs of their consumers without residential beds, through the new modalities in the state Medicaid plan.

Potential Negative Impacts of this Change:
14 consumers will need to be transitioned out of their current residential placement. In some cases, consumers have been in these facilities for many years. It will be difficult for consumers to make such a transition, despite good clinical planning and creative alternatives. The change will reduce the number of beds in Skagit County by at least 15 contracted beds.

Are there alternative Options?
No, there are no options to changing the IMD rule. The best option is to develop creative alternatives to meet the consumers' needs with services and housing options.

Recommendation
7

NORTH SOUND MENTAL HEALTH ADMINISTRATION

Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: 16 Bed limit on Residential Treatment Facilities. The Compass Health Crisis Respite Bed Program at the Bailey Center in Everett, WA has 25 beds.

Date of Work Sheet: 6/15/04 **Contact Person:** Tom Sebastian

Why is this an issue now?
This is a recent clarification of CMS rules. The actuarial study in 2003 brought this up as an issue. This need to change as soon as possible so current actuarial rates can be fairly set. Failure to make this change will reduce funding coming into State and Region in future years.

Number of current consumers affected: Recent census of the 25 beds has been around 16-17 consumers, so perhaps none will be affected.

Number of new consumers affected by this change per year: Unknown; potentially none.

Funds expended during the last year on this program: $1,006,466 at Bailey; $365,541 at Skagit.

Proposed Change:
To downsize the Crisis Respite Bed Program at the Bailey Center in Everett from 25 beds to 16 beds.
To increase the Skagit Behavioral Triage Program from 6 beds to 12 beds.

Potential Benefits of this Change:
This will preserve 6 of the 9 beds lost at the Bailey Center. In addition, Skagit County DASA dollars will support a Social Detox component to the Skagit program. No savings are expected from this change, because there will be losses to economies of scale at Bailey, and any expense reductions there will be offset by expense increases at Skagit, despite the addition of DASA funds.

Potential Negative Impacts of this Change:
Net loss of 3 Crisis Respite Beds.

Are there Alternative Options?
Please see "Proposed Change" Section above.

NSMHA Staff Review Comments:

Final Recommendation of Workgroup:

Recommendation 8

North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

117 North First Street, Suite 8 • Mount Vernon, WA 98273 • 360.416.7013
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Medicaid Transition Plan Work Sheet

Medicaid Transition Issue: Continuation of Children's Hospital Diversion Projects by Compass Health, which were funded through FEMA dollars that end June 30, 2004.

Date of Work Sheet: 6/8/2004 **Contact Person**: Carole Kosturn, Tom Sebastian

Statement of Issue: The FEMA dollars, which funded four projects designed to reduce children's hospitalizations, will end on June 30, 2004. The question is should these projects continue without continued funding, or can the "learnings" of the projects be integrated into current funded services with whatever resources providers have.

Why is this an issue now?
The FEMA money is ending June 30, which was a total of $493,433 for APN as a whole. In order to continue these services and programs as currently constituted, a total of $508,236 (assuming 3% increase in costs) would need to be found, or an equivalent amount of service would need to be cut from other core existing programs.

Number of current consumers affected: Approximately 40 children will be serve in this program in Snohomish County in 2003-04.

Number of new consumers affected by this change per year: This was a pilot project, so unless the project continues there would be no consumers next year impacted by the change.

Funds Expended during the last year on this program: None in 2002-03; $493,433 in 2003-04.

Proposed Change:
Each of the four projects were designed to meet the individual counties' needs. The proposal is to end the pilot project in each of the areas, allowing each community to define how they may take the "learnings" from the project and integrate those into their ongoing service delivery system. In Snohomish County, this would be done by continuing to better utilize our treatment aides and respite resources to meet the needs of the children in our community as well as continued focus on manager oversight prior to and after requests for hospital certification. In Skagit County, Compass Health is retaining some elements of the expanded Children's Crisis Team, absorbing part of the fund reduction in other programs.

