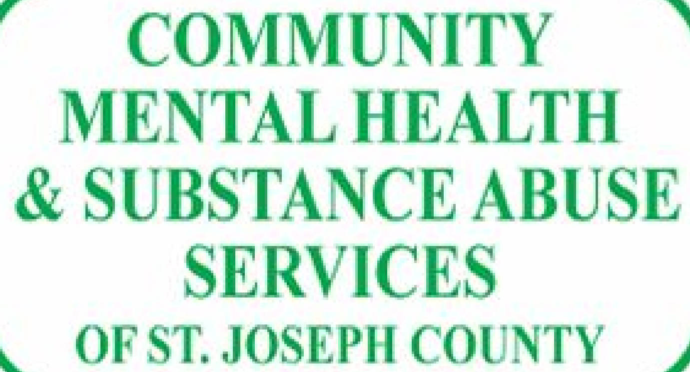
COMMUNITY
MENTAL HEALTH
& SUBSTANCE ABUSE
SERVICES
OF ST. JOSEPH COUNTY

CORPORATE COMPLIANCE PROGRAM

FY 14-FY 16

CORPORATE COMPLIANCE PROGRAM

I. INTRODUCTION

It is the responsibility of Community Mental Health & Substance Abuse Services of St. Joseph County (CMHSAS-SJC) to manage the Medicaid program in full compliance with all laws and regulations, including operating all services within the boundary of ethical integrity and legal practice. As such, it is the duty of each board member, director, employee, contractor, subcontractor or agent operating within the CMHSAS-SJC provider network to always render services in an ethical and legal manner, and to immediately report any person (or entity) who knowingly presents (or causes to be presented) a false or fraudulent claim for payment, or who falsifies a record or statement in order to get a claim paid

Purpose

CMHSAS-SJC is committed to identifying and complying with local, state and federal laws and regulations. The purpose of this Compliance Program is to outline the ways in which the CMHSAS-SJC employees and partners can ensure its provider network operates in compliance with such laws and regulations. We recognize that some areas of health care law, including certain statutes and regulations, may be contradictory or unclear. CMHSAS-SJC will use reasoned review and seek assistance from regulatory authorities when appropriate and available. As guidance concerning these laws and regulations continues to unfold, CMHSAS-SJC will continue to respond in a manner that fosters legal and ethical compliance.

A. Context

Establishing the CMHSAS-SJC *Compliance Program* is a response to federal requirements to ensure the agency operates its specialty behavioral healthcare network within the legal framework and intent of the law. In developing the enclosed *Compliance Program* reference was made to the Office of Inspector General (OIG); and later and new mandates under the Affordable Care Act of 2010 (P.L. 111-148 and P.L. 111-152), as an entity under direct federal contract, which operationalizes the provisions of the Deficit Reduction Act of 2005 (DRA).

In terms of these federal laws, the DRA requires any entity that has a direct federal contract, and which annually receives or pays-out more than $5.0 million dollars in Medicaid/Medicare federal funds must have a fully functional compliance program. The Affordable Care Act (ACA), and, in particular Section 6401 of that Act, requires that each health plan have a functional compliance program that prevents, monitors and reports fraud, waste and abuse (FWA) for its Medicaid and Medicare programs, and that the Compliance Program also pertains to their respective providers, vendors and suppliers. In short, under the ACA, compliance is now required of all healthcare

providers; and any suspicion, let alone identification of fraud, waste or abuse must be systemically reported, managed and addressed.

