SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY

NUMBER: BA032

NAME: CORPORATE COMPLIANCE PROGRAM

INITIAL APPROVAL DATE:	07/30/2002	BY: Sanilac CMH Board
(LAST) REVISION DATE:	11/30/2023	BY: CIO
(LAST) REVIEW DATE:	12/14/2023	BY: Policy Committee
DISCONTINUED DATE:	N/A	REPLACED BY: N/A

I. PURPOSE

To ensure Sanilac County Community Mental Health Authority (Sanilac CMH) staff are in compliance with federal and state regulations.

II. APPLICATION

Populations: **NA**
Programs: **Direct - ALL**
Contracted – ALL

III. POLICY

Sanilac CMH is committed to providing quality care for all individuals served. The safety and well-being of those it serves is the paramount consideration of all CMH activities. In furtherance of this commitment, Sanilac CMH strives to promote honesty, integrity and high ethical standards in the work environment and to comply with all applicable federal and state statutes and regulations and other legal and ethical obligations.

IV. DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2).

Alleged Illegal Conduct: That which, on its face, appears to conflict with that required by law.

Alleged Improper Conduct: That conduct which includes such behaviors as intimidation, harassment, and other unethical behavior.

Fraud (Federal False Claims Act): 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 including but not limited to the Federal False Claims Act and the Michigan False Claims Act (42 CFR 455.2).

Fraud (per Michigan statute and case law interpreting same): Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person "should have been aware that the nature of his or her conduct constitute a false claim for Medicaid benefits, akin to constructive knowledge." But errors or mistakes do not constitute "knowing" conduct necessary to establish Medicaid fraud, unless the

person's "course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present."

Provider: CMH and SUD Providers, individual or corporation; any CMH subcontracted provider/ practitioner, individual or corporation.

Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

V. INTRODUCTION

This policy describes Sanilac CMH's Corporate Compliance Program.

The Federal Medicaid Integrity Program requires entities receiving more than $5 million in Medicaid funds to have a Corporate Compliance Plan as referenced in 42 CFR § 438.608, which is attached.

Region 10 (Genesee, Lapeer, St. Clair and Sanilac CMHs) will maintain oversight of the Corporate Compliance Program for the Medicaid population. During this transition, it is our intent to maintain and carry out our current responsibilities as outlined within this plan until it is otherwise determined.

The compliance program covers the specific compliance principles, components, and activities the various entities perform as healthcare providers. Efforts to uncover fraudulent practices in the healthcare industry and to encourage public reporting of them were 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. In 2006 the Deficit Reduction Act made way for the creation of the Medicaid Integrity Program. Together they call for a standard approach to Medicaid compliance and integrity.

Compliance plans are now required of providers receiving more than $5 million in Medicaid State Plan monies. Program basics include:

- Written standards, policies and procedures
- Standards of conduct
- Designating a Compliance Officer
- Implementing a Compliance Committee
- Conducting effective training and education
- Developing effective lines of communication
- Enforcing standards through disciplinary guidelines
- Conducting independent monitoring and auditing; and
- Responding promptly to detected offenses and developing corrective action.

VI. FOUNDATION AND LEGAL BASIS OF PROGRAM

The Corporate Compliance Program is founded on (a) the ethical principles that are the basis of the "corporate" culture of the Authority; (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.

A. Ethical Foundation and Principles

Sanilac CMH has adopted and subscribes to a unified Code of Ethics which is attached hereto as Policy BA021. Compliance with this ethical foundation is reinforced through the annual staff evaluation process. Compliance with the ethical foundation by staff in contracted entities is monitored through the contract monitoring process.

B. Legal Foundation

The legal basis of the Compliance Program centers around three (3) Federal statutes and one (1) State statute. It is the overall role of the laws to prevent and detect fraud, abuse and waste.

- The Federal False Claims Act (1863): This Act permits individuals to bring action against parties which have defrauded the government and provides for an award of $^1/_2$ of the amount recovered. The Act contains protection from recrimination against those who report, testify or assist in investigation of alleged violations (whistleblowers) 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 most common criminal provisions invoked in health care prosecutions are prohibitions against:
    - False claims
    - False statements
    - Mail fraud and wire fraud

  Penalties are:
    - 5 years imprisonment
    - Fine of $250K for an individual or $500K for an organization, or 2x's the gross gain or loss from the offense, whichever is greater.
    - Mandatory exclusion from participation in federal health care programs

- The Michigan Medicaid False Claims Act (1977): An act to prohibit fraud in the obtaining of benefits or payments in connection with the program; to prohibit conspiracies in obtaining benefits or payments; to authorize the Attorney General to investigate alleged violations of this act; to provide for civil actions to recover money received by reason of fraudulent conduct; to prohibit retaliation (whistleblower's); to provide for certain civil fines; and to prescribe remedies and penalties.

- 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 goods or service paid for in connection with an individual's service delivery. There is a penalty for knowingly and willfully offering, paying, soliciting, or receiving kickbacks; violations are felonies; and maximum fine of $25K, imprisonment of up to 5 years.