Potential Benefits of this Change:

The pilot projects enabled each community to experiment with creative means to work with children in a preventative capacity or in an emergent capacity in order to reduce hospitalizations for children. In many

instances individual children were not hospitalized because of the programs. In all cases, staff became much more aware of what could be done by using alternative approaches to reach the children and families in order to prevent out-of-home placements into hospitals. Staff in all cases also altered their service process to benefit the children. In each county, parts of the service program will be integrated into the system as funding and general learnings allow.

Potential Negative Impacts of this Change:
The pilot projects will end as they are currently constituted. There is not sufficient money to continue such projects without closing other key services to children at this time. Therefore, the projects will not be as complete or as comprehensive as they cold be with full funding.

Are there alternative Options?
No, the best option is for agencies, using whatever resources they can, to integrate their learning from these projects into their care system. We can use this past experience to creatively use our resources to benefit the type of children we have served.

Recommendations
9, 10, & 11

Catholic Community Services'
Children's Hospital Diversion Program Continuation Plan

Greg – Rod asked me to send you an e-mail describing what aspects of Children's Hospital Diversion we intend to keep in Whatcom and Skagit. If you need this in more detail or some other form, please let me know.

As you know, some services in Whatcom were funded by dollars from our prior crisis respite program. Then, additional pieces were added on with FEMA $. We have found the whole project to be successful, and we are in the process of doing a written evaluation, which will be submitted to you soon. In the meantime, our budgeting process for the upcoming year has resulted in decisions about what we can keep and what we have to let go. Our budgets are not final yet, so this is where we sit at the current moment.

In Whatcom, we intend to keep our full-time HD Intensive Family Services Case Manager, a carry over from crisis respite dollars. We will also keep about 8-10 hours a month of psychiatric services for HD. This allows kids in hospital diversion mode to gain very quick access to psychiatry, as well as for weekly consultation between the psychiatrist and the HD team. For now, we will also continue to employ our full-time Community Stabilization Counselor, who is part of the HD team. (This decision could change if in continued budgeting and more information about our funding situation, we decide we can't afford to continue this position.) The two things that will not continue are specific flex funds for the HD team to spend and dollars for planned respite in foster care for HD kids. (For one thing, we don't have the money, and for another, Medicaid dollars can't be spend on these two things.) However, since we have County dollars in Whatcom for respite, we can still access respite through our R&R program for HD kids, so that is not a huge sacrifice.

In Skagit, our HD project had two parts: a half-time HD Intensive Family Services Case Manager and additional psychiatry hours. At this time, we anticipate discontinuing the case management, but we do anticipate keeping the additional psychiatry hours (about 8 hours per month) that was added. This has proved invaluable and is our priority to maintain. If in budget planning, we are able to maintain any part of our HD case management, we will do so, but right now it's not in our budget.

Hope this is what you need. If not, please let me know.

Kathy

Recommendation 11

POL# 2001

Subject: Business Ethics and Regulatory Compliance Program

I. MISSION STATEMENT

The mission of the North Sound Mental Health Administration (NSMHA) is to join together to enhance our community's mental health and support recovery for people with mental illness served in the North Sound region, through high quality and culturally competent services.
As we pursue this mission, we are committed to conducting all of our activities in compliance with applicable laws and regulations and in accordance with the highest ethical standards. We will maintain a business culture that builds and promotes professional responsibility and encourages colleagues to conduct all NSMHA business with honesty and integrity. Our commitment to compliance includes: communicating to all employees, consultants, independent contractors and subcontractors clear ethical guidelines; providing training and education regarding applicable laws, regulations, and policies; and providing monitoring and oversight to help ensure that we meet our compliance commitment. We promote open and free communication regarding our ethical and compliance standards and provide a work environment free from retaliation.

II. PURPOSE

The purpose of this policy is to outline and define the scope, responsibilities, operational guidelines, controls and activities employed by NSMHA to ensure that we maintain an environment that facilitates ethical decision making and that we act in accordance with the laws and regulations that govern us.