Efforts to uncover fraudulent practices in the healthcare industry and to encourage public reporting of them were originally mandated in the 1996 Health Insurance Portability and Accountability Act (HIPAA). Following findings of fraud in several locations by the Office of the Inspector General (OIG), the components of a Corporate Compliance program acceptable to the Federal government were articulated in several OIG Advisories, and were subsequently promulgated into law under the aforementioned DRA and the ACA federal laws. The purposes and elements of regulatory compliance programs are similarly articulated in all advisories and form the basis of the Agency's Compliance Program. These elements are:

- ✓ Designating a Compliance Officer (CO) to oversee the Compliance Program
- ✓ Designating a Compliance Committee to assist the CO to manage the program
- ✓ Implementing written policies, procedures and standards of conduct
- ✓ Conducting effective training and education
- ✓ Developing open lines of communication
- ✓ Enforcing standards through well publicized disciplinary guidelines
- ✓ Conducting internal monitoring and auditing
- ✓ Responding promptly to detected offenses and developing corrective action

B. Values

To facilitate continuous compliance with legal, ethical, and accreditation standards applicable to its activities, Community Mental Health & Substance Abuse Services of St. Joseph County hereby formally states its mission, vision and values as a member of the health care community:

MISSION:
We enhance the lives of the citizens we serve by providing a range of individualized mental health, substance abuse, wellness and recovery services.

VISION:
Community Mental Health and Substance Abuse Services of St. Joseph County will be the premier behavioral health care agency providing an excellent system of care for citizens in need by focusing on wellness and recovery.

STATEMENT OF ORGANIZATIONAL VALUES:
We will ensure that services are delivered in a manner that is:

- *Customer centered*
- *Community based*
- *Welcoming and accessible*

- *Outcome based and valued by customers*
- *Offered by competent, friendly, and helpful employees*
- *Supportive of cultural diversity*

CMHSAS-SJC's values reflect our concern for our Regional Partners, our provider network, our communities and our commitment to clinical practices which follow high standards of legal, moral, and ethical integrity. These values serve as the foundation for our corporate business decisions and relationships, and the guiding tenets for our Compliance Program. To achieve this end, CMHSAS-SJC will take immediate steps to correct any violation of the Compliance Program, including reporting as appropriate, refunding overpayments, implementing indicated systemic changes, and taking any necessary disciplinary action.

C. Code of Ethics

It is in accordance with the following ethical principles that CMHSAS-SJC business shall be carried out:

ETHICAL PRINCIPLES

The CMHSAS-SJC ethical code of conduct is established on six basic principles, which employees are expected to maintain:

1. *Honesty* – we will be truthful in all our endeavors, to be honest and forthright with one another and with our consumers, service providers and community partners.
2. *Respect* – we will treat one another with dignity and fairness, appreciating the diversity within our community and the uniqueness of each individual. Staff will use language that communicates respect.
3. *Trust* – we will build confidence through teamwork and open, candid communication at all levels of the organization.
4. *Responsibility* – we will speak up and allow others to speak without fear of retribution and report concerns within the organization, including any violation of law, regulation, ethical standard, and CMHSAS-SJC policy.
5. *Citizenship* – we will obey the laws of the land, work to make our community more productive, and act with pride and confidence as a representative of CMHSAS-SJC.
6. *Competency* – we will have and maintain the required competencies and credentials for carrying out job responsibilities (refer to 16.08 HR-Credentialing Requirements policy).

REPORTING OF VIOLATIONS

Employees are expected to report violations or suspected violations of this or any policy or the Code of Ethics to their supervisor, Corporate Compliance Officer, Recipient Rights Officer or the Human Resources Coordinator for investigation. Employees reporting violations, participating in hearings, investigations, legislative inquiries, or court actions are protected and there is to be no retaliation or retribution to the employee. If the

individual also believes the alleged unethical conduct violates state or federal law, he or she may file a complaint with the proper authorities (i.e., law enforcement, Recipient Rights, DHS, violator's certifying professional board/organization, etc.) See 16.17 HR-Ethics Complaint policy. Suspected violations may be reported to the CMHSAS-SJC Compliance officer via email, phone, in person, or anonymously via the black boxes in each office. They may also be reported directly to SWMBH Compliance at 800-783-0914.