- 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 or failure to give privacy notice and/or not following security measures (e.g. sharing passwords). HIPAA calls for a prison sentence of up to 10 years.

C. Other legal authority:

Regulations which implement the Federal Healthcare Law contained in the Social Security Act, as amended, include:

- Social Security Act, 1903(m)(95)(i);
- Regulations (CFR) implementing the Balanced Budget Act of 1996 with respect to the Management of Medicaid Managed Care Programs;
- Medicaid Integrity Program developed pursuant to the Deficit Reduction Act of 2006;
- 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; and
- Michigan Mental Health Code (1974; 1996) and Mental Health Administrative Rules, as promulgated by the State.

VII. COMPLIANCE PROGRAM PURPOSE

The purposes of the corporate compliance program are:

1. To prevent noncompliance with applicable law, whether accidental or intentional;
2. To detect noncompliance which may occur;
3. To discipline individuals involved in non-compliance;
4. To prevent reoccurrence of noncompliance.

VIII. SCOPE OF PROGRAM AND DELEGATION OF FUNCTIONAL RESPONSIBILITY

A. Compliance Responsibilities

The Compliance Officer functions have been assigned to a staff. The Corporate Compliance Officer is responsible for overall development, implementation, administration and enforcement of the Corporate Compliance Plan. The Corporate Compliance Officer meets with the Administrative Committee and/or other Directors/Officers on a periodic basis to review and resolve compliance issues and advise regarding program policy, policy development, training and other issues. The Corporate Compliance Officer also meets with the CMH Board's Executive Committee when there is a substantiated fraud and/or abuse violation. The Corporate Compliance Officer has the authority to review all documents and other information which are relevant to compliance activities, including but not limited to: individual case records, billing records, and individual personnel arrangements and agreements with other parties.

The Compliance Officer is charged with reviewing this policy annually with it ultimately finalized and approved by the Board of Directors. Any specific outcome goals and compliance improvement/ assessment activities will be identified in the annual QI Goals and Objectives which are reviewed regularly by the QI Committee. In addition, the Board of Directors shall review and approve the QI Goals and Objectives initially, mid-year and at the end of the plan year.

IX. FUNCTIONS

The functions of the compliance program operationalize the fundamental elements of an effective compliance program. This includes ongoing activities in the following areas:

A. Assessment of Risk

The Compliance Officer is responsible for ensuring that practices within operation of its program and its contract Medicaid service providers are such so that the risk of fraud and abuse is understood and minimized. This function involves 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 include the following:

- Network Management/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. The Authority 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 fraud. 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 upcoding or inflating claims, double-billing, billing for ineligible individuals 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.

Sanilac CMH, in accordance with "Security Standards for the Protection of Electronic Protected Health Information", found at 45 CFR Part 160 and Part 164, Subparts A and C, must complete a HIPAA Risk Assessment/Analysis. Sanilac CMH is also addressing the Meaningful Use (MU)/Electronic Health Record (EHR) requirement within the HIPAA Risk Assessment. An Assessment will be completed and submitted for approval from the Board. Goals and recommendations based on the findings will be implemented.

Region 10 PIHP manages most of the managed care administrative functions by contracting with the Community Mental Health Service Providers (CMHs) and Substance Use Disorder (SUD) Providers in Genesee, Lapeer, Sanilac and St. Clair counties for the management of specific delegated administrative functions and health care service provision. These responsibilities are detailed in the PIHP/CMH Provider contract or in the PIHP/SUD Provider contract, as applicable.

Sanilac CMH monitors to ensure it is fulfilling its contract obligations and delegation responsibilities, through on-going monitoring and reviews. The on-going monitoring consists of contract management reviewing contract providers' performance and compliance throughout the fiscal year. Reviews include utilization management audits, claims verification reports, corrective action plans, performance indicator reports, and budgetary reports. Most of these monitoring functions and reports occur on a quarterly basis.

B. Policy and Procedure Development, Review and Revision

The Compliance Officer, with the input from the Administrative Committee, the Quality Improvement Committee, and other resources, will determine what policies if any need to be developed to augment practices already in place to help ensure legal compliance.

Currently Region 10 PIHP policies in place include:

- 01-02-01 Corporate Compliance Program
- 01-02-03 Conflict of Interest
- 01-02-05 Corporate Compliance Complaint, Investigation and Report Process
- 01-05-01 Utilization Management Program
- 01-06-05 Credentialing and Privileging
- 03-01-02 Integrity of Electronic Data
- 03-03-01 HIPAA Privacy and Security Measures
- 03-03-02 HIPAA Privacy Measures – Protected Health Information
- 04-03-01 Denial of Claims Payment Appeal Process
- 04-03-02 Claims Verification
- 07-02-01 Grievance and Appeal System

Currently Sanilac CMH policies in place include:

- BA040 – Appeals, Grievances & Second Opinions
- BA045 – Network Management and Monitoring Plan

- BA028 – Credentialing and Privileging
- BA035 – Quality Improvement Committee
- BA023 – Safeguarding Records of Individuals Served
- BA032 – Corporate Compliance Program

C. Prevention Activities/Training

Sanilac CMH ensures that initial orientation and ongoing training are conducted using My Learning Point/Relias for direct staff and training materials available on our external webpage for contract providers. Sanilac CMH and its contract providers shall post Notice regarding how to access Corporate Compliance Offices and how to file a complaint. This information will also be available on the Agency's internal and external webpages.