III. POLICY

It is the policy of NSMHA to ensure through its Business Ethics and Regulatory Compliance Program compliance with the laws, regulations, principles and policies that govern us and to maintain an active program to correct problems that arise. The compliance program is implemented throughout NSMHA's internal operations and external provider network through the development of policies and procedures, appointment of a compliance officer and compliance committee, training and education, effective lines of communication, monitoring and auditing functions, enforcement standards and response mechanisms.

IV. DEFINITIONS

Abuse: means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to NSMHA and/or Department of Social and

Health Services/Mental Health Division (DSHS/MHD) Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes service recipient practices that result in unnecessary cost to the NSMHA and/or DSHS/MHD.

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Compliance Officer: means the person within NSMHA with the primary responsibility to implement and coordinate the Business Ethics and Regulatory Compliance Program and associated activities.

Ethics and Compliance Committee: means the NSMHA board designated committee with the responsibility to establish overall policy and standards for the Business Ethics and Regulatory Compliance Program and to provide oversight.

Medicaid Managed Care Abuse: means practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care.

Medicaid Managed Care Fraud: Any type of intentional deception or misrepresentation made by and entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

Provider: means any individual, community mental health agency or entity providing NSMHA funded public mental health services through contractual agreement with NSMHA Board of Directors.

V. STANDARDS OF CONDUCT AND COMPLIANCE POLICIES AND PROCEDURES

North Sound Mental Health Administration is committed to conducting its business with integrity and in compliance with all applicable laws. NSMHA has developed and maintains the Guidelines for Business and Ethical Conduct. The purpose of the guidance is to communicate to all NSMHA employees, contractors and subcontractors an expectation and requirement of ethical compliance with all applicable laws, policies, rules and regulations. The NSMHA Guidelines For Business and Ethical Conduct is intended to establish clear, over-arching guidance. It does not address in detail every specific compliance issue that might arise. It does provide a framework for seeking guidance and for decision making. The

NSMHA Guidelines for Business and Ethical Conduct should be regarded as a set of guiding principles that apply to every NSMHA employee.

NSMHA's compliance policies and procedures provide further guidance on specific compliance risk areas. At a minimum, NSMHA will develop and maintain policies to address the relevant risk areas identified by the OIG in its "Compliance Guidance to Medicare + Choice Organizations," which are:

1. Marketing Materials and Personnel
2. Selective Marketing and Enrollment
3. Disenrollment
4. Underutilization and Quality of Care
5. Data Collection and Submission Policies
6. Anti-Kickback Statute and Other Inducements
7. (Emergency Services – NSMHA does not participate in the provision of emergency services as defined by the OIG guidance)

NSMHA will also develop policies to implement substantive contractual and regulatory obligations imposed by DSHS-MHD. NSMHA will develop policies and procedures designed to prevent and detect known compliance problems identified through its compliance program.

VI. COMPLIANCE ORGANIZATION AND OVERSIGHT

A. The NSMHA Board of Directors has ultimate responsibility for NSMHA's Business Ethics and Regulatory Compliance Program.

B. NSMHA has appointed the NSMHA Contracts Manager as the Compliance Officer, also known as the Program Integrity Officer under the Medicaid program, and the NSMHA Financial Committee as the Ethics and Compliance Committee (ECC). Together the Ethics and Compliance Committee and the Compliance Officer maintain primary responsibility to oversee and coordinate the Program. The ECC reports to the NSMHA Board of Directors. While the Compliance Officer generally reports to the ECC, when circumstances warrant as determined by the Compliance Officer, the Compliance Officer has the authority to meet directly with the Board of Directors.

1. The Compliance Officer has direct access to the ECC, NSMHA Executive Director, Board of Directors, senior management and legal counsel. The Compliance Officer's duties and authority include the following:

   a. Implement and monitor NSMHA compliance activities.

   b. Report directly to the ECC on at least a quarterly basis regarding all compliance activities including policy development, training, monitoring, business and ethical issues addressed, and reports of suspected noncompliance.

c. Develop policies and procedures that are designed to address substantive regulatory compliance risk areas.

d. Develop and implement education and training programs for employees.

e. Report on a periodic basis to the NSMHA Board of Directors on the progress of the implementation of the Program.