AGENCY RESPONSE TO A REPORT OF SUSPECTED VIOLATION

A. All reports of suspected ethics violations will be investigated. The procedures for the suspected violation will be determined by the type of violation. Recipient Rights issues will be investigated by the Office of Recipient Rights (as per Recipient Rights policies and/or procedures in sections 24, 25 & 26). Regulatory Management (i.e., Medicaid Fraud and Abuse) issues will be investigated by the Corporate Compliance Officer (as Corporate Compliance policies and procedures in section 10). The HR Coordinator will investigate other suspected code of conduct violations. In instances where the HR Coordinator feels there would be a conflict of interest, or the scope of the investigation is beyond his/her experience or expertise, the HR Coordinator will consult with the Executive Director or the Corporate Compliance Officer on whether an outside party may be needed to assist or complete the investigation.

B. At a minimum, such investigation will involve a review of written documentation and supervisory interviews with the complainant, alleged violator and witness. The investigation and report will be completed according the guidelines with the applicable Recipient Rights or Corporate Compliance policies and procedures. In cases where there are not timelines established, the investigation and report will be completed within 30 calendar days of the reported violation.

C. If the investigation finds that an ethics violation did occur, the agency may report such violation to the violator's certifying professional board or organization. Such a report will be made if the employee's misconduct is considered severe or if there is a pattern of repeated violations.

D. The agency will, within the limits of state and federal law, cooperate with any investigation that may be conducted by the police, other local state or federal agency or certifying board or organization.

Compliance in all areas of business is a subject we take seriously. We encourage open communication with our employees to and suggest to them: **"when in doubt, ask"**. Whenever they have a question or concern, are unsure about what the appropriate course of action is, or believe that a violation of the law has occurred, ask your immediate supervisor or any member of management with whom you feel comfortable.

This Compliance Program is applicable to all Community Mental Health & Substance Abuse Services of St. Joseph County employees, directors, and officers, including the Executive Director; and also all provider organizations. It is the intent that every person working for or within the CMHSAS-SJC provider network and its specialty healthcare system knows about this Compliance Program and abides by it.

II. FOUNDATION AND LEGAL BASIS FOR PROGRAM

A. Legal Foundation

The Community Mental Health & Substance Abuse Services of St. Joseph County Corporate Compliance Program is founded on a) the ethical principles that are the basis of corporate culture, b) a body of laws which defines actions that constitute criminal behavior and establish civil and criminal penalties and c) on regulations which implement Federal and State law and prescribe financial sanctions, and/or civil and criminal penalties for violation.

- ✓ The **Affordable Care Act** (2010). This Act requires a written and operable Compliance Program capable of preventing, identifying, reporting, and ameliorating fraud, waste and abuse across the provider network. All programs funded by the PIHP's Medicaid program, including CMHs, sub-contract provider organizations and practitioners, board members and others involved in rendering Medicaid program services fall under the purview and scope of the compliance program.

- ✓ The **Federal False Claims Act** (1863; 1986). This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal Government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; Conspires with other to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal Government (or its designated entity). The Act also permits individuals to bring action against parties which have defrauded the government and provides for an award of one-half the amount recovered. The Act contains protection from recrimination against those who report, testify or assist in investigation of alleged violations and provides a broad definition of 'knowingly' billing Medicaid or Medicare for services which were not provided, not provided according to requirements for receiving payment or were unnecessary.

- ✓ The **Michigan False Claims Act** (Act 72 of 1977). An ACT to prohibit fraud in the obtaining of benefits or payments in conjunction with the Medicare/Medicaid assistance program; to prohibit kickbacks or bribes in connection with the program to prohibit conspiracies in obtaining benefits or payments; and to authorize the attorney general of the state of Michigan to investigate alleged violations of this Act.

- ✓ The **Anti-Kickback Statute** prohibits the offer, solicitation, payment or receipt of remuneration , in cash or in kind, in return for or to induce a referral for any service paid for or supported by the federal government or for any good or service paid for in connection with consumer service delivery.

- ✓ The **Stark Laws (Self-Referral Prohibitions)** prohibit referral by physicians to entities in which the physician or immediate family has a financial interest.

- ✓ **HIPAA (1996)** expands the definition of 'knowing and willful conduct' to include instances of 'deliberate ignorance' such as failure to understand and correctly apply billing codes.