All employees, direct and contractual, are to be trained annually; each new employee of Sanilac CMH will be trained and provided with written information and discussion on an individual basis as part of the new employee orientation. Contract provider entities are responsible for training their staff; or may request the Authority to provide this training on its behalf.

D. Customer Service

Sanilac CMH provides Customer Service support to individuals served, as well as the community, by offering a toll-free customer services telephone line and access to alternative telephonic communication methods. This information is displayed on Agency brochures and public information material and these supports are available from a live voice during regular business hours.

Sanilac CMH Customer Service staff receive training to welcome people to the public mental health system and possess a current working knowledge or know where in the organization detailed information can be obtained.

Sanilac CMH makes available to individuals served and the community the following information in the form of the Sanilac CMH Services Guide and Sanilac CMH Provider Network List. These documents can be accessed thru the Agency website, www.sanilaccmh.org, or by contacting Sanilac CMH customer services staff. These documents are reviewed and updated regularly. These documents comply with the following mandates:

1. Languages and Interpretation

To ensure that all individuals have access to information to understand the requirements and benefits of their CMH services, Sanilac CMH will provide the following:

- Make oral and written interpretation available in all non-English languages.
- Make written material that is critical to obtaining services in all non-English languages prevalent in the Sanilac County community.
- Make interpretation services available to individuals free of charge.
- All written material will be easily understood and available in a font size no smaller than 12-point.

2. Covered Services

Sanilac CMH will ensure that individuals have access to information about the following items:

- Basic features of a managed care system
- Services covered by the providers
- Covered benefits and which benefits are offered by each provider
- Covered benefits offered through a contract system or CMH system
- Any cost sharing that might be imposed by the provider.

3. Change in Services/Provider Network

Sanilac CMH will provide individuals with advance notice related to significant changes in services and/or provider network.

- Sanilac CMH will make all effort to give written notice of termination of a contract to individuals that receive services through the contract. Notice of the termination will be provided within 30 calendar days.

E. Ensuring that Information regarding Current Law and Regulation is disseminated
The Compliance Officer is responsible for reviewing all new compliance related law, regulation and official interpretation of law, and regulation which is issued by State and Federal agencies for the CMH network. Administrative memos (including emails) to employees and/or Policy Alerts will be issued as appropriate. Compliance relevant alerts may also be issued when particular compliance programs are suspected.

F. Detection Activities
The system for detecting noncompliance has two (2) components:

- The first is a body of auditing and review mechanisms conducted by staff of the provider network. These auditing reviews include contract reviews; Medicaid Claims Verification reviews; and Utilization Management reviews. All audit functions are part of the overall Corporate Compliance program. The function of the Corporate Compliance program in this regard is to ensure that audits include issues of regulatory concern and that monitoring tools are regularly updated to reflect both existing and new issues. Reviewers will report for the presence of issues that require investigation from a compliance perspective.

- The second component is a mechanism for confidential reporting of suspected incidents of noncompliant behavior. In this regard all staff must know that failure to report suspected fraudulent behavior is unethical and thus itself is noncompliant. Staff are also assured that allegations will be held in confidence, to the limit allowed by law, that they will not be penalized for reporting suspected incidents and that fair and objective investigation of all allegations will be conducted prior to any action.

G. Investigation, Disciplinary Activity, Disclosure Activities
Sanilac CMH undertakes investigative activities when a preliminary review of audit and monitoring data or a report of suspected noncompliance indicates reasonable cause to suspect noncompliance is occurring. Documentation of all investigations and outcomes is maintained by Sanilac CMH.

H. Financial Reporting and Payments
All financial reports, accounting records, research reports, expense accounts, timesheets, and other documents will accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting contrary to the policy of the CMH may violate the Corporate Compliance Program Plan. All overpayments identified or recovered known to the Agency or its subcontractor shall be promptly reported to the PIHP. Sanilac CMH and its subcontractors will comply with the requirements outlined in 42 CFR § 438.608.

X. COMPLIANCE CODE OF CONDUCT - PRINCIPLES

The Compliance Code of Conduct (Code) contains Principles articulating the policy of Sanilac CMH and Standards which are intended to provide additional guidance to Sanilac CMH personnel. Conduct not specifically addressed by the Standards must be consistent with the Principles. All Sanilac CMH personnel are responsible to ensure that their behavior is consistent with the Code.

Sanilac CMH expects all personnel to abide by the Code and to conduct the business and affairs of Sanilac CMH in a manner consistent with the Code. Failure to abide by the Code may result in disciplinary action. In Sanilac CMH’s sole discretion, discipline may range from verbal correction to termination.

