Sanilac County Community Mental Health Authority

FY 2021

Corporate Compliance Plan

Mission

The purpose of the Sanilac County Community Mental Health Authority (CMH) Corporate Compliance Program Plan is 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.

Sanilac County CMH wants to deter fraudulent acts, detect misconduct, and prevent the waste and abuse of government resources and monies. In the spirit of the Medicaid Integrity Rules, everyone has responsibility to make sure that monies provided for healthcare are spent on the right individuals, the right providers, for the right services.

Overview

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 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 (MIP). Together, along with the Code of Federal Regulations (CFRs), they call for a standard approach to Medicaid compliance and program integrity.

Corporate compliance plans are required of providers receiving more than five (5) million dollars 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
- Responding promptly to detected offenses and developing corrective action
- Staying current with the law/regulations.

Corporate Compliance Office and Committees

Due to Sanilac County CMH size the administrative group has taken on the responsibility of being the Compliance Committee which oversees the organization's compliance program. Members include the Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, Chief Information Officer (Corporate Compliance Officer), the Human Resource Manager, and the Recipient Rights Officer.

The Sanilac County CMH has designated a Corporate Compliance Officer as the individual, within the CMH, who is responsible for overall development, implementation, and administration of Sanilac County CMH's Corporate Compliance Program Plan including enforcement activities. The Corporate Compliance Officer reports directly to the Chief Executive Officer and the Board of Directors and is responsible to ensure:

- Personnel are receiving education and training regarding the Corporate Compliance Program Plan and that such education and training is documented
- Competency is maintained as received through effective and ongoing training
- Prompt response to detected offenses and that a complaint is initiated to report, investigate, and follow up on any suspected fraud, abuse, waste, and/or other improper conduct
- Appropriate reporting/referrals are made because of complaint investigations
- Notification is provided to the PIHP and Office of Inspector General regarding ongoing program integrity activities and all allegations of Medicaid fraud/waste/abuse
- Guidance is provided on program integrity activities to subcontracted entities and ensure requirements are included in any subcontracts
- The Compliance Committee is appropriately informed of significant corporate compliance issues and risks
- Policy development and implementation
- Code of Conduct development and implementation
- Provisions for internal monitoring and auditing
- Dissemination of appropriate contact information for reporting.

Policy and Procedure Development, Review and Revision

The Corporate Compliance Officer, with input from the 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 policies include (but are not limited to):

- BA032 Corporate Compliance Program
- DA1005 Corporate Compliance Complaint, Investigation and Reporting Procedure
- RR005 Confidentiality and Disclosure of Information
- BA141 Utilization Management Program
- BA045 Network Management and Monitoring Plan
- DA1054 Network Monitoring

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical 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 of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Fraud:

(Federal False Claims Act, 1863): 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)

(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 constituted 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".

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.

Compliance and Practice Standards

- The Affordable Care Act (2010): This Act requires the CMH to have a written and operable compliance program capable of preventing, identifying, reporting, and ameliorating fraud, waste, and abuse across the CMH's provider network. All programs funded by the CMH, subcontract provider organizations and practitioners, board members and others involved in rendering CMH covered services, fall under the purview and scope of the compliance program.

- 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 half 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 2 times the gross gain or loss from the offense, whichever is greater
  - Mandatory exclusion from participation in Federal Health Care Program

- The Michigan Medicaid False Claims Act (1977): An act to prohibit fraud in the obtaining of benefits or payments in connection with the medical assistance program; to prohibit kickbacks or bribes 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 (against whistleblowers); to provide for certain civil fines; and to prescribe remedies and penalties.

- The Anti-Kickback Statue: Prohibits the offer, solicitation, payment or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any services paid for or supported by the Federal Government or for any good 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. HIPAA calls for a prison sentence of up to 10 years.

- Additional areas of potential risk and/or possible findings of non-compliance can be found in the CMH policies referenced earlier.

Training and Communication

The CMH maintains effective training and communications between the Corporate Compliance Officer and employees, as well as members of its provider network. Examples of this include reviewing the corporate compliance plan with the Board and posting online, ongoing communication with all staff members and providing updates whenever there are changes or new legal requirements.

The Complaint Process

Sanilac County CMH supports open lines of communication and, as such, a written compliance policy (Corporate Compliance Complaint, Investigation & Reporting Process (DA1005)) that includes the process for filing complaints, investigative procedures, corrective action plans when necessary as well as discipline or other consequences that are deemed appropriate. Additionally, a standardized complaint reporting form is posted online.

Conducting Monitoring and Auditing

The Corporate Compliance Officer and Committee will conduct an annual evaluation of the Corporate Compliance Program Plan. This will determine whether the required elements have been implemented as well as whether activities have resulted in meeting established goals. Methods that can be used to assess and evaluate the plan include the following:

- Work with CMH providers to coordinate corporate compliance activities
- An analysis of reports generated as part of the Medicaid Claims Verification reviews and Utilization Review processes to identify potentially abusive claims payment and service provision practices.
- An analysis of all allegations of abuse and/or fraud and reporting requirements/process to provide notification to MDHHS/Office of Inspector General (OIG)
- A review and analysis of compliance activities within provider agencies via the ongoing and annual network monitoring process

The Corporate Compliance Officer shall take the lead to develop an annual Corporate Compliance Report of this assessment and evaluation and to provide such to key stakeholders. The Corporate Compliance Officer takes the lead to update the annual corporate compliance plan if needed.