B. Federal and State Regulations

There are numerous federal and state regulations that impact the Compliance Program. Some of these laws not referenced above include but are not limited to:

- ✓ Regulations implementing the **Balanced Budget Act of 1997** with respect to the Management of Medicaid Managed Care Programs, especially the federal **Code of Regulations** 42 CFR § 438
- ✓ **Social Security Act**, specifically 1903(m)(95)(i)
- ✓ **Civil False Claims Act of 1863** (Amended 1986)
- ✓ **Michigan False Claims Act** (Act 72 of 1977)
- ✓ **Whistleblowers Protection Act** of 1980
- ✓ **Sarbanes – Oxley Act** of 2002
- ✓ **Civil Monetary Penalties Law** of 1981
- ✓ **HITECH Act** of 2009
- ✓ **Healthcare Fraud and Abuse Commission Act** of 1993
- ✓ **Michigan Medical Records Access Act,** Public Act 47 of 2004
- ✓ **Rehabilitation Act** of 1973
- ✓ **Americans with Disabilities Act** of 1990
- ✓ **HHS-OIG Advisories** issued by the HHS Office of the Office of Inspector General (OIG) for the conduct of Fraud and Abuse Compliance Programs
- ✓ **Guidelines for Addressing Medicaid Fraud and Abuse in Managed Care,** issued by the Department of Health and Human Services
- ✓ **Michigan Mental Health Code (1974;1996)**
- ✓ **MDCH Mental Health Administrative Rules**, as promulgated by the State of Michigan

III. COMPLIANCE PROGRAM PURPOSE

Community Mental Health & Substance Abuse Services of St. Joseph County *Compliance Program* is designed to provide safeguards to ensure both the agency and the provider network compliance with laws and regulations relating to fraud and abuse, as well as to prevent members of management, employees, contractors, subcontractors and agents from (i) using their positions for purposes that are, or giving the appearance of being, motivated by a desire for private financial gain or themselves or others such as those whom they have family, business or other ties; and (ii) from violating their duty to the agency from disclosing confidential information.

In this context, the overall purpose of the Corporate Compliance Program is:

1. To prevent noncompliance with applicable laws, whether accidental or intentional
2. To detect any noncompliance initiative(s) which may occur
3. To ensure the discipline of individuals and entities when involved in non-compliance, including the institution of formal sanctions and/or disbarment when warranted
4. To prevent the reoccurrence of noncompliance

IV. PROGRAM SCOPE

The scope of the *Compliance Program* extends to all activities funded by the agency. Compliance is a job duty for all employees. Each employee, provider, contractor, subcontractor, and/or agent operating with the provider network is expected, through its direct employment by the agency or contractual involvement in the provider network, to initiate corporate compliance activities.

Pursuant to OIG advisories, all health care entities (regardless of size) are subject to the laws and regulations which form the focus of compliance programs. There is an explicit division of responsibilities to ensure that activities carried out are comprehensive, but not duplicative; and that the risk assumed by CMHSAS-SJC is appropriately managed.

At the provider-level, each health care entity is required to have internal compliance processes and safeguards and that ensure compliance with all of Community Mental Health & Substance Abuse Services of St. Joseph County compliance program, including all policies, processes and staff training requirements. All organizational provider compliance practices and processes must be integrated into the CMHSAS-SJC program for compliance reporting, monitoring and correction purposes.

Compliance Responsibilities

1. Compliance Officer

   CMHSAS-SJC shall directly employ a **Compliance Officer**. The Compliance Officer shall have direct access to the Board and its Executive Director.