Nothing in the Code is intended to, nor shall be construed as, providing any employment or contract rights or other binding obligations to any Sanilac CMH personnel, or other person. Notwithstanding any of the principles, standards, or policies herein, the employment relationship is terminable at the will of either Sanilac CMH or the employee, at any time, for any reason or no reason, without advance notice, in the absence of a legally binding written agreement requiring otherwise.

Sanilac CMH will generally attempt to communicate a change to the Code before the change is implemented. However, Sanilac CMH reserves the right to modify, amend or alter the Code without advance notice to any personnel.

PRINCIPLE 1 – LEGAL COMPLIANCE
Sanilac CMH will strive to ensure all activity by or on behalf of the Agency is in compliance with applicable statutes and regulations and other legal obligations.

The following standards are intended to provide guidance to Sanilac CMH personnel to assist them in their obligation to comply with applicable statutes and regulations and other legal obligations. These Standards are neither exclusive nor complete. Sanilac CMH personnel are required to comply with all applicable statutes and regulations, whether or not specifically addressed in these Standards. If any Sanilac CMH personnel have questions regarding the existence, interpretation, or application of any statute or regulation or legal obligation, they should contact the Corporate Compliance Officer.

Fraud and Abuse
Sanilac CMH and its personnel will refrain from conduct which may violate state or federal fraud and abuse statutes and regulations. In general, these laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of individuals; (2) the submission of false, fraudulent, or misleading claims to any third party payer, including claims for services not rendered, claims which characterize the service differently from the service actually rendered, or claims which do not otherwise comply with applicable health benefit program or contractual requirements; and (3) making false representations to any person or entity in order to gain or retain participation in a health benefit program or to obtain payment for any service.

Kickbacks
Sanilac CMH and its personnel will not offer, give, solicit, or receive payments or gratuities, in cash or in kind, that are intended to induce the referral of individuals to Sanilac CMH or to any health care provider.

Self-Referral
Sanilac CMH and its personnel will refrain from conduct which may violate state or federal self-referral statutes and regulations. In general, these laws prohibit medical practices and physicians from referring individuals to certain health care providers for the delivery of certain health services. Sanilac CMH personnel will not refer an individual to a provider with whom Sanilac CMH personnel or their family members have a financial relationship unless the referral is permissible under state and federal laws.

Debarred Provider
Sanilac CMH personnel will not provide any service to individuals while he or she is debarred, excluded, suspended, or otherwise ineligible for participation in any governmental health care program, including without limitation, Medicaid and Medicare. Sanilac CMH will not do business with any health care provider who is debarred, excluded, suspended or otherwise ineligible for participation in any governmental health care program.

Dealings with Governmental Agencies
Sanilac CMH has dealings with governmental agencies in the normal course of its business. All such dealings with governmental officials and agencies will be conducted in an honest and ethical manner. Any attempt to influence the decision-making process of governmental officials or agencies by an improper offer of any benefit is absolutely prohibited. Any requests or demands by any governmental representative for any improper benefit should be immediately reported to the Corporate Compliance Officer.

Choice of Providers and Suppliers
Sanilac CMH's choice of medical suppliers, equipment, ancillary services, and other goods and services used in its business will be made upon the basis of quality, usefulness, safety and price.

Licensure
Sanilac CMH personnel will obtain and continuously maintain all permits, certifications, registrations, and licenses required under local, state and federal laws for the performance of the medical or administrative services he or she performs for Sanilac CMH.

Discrimination
Sanilac CMH will not unlawfully discriminate against any individual on the basis of race, color, religion, sex, ethnic origin, age, disability, or any other classification prohibited by law.

Michigan Mental Health Code
Sanilac CMH personnel will comply with the requirements of the Michigan Mental Health Code relating to Community Mental Health Service Programs, if applicable.

PRINCIPLE 2 – BUSINESS ETHICS
Sanilac CMH will strive to maintain high standards of business ethics and integrity. The following Standards are designed to provide guidance to Sanilac CMH personnel to ensure that Sanilac CMH's business activities reflect high standards of business ethics and integrity.

Honest Communication
Sanilac CMH expects candor and honesty from Sanilac CMH personnel in the performance of their responsibilities and in communication with Sanilac CMH attorneys and auditors. Sanilac CMH personnel will not make false or misleading statements to any individual or entity doing business with Sanilac CMH about other individuals or entities doing business or competing with Sanilac CMH. Sanilac CMH personnel will not misrepresent Sanilac CMH's services or the services of Sanilac CMH's competitors.

Activities
Sanilac CMH personnel will accurately and honestly represent Sanilac CMH and will not engage in any activity or scheme intended to defraud anyone of money, property or services.

PRINCIPLE 3 – CONFIDENTIALITY
Sanilac CMH will strive to maintain the confidentiality of individuals served and other confidential information in accordance with applicable legal and ethical standards.