f. Receive reports of possible violations of the Program.

g. Research and provide answers to business ethics and regulatory questions that arise.

h. Investigate all potential incidents of noncompliance, including reviews of relevant documents and interviews of relevant people.

i. Refer potential fraud to one or more of the appropriate authorities including but not limited to:

- DSHS/MHD;
- DSHS/Medical Assistance Administration (MAA) Payment Review and Audit Section;
- WA State Auditors Office;
- WA State Medicaid Fraud Control Unit/Office of Attorney General;
- Office of Civil Rights;
- Department of Health and Human Services /Office of Inspector General (DHHS/OIG); and/or
- Center for Medicare and Medicaid Services (CMS) Regional Fraud and Abuse Coordinator.
- Director of the Managed Care Contracting Division of the Department of Health Care Policy and Financing.

j. In consultation with the ECC develop corrective action plans to correct compliance violations, prevent future incidents of noncompliance and steps for monitoring progress.

k. Develop a reporting process that is clearly defined and communicated to employees, contractors and consumers.

l. Implement measures developed by the Executive Director, the ECC and the Board of Directors, which are designed to create an environment where employees, contractors, providers, and consumers are encouraged to raise

ethical questions, report potential incidents of noncompliance, and report suspected fraud and abuse without fear of retaliation.

m. Assist the Executive Director, the ECC and the Board of Directors in reviewing NSMHA functions as they relate to fraud and abuse prevention, detection and reporting and in establishing methods to reduce NSMHA vulnerability to incidents of fraud and abuse.

n. Maintain a tracking system for business ethical issues, questions about regulatory compliance, reports of potential noncompliance and reports of suspected fraud and abuse and develop and present a quarterly status report to the ECC.

o. Ensure that appropriate contract provisions are in place that requires contractors and subcontractors to have a compliance program.

2. The Ethics and Compliance Committee has direct access to the Compliance Officer, NSMHA Executive Director and Board of Directors. The ECC duties include the following:

a. Ensure that the Business Ethics and Regulatory Compliance Program is designed to provide an ethical framework for decision-making.
b. Ensure that the Business Ethics and Regulatory Compliance Program is designed to prevent and/or detect violations of the law and NSMHA's policies and procedures.
c. Oversee the development and revision of the Guidelines for Business and Ethical Conduct and policies and procedures that implement the Program.

d. Together with the Compliance Officer periodically review and revise the Business Ethics and Regulatory Compliance Program to meet changing regulations or trends and submit the revised Program to the Board of Directors for approval.

e. Receive reports on investigations being conducted by the Compliance Officer unless such reports would potentially compromise an investigation.

f. Receive status reports from the Compliance Officer on a quarterly basis and take such steps as may be necessary to resolve any problems that prevent action or limit the effectiveness of the program.

g. Together with the Compliance Officer ensure communication of the Program and associated activities to all employees including changes in laws, regulations or policies, as necessary, to assure continued compliance.

h. Make efforts to create an environment where employees, contractors, providers, and consumers are encouraged to raise ethical questions, report potential incidents of noncompliance, and report suspected fraud and abuse without fear of retaliation.

3. Any potential fraud and/or abuse occurrences identified by providers or by NSMHA employees during the course of performing their duties are reported to the NSMHA Compliance Officer as outlined in section IX (Effective Lines of Communication for Reporting and Clarifying Policy) of this Plan. The Compliance Officer may conduct an investigation in an effort to verify such items as the source of the complaint, type of provider, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case. The Compliance Officer reviews the report with NSMHA's Executive Director and Legal Counsel and if appropriate, the report is forwarded to one or more of the authorities listed in (VII.B.1.f.) of this program. The Compliance Officer is authorized to exercise independent discretion in reporting suspected fraud and/or abuse to any and all appropriate authorities.

VII. TRAINING AND EDUCATION

A. NSMHA is committed to communicating our standards for ethical conduct, compliance awareness and compliance policies to all employees. All NSMHA employees receive copies of NSMHA's Guidelines for Business and Ethical Conduct and mandatory training on NSMHA's Business Ethics and Regulatory Compliance Program. Training may include, but is not limited to, the following topics:

1. Employee's responsibility to know and comply with State and Federal laws and regulations and NSMHA policies that apply to their job and to ask questions when the correct course of action is unclear.