The **Compliance Officer** shall oversee and coordinate all compliance activities for the agency and its provider network including:

- Serve as the primary point of contact for all corporate compliance activities and issues for the provider network
- Overseeing and monitoring the implementation of the Compliance Program
- Establishing methods, such as periodic audits, to improve the efficiency and quality of services, and to reduce the vulnerability to fraud and abuse
- Periodically revising the *Compliance Program* in light of changes in the needs of the agency, or changes in the law and in the standards and procedures of public sector payor health plans
- Ensuring the development of a *Work Plan* for the CMHSAS-SJC and annually reviewing it for updates as needed.
- Developing necessary compliance program *Policies and Procedures* for the agency.
- Developing, coordinating and participating in a compliance program *Training Program* that focuses on the components of the compliance and risk management program; seek to ensure that training materials are appropriate
- Ensuring that all current and new employees are informed of their compliance duties and are screened against the OIG's list of Excluded Individuals and Entities, and the General Service Administration's (GSA's) List of Parties Debarred from Federal Programs
- Investigating any report or allegation concerning possible unethical behavior or improper business practices, and monitoring subsequent corrective action and/or compliance

2. Compliance Committee

The **Compliance Committee** will advise the Compliance Officer and assist in the implementation of the Compliance Program, including:

- Identifying areas of risk
- Monitoring audits and investigations
- Developing Policies and Procedures
- Implementing the Compliance Program
- Developing Compliance Strategies
- Reviewing resources devoted to compliance to ensure adequacy for maintaining the Compliance Program's overall effectiveness

The Compliance Officer shall ensure the Compliance Committee meets at least semi-annually, or more frequently if necessary, to review and resolve compliance issues and advise regarding its compliance program.

3. Compliance Plan

Corporate Compliance is a functional program. As such, the Compliance Committee is charged with developing, reviewing the plan annually and revising the Compliance Plan as needed, including specific outcome goals and compliance improvement/assessment activities to be undertaken either by the Compliance Coordinator, Compliance Committee, or providers. The Compliance Plan is ultimately finalized and approved by the Board.

4. Compliance Program versus Contract Compliance

It must be noted that while the methods used to prevent, detect and remediate corporate compliance issues are similar to the methods used to promote Contract Compliance and/or Quality Improvement, there are significant differences between Contract Compliance, Quality Improvement and Corporate Compliance. These differences may be summarized as follows:

- ✓ Corporate Compliance deals with the prevention, detection and disposition of violations of law or regulations which have the force of law. Consequently, contract compliance issues between the CMHSAS-SJC and MDCH or between CMHSAS-SJC and its contracted providers are corporate compliance issues only when law or regulation is specifically the issue.
- ✓ Corporate Compliance issues may involve civil or criminal penalties as provided for within specific laws. These penalties are frequently applied to individual employees and may involve substantial financial penalties and/or prison sentences. Quality Improvement issues, on the other hand, generally involve negotiated improvement activities or, ultimately, contract specific financial penalties to the organization or termination of the contract itself.

V. PROGRAM FUNCTIONS

The functions of Community Mental Health & Substance Abuse Services of St. Joseph County Compliance Program shall operate using the functions of an effective compliance program identified by the OIG. This includes ongoing activities in the following areas.

A. Assessment of Risk and Establishing Audit Priorities

The Compliance Officer is responsible for ensuring that practices within the agency and its contracted Medicaid service providers are conducted so that the risk of fraud and abuse is understood and minimized. The Compliance Officer begins this activity by identifying the areas in the agency and provider network that present potential legal exposure. This function involves an on-going assessment of both existing and planned activity to identify potential risks and the level of that risk. Many areas of risk begin as failures to adequately perform under existing contracts, or policies and procedures; however, if not stopped or when combined with other undesirable practices, they may be

considered fraud. Major areas of potential risk for CMHSAS-SJC include an assessment of the following:

- ✓ Written policies and procedures and its claims submission practices. In particular, the Compliance Officer should pay close attention to contracting issues, including the potential that subcontractors have inadequate or falsified provider credentials, have falsified solvency requirements, engage in bid-rigging or collusion among providers or violate standards related to conflict of interest or principal-agent requirements. CMHSAS-SJC is also at risk of having a service array which has inadequate capacity to provide the scope, intensity and duration of services required by Medicaid regulations, or of paying for services at rates which have inadequate economic justification.
- ✓ Inappropriate Utilization issues. When practices result in a pattern of denying eligible persons necessary services on a timely basis, it may be considered Medicaid waste or abuse. Examples include delay in providing services, defining 'appropriate care' in a manner not consistent with standards of care, inappropriate Utilization Review Guidelines, inhibiting the appeal process for beneficiaries, an ineffective grievance process, unreasonable prior authorization standards, provider incentives to limit care and routine denial of claims.
- ✓ Claims Submission and Billing Procedures. Examples include up-coding or inflating claims, double-billing, billing for ineligible consumers or for services not rendered, and billing for unnecessary services,
- ✓ Failure to meet other requirements of Federal or State law and regulations, including the Balanced Budget Act, and HIPAA.