Sanilac CMH and its personnel are in possession of and have access to a broad variety of confidential, sensitive, and proprietary information. The inappropriate disclosure of such information could be injurious to individuals served, Sanilac CMH and other persons. (See policies BA004, BA023 and RR005.)

PRINCIPLE 4 – CONFLICTS OF INTEREST
Sanilac CMH personnel owe a duty of undivided and unqualified loyalty to Sanilac CMH. Sanilac CMH personnel will not use their positions to profit personally or to assist others in profiting in any way at the expense of Sanilac CMH.

Sanilac CMH employees, Board, and contractors (including family, business, and other ties) who are involved in any grant supported activities will refrain from any actual or perceived conflicts of interest. Any outside activity, relationship, or financial interest that is a conflict of interest or could be interpreted as such, must be disclosed to the Corporate Compliance Officer. Violation of this standard could result in the loss of contract, change in duties, or other actions as outlined in Agency policy.

PRINCIPLE 5 – BUSINESS AND INDIVIDUAL RELATIONSHIPS
Sanilac CMH personnel will transact Sanilac CMH business and provide medical services to individuals without offering, giving, soliciting or accepting gifts, favors, entertainment or other gratuities of greater than nominal value. Sanilac CMH personnel will not offer, solicit or accept gifts, gratuities, or other improper inducements in exchange for, or as a condition of, influence or assistance in a business transaction or providing medical services. Additionally, all employee relationships with individuals served by Sanilac CMH should be therapeutic and professional in nature. In order to protect the welfare of individuals served, Sanilac CMH encourages adherence to established professional standards and codes of conduct in order to continue to preserve the public image and integrity of the Agency (i.e. the NASW Code of Conduct, the Michigan Certified Peer Support Specialists Code of Ethics, and A Nurses Guide to Professional Boundaries).

The following standards are intended to guide Sanilac CMH personnel in determining the appropriateness of their activities or behaviors within the context of Sanilac CMH business and client relationship. These Standards should be construed broadly to avoid even the appearance of improper activity. If there is any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, Sanilac CMH personnel should contact the Corporate Compliance Officer.

Boundaries
A boundary violation occurs when a professional, consciously or unconsciously, uses the professional-client relationship to meet personal needs rather than the needs of the individual served.

1. For all professional staff, it is an expected standard governing the practice and conduct of the respective health care professions to not form personal or business relationships with the individuals under their care.

2. Peer support specialists and/or recovery coaches who are Sanilac CMH employees or contractors should not be treated differently or have additional rules created to enhance or excuse them from the first standard of conduct that is expected of all Sanilac CMH employees or contracted affiliates.

3. It is the policy of Sanilac CMH that an employee shall not be directly involved in providing care or treatment to an individual who is a friend or relative of the employee. Employees are prohibited from forming social or business relationships with individuals they serve currently or have served in the past.

Sexual Boundary Violation
A violation of sexual boundaries between the healthcare provider and individual served involves words, behavior or actions designed or intended to arouse or gratify sexual desires. Sexual or romantic relationships with a current or former individual served in which the healthcare provider uses or exploits knowledge, emotions or influence derived from the professional relationship; off-color or suggestive humor; and/or any words, actions or behavior that could reasonably be interpreted as sexually inappropriate or unprofessional are prohibited.

Gifts and Gratuities

Gifts to and from Individuals Served. Sanilac CMH personnel will not solicit or receive from, or give to, an individual served or their family member monetary gifts or other gratuities. If an individual wishes to present a non-monetary gift (cards, drawings, etc.) to Sanilac CMH personnel, they can be accepted but the staff should have a discussion with their Supervisor. Sanilac CMH personnel may not offer, give or accept a monetary gift of even a minimal value from or for an individual or their family member, only if in compliance with applicable law, standards of care, and ethical obligations.

Gifts Influencing Decision-Making. Sanilac CMH personnel will not accept gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting Sanilac CMH might be influenced. Sanilac CMH personnel will not offer or give money, services or other things of value with the expectation of influencing the judgment or decision-making process of any individual served, health care provider, government official or agency, third-party payer or vendor.

Gifts from or to Health Care Providers. Sanilac CMH personnel will not offer or give money, gratuities or gifts to or from health care providers, except gifts or meals of nominal value only in permissible circumstances. Sanilac CMH personnel will not solicit money, gifts or gratuities from health care providers. Sanilac CMH personnel may accept gifts or meals of nominal value only in permissible circumstances from health care providers. To the extent possible, such gifts or meals should be shared with Sanilac CMH personnel's co-workers.

Workshops, Seminars and Training Sessions. Attendance at local workshops, seminars and training sessions sponsored by health care providers or vendors is permitted only in accordance with guidelines set forth in Agency policies and procedures. Attendance at health care provider or vendor expense, at out-of-town seminars, workshops or training sessions is permitted only with the prior approval of the Human Resources Manager in accordance with guidelines set forth in Agency policies and procedures.