2. The specific components of the NSMHA Business Ethics and Regulatory Compliance Program, including NSMHA's standards for ethical business conduct.

3. An overview of what constitutes fraud and abuse in a Medicaid Managed Care environment.

4. Clarification of roles and responsibilities of NSMHA, State and Federal resources and contacts (i.e. Compliance Officer, Ethics and Compliance Committee, Medicaid Fraud and Control Unit, State Auditors Office, Office of Inspector General, etc.).

5. How to raise questions about ethical behavior and regulatory compliance and how to report suspected violations and questionable conduct.

6. A review of specific State contract requirements applicable to NSMHA business.

7. The consequences of failing to comply with applicable law and NSMHA's compliance standards.

8. As new developments or concerns arise, the NSMHA Compliance Officer will ensure the information is disseminated to all employees and to contractor management for dissemination to contractor staff and subcontractors.

B. As outlined in the NSMHA Agreement General Terms and Conditions each Provider is required to participate in Medicaid fraud and abuse training. NSMHA will notify Providers of applicable fraud and abuse training opportunities offered through CMS, Washington State Attorney General's Medicaid Fraud Unit, Washington State Auditor's Office, MHD, NSMHA or any other relevant entity.

VIII. COMPLIANCE MONITORING AND AUDITING

Detection and prevention of fraud and abuse is conducted by NSMHA through a variety of auditing and monitoring processes and activities. NSMHA's Quality Management plan includes activities designed to ensure provider compliance. NSMHA's Biennial Administrative, Fiscal, Quality Assurance/Improvement On-site Provider Contract Review is designed to ensure contractor compliance. Other fiscal policies and audits ensure compliance with payment standards that apply to NSMHA. At a minimum, NSMHA will conduct monitoring activities that encompass the relevant risk areas identified by the OIG in its Compliance Guidance to Medicare + Choice Organizations (see section V).

IX. EFFECTIVE LINES OF COMMUNICATION FOR SEEKING GUIDANCE AND REPORTING PROBLEMS

A. NSMHA employees and contractors have a responsibility to raise questions about business ethics and regulatory compliance, to report incidents of potential noncompliance and to report suspected fraud and abuse identified during the course of performing work responsibilities to the Compliance Officer.

B. A report is made to the Compliance Officer using one of the following options:

1. In person, to the Compliance Officer.

2. Faxing a report to the Compliance Officer at (360) 416-7017

3. Anonymously and confidentially calling the Compliance Officer at (360) 416-7013 Ext. 228 or (800) 684-3555.

4. Mailing a written concern or report to:

Compliance Officer
North Sound Mental Health Administration
117 N. 1st Street, Suite 8
Mt. Vernon, WA 98273-2858

(Please identify as **Confidential** on outside of envelope)

5. In addition, NSMHA and contractor employees may report any potential fraud or abuse to their supervisors who must then report the suspected misconduct to the NSMHA Compliance Officer.

C. All contacts that cannot be resolved in one conversation are documented to track and monitor reported concerns to resolution.

D. All known reporting persons are advised that they may call back at a later time to receive an update on their reports.

X. INVESTIGATIONS, CORRECTIVE ACTION PLANS AND OTHER RESPONSES

A. All reports of potential violations of laws, regulations, policies or questionable conduct, from any source, shall be logged and reviewed by the NSMHA Compliance Officer. It after initial investigation and consultation with the NSMHA Executive Director and Legal Counsel, and the Compliance Officer determines there are genuine compliance concerns, the Compliance Officer informs the ECC and forwards reports of potential fraud and abuse to the DSHS/MHD and all other appropriate regulatory authorities.