Although embezzlement and theft are clear violations of law, they are generally not within the scope of activity of the compliance program, unless one of the risk areas defined above is the mechanism for carrying out the embezzlement/theft.

Both the Compliance Committee and Officer will assess the effectiveness of the *Compliance Program* to determine areas of risk, and, if necessary, identify measures to address any areas of risk.

Functional Responsibilities will include conducting an annual assessment of risk throughout the agency under the direction of the Compliance Officer.

B. Monitoring Audits and Investigations

The Compliance Office, with input and review from the Compliance Committee, monitors the results of both internal and external audits for the purpose of identifying potential risk areas and recommending and implementing appropriate follow-up action measures, but incorporating such activities into its annual Compliance Plan.

- ✓ Internal Audit Reports to be reviewed by the Compliance Officer and/or Compliance Committee include but are not limited to: Risk Assessment Audit (Annual); Utilization Review (UR) reports (i.e. case-record reviews); Compliant Management System Reports (Quarterly/Annual); ORR system reports; IT Compliance Reports

(i.e. HIPAA security assessments; ISCATs, etc); Critical Incident Report including Sentinel Events; QM Reports; Claims Review (CR) reports; Credentialing/Profiling (Suspension/Revocation) reports; HR system performance issue reports, and other risk management monitoring functions identified by the Compliance Committee.

✓ External Reports may include, but not be limited to: MDCH Audit Reports; EQRO Audit Reports; Accreditation Body Report; PIHP monitoring reports of CMHSAS-SJC; etc.

Additionally, the Compliance Committee should review the outcome of any compliance investigation, and make recommendations, if necessary, for future detection and prevention. Any substantiated investigation will be disciplined according to agency policy, up to and including termination.

C. Policy and Procedure Review, Revision and Development

CMHSAS-SJC shall be the responsible entity to develop corporate compliance policies, processes, protocols and forms to be used across the provider network to ensure adherence to this Compliance Program.

Policies and procedures are subject to the initial and on-going organizational assessment of the provider network, and thus considered areas of high risk.

D. Prevention Activities (Training Staff and Dissemination of Information Regarding Corporate Compliance Program and Expectations)

The Compliance Officer conducts initial orientation and training activities.

On-going training sessions are organized by the Compliance Officer with the assistance to ensure all employees receive the necessary trainings on Corporate Compliance. Gaps and issues are communicated to the CO for follow-up. Each new employee shall be afforded required training and provided with written information and discussion as part of the new employee orientation.

The Compliance Program is a value based, ethics oriented program. Consequently, training and orientation programs focus not only on the content of law and regulation but on conducting business in a manner which results in doing what is right for consumers and the community.

E. Ensuring that Information regarding Current Law and Regulations is disseminated

The Compliance Officer with the assistance of the Compliance Committee and other experts is responsible for reviewing all new compliance related law, and regulation and official interpretation of law and regulation which is issued by State and Federal agencies for the network. The Compliance Officer shall take lead responsibility to disseminate any new regulatory laws, rules and guidelines provider network.

Regulatory review shall be done through regular monitoring of web sites such as those of the Centers for Medicare and Medicaid Services, the Office of the Inspector General and the Michigan Department of Community Health) to employees and Policy Alerts to Executive Director and/or Compliance Officer. PIHP Compliance relevant alerts are also issued as necessary.

VI. APPROVAL

As the board, the Corporate Compliance Program was subsequently reviewed and approved at a regular meeting on March 25, 2014.