Contracts

Sanilac CMH personnel will conduct all business relations with health care providers and vendors at arm's length both in fact and in appearance and in compliance with Sanilac CMH's contract policies and procedures and applicable laws. Sanilac CMH personnel will disclose personal relationships and business activities with health care providers or vendors which may be construed by an impartial observer as influencing the Sanilac CMH personnel's performance or duties.

Business Inducements

Sanilac CMH personnel will not seek to gain any advantage through the improper use of payments, business or professional courtesies or other inducements. Offering, giving, soliciting or receiving any form of bribe or other improper payment is prohibited.

Marketing Practices

Pursuant to A-87, Sanilac CMH is not able to market its professional services to individuals, health care providers, and third-party payers. Sanilac CMH will only offer educational information, training, materials, etc. to staff, individuals served, health care providers, third-party payers as well as the community. Sanilac CMH staff will not offer or give anything of value to induce a potential individual or referral source to use Sanilac CMH services.

PRINCIPLE 6 – DOCUMENTATION AND BILLING PRACTICES

Sanilac CMH will strive to ensure that medical services are fully documented and that all claims, bills and other submissions for reimbursement to individuals served and third-party payers for services rendered by Sanilac CMH or by any Sanilac CMH personnel or independent contractor comply with applicable local, state and federal laws and third-party payer requirements.

Documentation, Billing and Collection Procedures
Sanilac CMH personnel will comply with the documentation, billing and collection procedures contained in the Agency policies and procedures. Health care providers and billing and management personnel are responsible for knowing the legal and third-party payer requirements applicable to their services with Sanilac CMH.

Record Integrity
Sanilac CMH personnel will not destroy or alter individual health or business records, except strictly in accordance with a written record retention policy of Sanilac CMH (Policies BA004 and BA023), will retain all individual and business records for such periods of time as Sanilac CMH directs, and will not copy or remove such records from Sanilac CMH offices except as provided in the Agency policies and procedures.

Witnessing of Documents
Sanilac CMH staff shall not serve as the witness of documents which establish power of attorney, guardianship, and/or advanced directives.

PRINCIPLE 7 – SANILAC CMH PERSONNEL AND HEALTH CARE PROVIDER SCREENING
Pursuant to Policy BA028 and Procedure DA1007, Sanilac CMH will make reasonable inquiry into the background of Sanilac CMH personnel, independent contractors and health care providers who render medical services or whose job functions or activities may materially impact the claim development and submission process, Sanilac CMH's relationship with third-party payers, or referral patterns between Sanilac CMH and health care providers.

PRINCIPLE 8 – INVESTIGATION AND RESPONSE
It is Sanilac CMH's policy to respond promptly and thoroughly to reports by Sanilac CMH personnel, or others that Sanilac CMH personnel or independent contractor is engaging in activity which may be contrary to applicable laws, that such an individual may be submitting bills or claims in a manner which does not meet the Medicare, Medicaid or other third-party payer requirements, or that the individual is not complying with Sanilac CMH's compliance policies and procedures. It is further Sanilac CMH's policy to respond promptly and thoroughly to problems or concerns which are discovered in the course of monitoring activities.

Sanilac CMH Personnel Participation and Reporting
It is the responsibility of all Sanilac CMH personnel to report to Sanilac CMH his or her good faith belief of any violation of the Compliance Policy, the Compliance Code of Conduct, any other compliance policy or procedure, or an applicable law or other legal obligation. Sanilac CMH, at the request of the Sanilac CMH personnel reporting the violation, will provide such anonymity to the reporting person as is possible under the circumstances in the judgment of Sanilac CMH, consistent with its obligations to investigate personnel concerns and take necessary corrective action. Sanilac CMH and its personnel will not retaliate against any Sanilac CMH personnel for good faith reporting of a suspected violation.

Purpose and Control of Investigations
The purpose of an investigation will be to: (a) identify those situations in which the compliance policies and procedures, or applicable law or other legal obligation may not have been followed; (b) identify individuals who may have knowingly or inadvertently engaged in non-compliant activity; (c) facilitate the correction of any non-compliance practices; (d) implement those procedures necessary to insure future compliance; (e) protect Sanilac CMH in the event of civil or criminal enforcement action; and (f) preserve and protect Sanilac CMH's assets. Legal counsel will be engaged as approved by the Corporate Compliance Officer to direct the investigation of the alleged problem or incident. Legal counsel may engage other advisors with knowledge of the applicable requirements or standards that relate to the specific problem in question, as approved by the Corporate Compliance Officer.

Investigations
An investigation will be conducted in accordance with the steps set forth in the compliance policies and procedures (DA1005 Corporate Compliance Complaint, Investigation & Reporting Procedure) upon receipt of a report or other information, including a monitoring result, which suggests conduct in violation of the compliance policies or procedures or applicable laws or other legal obligations.

Resolution
If Sanilac CMH finds what appears to be criminal or other improper activity on the part of any Sanilac CMH personnel or Sanilac CMH uncovers inappropriate practices or procedures during monitoring activities, Sanilac CMH will undertake reasonable and appropriate steps to resolve the problem. Such steps may include, but not be limited to, stopping all billing related to the problem until such time as the offending practices are corrected, initiating an appropriate corrective action plan, taking disciplinary action against the individual or individuals whose conduct violates the compliance program or applicable laws, notification of government agencies, and repayment of improper payments.