B. When an instance of non-compliance has been determined and confirmed, the Compliance Officer develops and recommends an initial corrective action plan and submits it to the ECC for review. The ECC, after consideration and any modification, shall approve a corrective action plan. Upon approval, the Compliance Officer and ECC will develop a strategy for implementation of the corrective action plan, with the advice and guidance of the NSMHA Executive Director and Legal Counsel. The corrective action plan will focus on implementing changes designed to ensure that the specific violation is addressed and, to the extent possible, improve, prevent or detect any additional compliance inadequacies. The corrective action plan may include one or all of the following areas:

- Specific areas requiring compliance attention
- Requirements of additional training and education
- Further audit and/or investigation
- Disciplinary Action
- Monitoring the results.

C. If the initial investigation reveals possible criminal activity, the corrective action plan includes:

1. Immediate cessation of the activity until the corrective action plan is in place.

2. Initiation of appropriate disciplinary action against the person or persons involved in the activity.

3. Notification to such law enforcement and regulatory authorities as NSMHA Legal Counsel advises, which at a minimum includes for Medicaid Fraud, notification to the Medicaid Fraud Unit of the Washington Attorney General's Office and the Director of Managed Care Contracting Division of the Department of Health Care Policy and Financing.

4. Specific requirements for additional training and education of employees to prevent future similar occurrences.

5. Initiation of any necessary action to ensure that no consumers are placed at clinical risk.

D. Any threat of reprisal against a person who makes a good faith report under the Plan is against NSMHA policy. Reprisal, if found to be substantiated, is subject to appropriate discipline, up to and including termination.

F. NSMHA, at the request of a reporting person, shall provide such anonymity to the reporting person as is possible under the circumstances in the judgment of the Compliance Officer, consistent with NSMHA obligation to investigate concerns and take necessary corrective action. Anonymous reporting persons are advised that while they may remain anonymous, the content of their reports is not confidential.

G. If the identity of the complainant is known, the Compliance Officer provides a written report to the reporting individual that an investigation has been completed and, if appropriate, the corrective action that has been taken.

XI. ENFORCEMENT AND DISCIPLINARY MECHANISMS

A. Employee Disciplinary Action

NSMHA will initiate appropriate disciplinary action against employees who fail to comply with applicable laws, regulations, and policies. The seriousness of the violation will determine the level of the discipline.

B. Contractor Discipline/Termination

NSMHA contracts require that providers comply with all NSMHA policies and procedures that impact the prevention and detection of fraud and abuse, including the NSMHA Business Ethics and Regulatory Compliance Program. The contracts clearly state that breach of these provisions will be events for corrective action or termination of the contract after failure to cure.

XII. PROVIDER RESPONSIBILITIES

A. NSMHA includes the requirement to report suspected incidents of fraud and abuse into its direct contracts and requires its providers, in turn to pass those requirements to their subcontractors.

B. NSMHA's direct contracts require that providers comply with all NSMHA Policies and Procedures including those that impact the prevention and detection of fraud and abuse. Likewise, providers are required to include compliance with NSMHA Policies and Procedures as a contract term in their subcontracts.

C. NSMHA requires providers to implement procedures to screen its employees and contractors to determine whether they have been (1) convicted of a criminal offense related to health care; or (2) listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation as verified through the United States Health and Human Services website at http://exclusions.oig.hhs.gov., and the Excluded Parties Listing System at http://www.epls.gov. Employees or subcontractors found to have a conviction or sanction or found to be under investigation for any criminal offense related to health care are to be removed from direct responsibility for, or involvement with NSMHA funded services.

D. NSMHA's direct contracts require that providers develop and implement administrative and management procedures that are designed to ensure regulatory compliance including:

1. The adoption of a mandatory compliance plan that includes the seven components recommended by the federal sentencing guidelines;

2. Participation by the provider and any subcontractors in Medicaid fraud and abuse training conducted by the Washington State Attorney General's Medicaid Fraud Unit.

3. Reporting of fraud and/or abuse information of the provider or subcontractors to NSMHA as soon as it is discovered or suspected, including the consumer name/ID number if applicable, the source of the complaint, type of, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

XIII. COORDINATION WITH GOVERNMENTAL AGENCIES

A. NSMHA will assist various governmental agencies as practical in providing information and other resources during the course of investigations of potential fraud or abuse. These agencies include, but are not limited to those listed in (VII.B.1.f.) of this Plan.