Notification
The CMH Provider shall maintain the confidentiality, security and integrity of enrollee information that is used in connection with the performance of its contract with MDHHS to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 CFR Part 2.

The CMH Provider complies with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, disclosed or transmits in the performance of its functions.

The covered entity, following the discovery of a breach of unsecured PHI, notifies each enrollee whose unsecured PHI has been or is reasonably believed by the covered entity to have been accessed, acquired, used or disclosed as a result of such a breach.

- A breach shall be treated as discovered by a covered entity as of the first day on which such breach is known to the covered entity, or, by exercising reasonable diligence would have been known to the covered entity.
- A covered entity shall be deemed to have knowledge of a breach if such a breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce enrollee or agent of the covered entity (determined in accordance with the federal common law of agency).

Except as provided in 45 CFR 164.412 (law enforcement delay), the covered entity provides notification to individuals affected by a breach without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach.

Notification to CMH Board
If the Corporate Compliance Officer substantiates a complaint of fraud and/or abuse, a special meeting of the CMH Board's Executive Committee will be called. The CEO and Corporate Compliance Officer will review with the Committee the allegations, the investigation and the findings.

PRINCIPLE 9 – DISCIPLINE AND EVALUATION
Pursuant to Policy BA044, it is Sanilac CMH's policy to discipline any Sanilac CMH personnel who willfully or negligently fail to comply with the compliance policies and procedures or applicable laws. It is further Sanilac CMH's policy to evaluate Sanilac CMH personnel based in part on their efforts to ensure Sanilac CMH's compliance with the compliance policies, procedures and all applicable laws.

PRINCIPLE 10 – CODE OF ETHICS
Sanilac CMH will provide competent, therapeutic service with compassion and respect for human dignity.

Individual Rights of Recipients of Mental Health Services (RR026)
Sanilac CMH will inform all individuals that they have the right to receive mental health services, suited to their condition, in a safe, sanitary, and humane treatment environment, and to be treated with dignity and respect.

Professional Responsibility
All licensed professionals employed by Sanilac CMH are expected to follow the Code of Ethics of their respective disciplines.

XI. ATTACHMENTS

42 CFR § 438.608
Mission and Vision Statement
Core Values
Code of Ethics – Policy BA021
Corporate Compliance Complaint, Investigation & Reporting Procedure – Procedure DA1005

XII. REFERENCES

45 CFR § 75.112

42 CFR § 438.608 - Program integrity requirements under the contract

(a) Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. The State, through its contract with the MCO, PIHP, or PAHP, must require that the MCO, PIHP, or PAHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims under the contract between the State and the MCO, PIHP, or PAHP, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

(1) A compliance program that includes, at a minimum, all of the following elements:
- (i) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.
- (ii) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.
- (iii) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.
- (iv) A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.
- (v) Effective lines of communication between the compliance officer and the organization's employees.
- (vi) Enforcement of standards through well-publicized disciplinary guidelines.
- (vii) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

(2) Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

(3) Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:
- (i) Changes in the enrollee's residence;
- (ii) The death of an enrollee.

(4) Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.

(5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

(6) In the case of MCOs, PIHPs or PAHPs that make or receive annual payments under the contract of an agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) if the Act, including information about rights of employees to be protected as whistleblowers.

(7) Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
(8) Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with§ 455.23 of this chapter.

(b) ***Provider screening and enrollment requirements.*** The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

(c) ***Disclosures.*** The State must ensure, through its contracts, that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors:
(1) Provides written disclosure of any prohibited affiliation under § 438.6l0.
(2) Provides written disclosures of information on ownership and control required under § 455.104 of this chapter.
(3) Reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

(d) Treatment of recoveries made by the MCO, PIHP or PAHP of' overpayments to providers.

(1) Contracts with a MCO, PIHP, or PAHP must specify:
(i) The retention policies for the treatment of recoveries of all overpayments from the MCO, PIHP, or PAHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
(ii) The process, timeframes, and documentation required for reporting the recovery of all overpayments.
(iii) The process, timeframes, and documentation required for payment of recoveries of overpayments to the State in situations where the MCO, PIHP, or PAHP is not permitted to retain some or all of the recoveries of overpayments.
(iv) This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations

(2) Each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment.
(3) Each MCO, PHHP, or PAHP must report annually to the State on their recoveries of overpayments.
(4) The State must use the results of the information and documentation collected in paragraph (d)(l) of this section and the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for each MCO, PIHP, or PAHP consistent with the requirements in§ 438.4.