B. All information identified, researched or obtained for, or as part of, a potential fraud and abuse investigation is considered confidential by NSMHA and the participating investigative governmental agencies. Any information shared among and/or developed by participants in the investigation of a potential fraud and abuse occurrence is maintained solely for this specific purpose and no other.

C. NSMHA will implement processes that comply with specific reporting procedures developed by DSHS/MHD and with processes establishing and administering penalties and sanctions for fraud and abuse.

NSMHA-APN CONTRACT AMENDMENT #1
JUNE, 2004

BOARD OF DIRECTORS

EXECUTIVE SUMMARY

Purpose: In May, NSMHA entered into contract negotiations with APN in order to restructure the relationship to incorporate changes imposed by BBA regulations and by the MHD State Medicaid Plan Waiver approval process. The proposed contract amendment is the result of the negotiation process. Both parties agreed to use the transition planning process to make further structural changes and establish a framework which will lead to more contract modifications without the need to re-enter negotiations.

Scope: The scope of change was significant and this summary does not discuss the particulars of every language change. The changes fall into two categories: BBA/Health Plan regulations and MHD Waiver. A summary of the regulatory change and a summary of contract changes that result follows. Also a summary of the transition planning process that was developed is found below.

BBA/Health Plan Regulations
Regulatory Summary: Through the Balanced Budget Act, Congress required CMS to regulate health plans that serve Medicare and Medicaid enrollees. CMS implemented the BBA regulations and it has been determined that RSNs are a type of health plan subject to the regulations. First, the regulations restricted activities that could be delegated to providers. Second, the regulations created significant protections for enrollees. While the state already had significant protections for enrollees, the two regulatory frameworks must be brought together. Finally, the BBA regulations impose additional responsibilities on NSMHA. Information from MHD to clarify these requirements was not received until April, 2004.

Contract Changes Summary:
Resource Management becomes a NSMHA responsibility, as it cannot be delegated.
When a Medicaid enrollee meets the access to care standards they are automatically authorized for outpatient services
Actions that deny or limit services and Notices of Action are a NSMHA responsibility (no longer delegated to APN).
Appeals are added to Complaints, Grievances and Fair Hearings as steps a consumer can take.
Various enrollee protection language was added/modified including communication requirements, restrictions on liability and advance directives.

MHD Waiver

Regulatory Summary: CMS altered the financing structure for Washington's Public Mental Health system through the waiver. Specifically, Medicaid funds cannot be used to care for Non-Medicaid clients. A second change is the limitation on the use of Medicaid funds to CMS approved services. Currently the region is expending more on non-Medicaid then we are allowed under the new regulations. Finally is the requirement that residential facilities not have more than 16 beds (the "IMD rule").

Contract Changes Summary

A draft MHD-NSMHA contract revision was the basis for many of the changes. The parties felt that, given the enormous impact of the financing changes, it was not appropriate to wait for more definite guidance from the state.

Language regarding residential treatment and housing supports was substantially revised reflecting the fact that Medicaid funds may only be used for services, not room and board, and reflecting the impact of the IMD rule.

Language regarding services to Non-Medicaid consumers was added clarifying that only state, local and federal block grant funds may be used.

Language was added limiting Medicaid expenditures to Medicaid approved services.

APN received authority to charge for payee services.

Mutual Commitments/Transition Planning

The parties mutually agreed to provide services paid for with Medicaid funds in compliance with CMS requirements, as specified in the state Medicaid plan.

The parties agreed to a transition planning process. The transition plan will be approved by the NSMHA Board of Directors, at which point it is incorporated as Attachment XXX to the NSMHA-APN contract.

The parties agreed that amendments to specific sections and attachments to the contract could also occur during transition planning. These changes would also be approved by NSMHA's Board of Directors and incorporated into the contract without further action by the parties. A list of contract sections that could amended in this manner was included. APN reserved the right to call for negotiation on any specific section of the plan or proposed amendment to the contract and a process was developed for that situation.