Our mission: Enhancing Lives, Promoting Independence, Embracing Recovery

The Vision behind the Mission:
Sanilac Mental Health values its place as a respected leader among behavioral health organizations recognized for:

- Compassionate personalized supports and services for the people we serve and our partners in the community
- Innovative and cost-effective treatment options designed to produce positive outcomes
- Recipient rights, advocacy and implementation of mental health treatment that promotes human dignity, respects choice, and recognizes the potential in everyone we serve
- Services that promote healthy individuals, families and communities
- Maintaining a quality work environment that fosters professional growth and mutual support
- Continuous efforts to reduce the stigma associated with mental illness and developmental disabilities and to promote community integration
- Providing active outreach and support as an integral part of Sanilac County's community-wide system of care
- Integrated Care in which we treat the whole person, including both their behavioral health and physical health care needs.

CORE VALUES

WE ARE:

- Leaders
- Service providers
- Partners
- Educators

We operate within six basic principles:

1. RESPECT

- Acknowledge that our consumers possess inherent strengths and our services are designed to build upon those strengths
- Operate programs with individuals' needs foremost
- Provide public education, advocacy and awareness of mental health issues

2. ETHICS

- Adhere to ethical principles, high standards of professional performance
- Demonstrate integrity

3. TEAMWORK

- Believe in collaboration and encourage partnership and teamwork
- Engage in partnerships or alliances which provide opportunities for personal and organizational growth
- Be proactive in positioning our Agency as a vital participant in shaping the future of our community and other behavioral health providers

4. EMPOWERMENT

- Increase the level of consumer involvement and empowerment in the choice of service options and Agency direction
- Advocate for full participation of consumers in decisions affecting their lives
- Believe that mental health services should be community based
- Respect individuals and their differences

5. QUALITY

- Demonstrate customer driven services
- Believe that clinical intervention should be as early as possible
- Develop and continuously improve our best practice services to exceed our consumer's expectations
- Demonstrate the quality and effectiveness of program services through outcome-based evaluations

6. TRUST

- Affirm the need for increased individual and provider satisfaction
- Be committed to responsible management of the resources entrusted to us

SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

CODE OF ETHICS

Mental Health Care

The ethics of mental health care do not require complex analysis, just firm commitment for they are simple. Listen well; respond appropriately. Watch words you use as they become actions. Treat the family compassionately. Honor the importance of education. Respect the people with whom you work. Respect yourself. Understand your skill. Respect that each person is an expert in his or her own life. Understand your own power. Empower others. Do not exceed your limits. Be with the person where he or she is. Validate strengths. Recognize each person's right to "confidentiality". Recognize the healing partnership between the people receiving services, provider and payer. Recognize the importance for hope. Embrace an environment conducive to Recovery.

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WHEREAS, *the Sanilac County Community Mental Health Authority Board and its staff hold to the highest moral, legal and professional standards for their conduct and services, and*

WHEREAS, *the Sanilac County Community Mental Health Authority Board and its staff maintain respect both for the privacy and well-being of the persons served and for the welfare and protections of the general public, and*

WHEREAS, *the Sanilac County Community Mental Health Authority Board strives to enhance the principles of competency, accountability, responsibility, nondiscrimination and service excellence.*

NOW BE IT RESOLVED*…that the Sanilac County Community Mental Health Authority Board and its staff voluntarily subscribe to and uphold the following principles:*

1. *The interest of the person served is always respected. Activities on behalf of the persons served, whether individuals, families or organizations, shall always be determined by their best interests. Their rights, including appropriate care, confidentiality, informed consent, self-determination and access to records, are guaranteed.*

2. *Activities shall reflect the best interests of the general public. Authority of and accountability to the community are recognized by this governing board in determining priorities, policies and programs. Prevailing legal and moral standards shall be upheld. Questionable practices and programs are not condoned. The public's right to have information about programs, finances, policies and procedures is acknowledged.*

3. *High professional standards will be maintained and promoted. The Sanilac County Community Mental Health Authority Board and its staff at all times require conduct based on accepted principles and professional standards of practice. All staff shall avoid conflicts of interest and misrepresentation of their services, credentials or skills. They recognize accountability to the organization, persons they serve, and accept responsibility for their own actions. Non-discriminatory policies are promoted and observed among all persons. Also, the Sanilac County Community Mental Health Authority Board and its staff have a primary responsibility to maintain high standards of professional competence and to provide the highest quality of care possible.*

4. *Regard for the integrity of Sanilac County Community Mental Health Board's private organizations and other agencies shall be maintained. The rights and interests of all contract agencies shall be protected and promoted. No actions shall be taken which are detrimental to any contract agency by the Sanilac County Community Mental Health Authority Board without due process and Board action. Respect shall be maintained for the rights, policies and procedures of other professional organizations and governmental agencies.*

5. *Regard for the integrity of its funding services will be maintained. Any activities suspected of being fraudulent, abusive or wasteful shall be reported. The rights and interests of the reporting staff shall be protected.*

BE IT FURTHER RESOLVED*…that this Code of Ethics be reviewed annually by the Board of Directors for the information and guidance of Board members and staff. All new Board members and staff will be advised in writing of this code upon entering their duties and that this code shall be reviewed annually with them.*