ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

BOARD POLICY

Date Issued 3/24

CHAPTER Administrative		**CHAPTER** 01	**SECTION** 002	**SUBJECT** 0020
SECTION Operations	**SUBJECT**	Corporate Compliance Complaint, Investigation and Reporting Process, and Non-Retaliation		
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I. APPLICATION:

☒ SCCCMHA Board
☒ SCCCMHA Providers & Subcontractors
☒ Direct-Operated Programs
☒ Community Agency Contractors
☒ Residential Programs
☒ Specialized Foster Care

II. POLICY STATEMENT:

It is the policy of the St. Clair County Community Mental Health Authority (SCCCMHA) to maintain compliance with all applicable laws, rules, and regulations in order to prevent misconduct and correct inappropriate behavior wherever it may occur in our organization.

SCCCMHA shall have a Corporate Compliance Program that promotes a culture of honesty, integrity, and high ethical standards in the work environment, where individuals can, in good faith, report compliance and ethics concerns, inappropriate behavior, and suspected violations of laws, rules, and regulations. Components of the Corporate Compliance Program include a compliance plan; education and training for staff; a process for receiving and investigating complaints; internal monitoring and auditing, and reporting on compliance activity.

SCCCMHA expressly prohibits any form of Retaliation against an individual for reporting, in good faith, a compliance or ethics concern, suspected violation, or inappropriate behavior, or for participating in an investigation, or for refusing to participate in inappropriate or wrongful activity (Protected Activity).

This policy is intended to address matters relating to the Federal False Claims Act (1863), Michigan Medicaid False Claims Act (1977), The Anti-Kickback Statute (1972), The Physician Self-Referral Law (commonly called "The Stark Law")(1989), Health Insurance Portability & Accountability Act (HIPAA) (1996), the Balanced Budget Act (1996), the Deficit Reduction Act (Medicaid Integrity Program) (2006), and the Eliminating Kickbacks in Recovery Act (2018) as well as any other circumstance in which the potential for or actual occurrence of Medicaid fraud, waste, or abuse is involved.

III. DEFINITIONS:

A. Abuse: Means 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).

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

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

D. Fraud (per Federal False Claims Act): Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law including but not limited to the Federal False Claims Act and the Michigan False Claims Act (42 CFR §455.2).

Fraud (per Michigan statutes 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." Errors or mistakes do not necessarily 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."

E. High Probability: Considered to exist whenever one of the following circumstances is present:

1. When the allegation arises as a result of regular review of claims, case review, or other routine monitoring and detection activities, and the number of improprieties exceeds the level a reasonable person would categorize as a mistake.
2. When the allegation arises as a result of routine detection and monitoring activities, and the same impropriety continues after a warning has been issued.
3. Whenever a specific allegation of improper or illegal activity has been brought to the SCCCMHA Corporate Compliance Office or SCCCMHA Quality Improvement Committee (QIC) by a credible person.

F. Protected Activity: Protected Activity means the good faith reporting of a compliance or ethics concern, inappropriate behavior, or suspected violations of laws, rules, or regulations; participating in an investigation; or refusing to participate in inappropriate, wrongful, or illegal activity.

G. Provider: SCCCMHA providers, individuals, or corporations, or any SCCCMHA subcontracted provider or practitioner, individual, or corporation.

H. Reportable Event: A Reportable Event means any situation that involves:

1. A substantial overpayment (an occurrence or series of occurrences exceeding $100,000); or
2. A matter that a reasonable person would consider a potential violation of any criminal, civil, or administrative statute or regulation applicable to any federal health care program for which criminal penalties, civil monetary penalties, or exclusions may be authorized.
3. A reportable event may be the result of an isolated event or a series of occurrences.

    a. Specifically, in relation to this policy and the SCCCMHA Corporate Compliance Program, a reportable event is any incident in which the reporter suspects that an employee, contracted provider, or SCCCMHA Board member is knowingly engaged in activities that violate the legal basis of the SCCCMHA Compliance Program, pertaining to the following statutes.

        (1) The Federal False Claims Act (1863). An act permitting individuals to bring action against parties which have defrauded the government and providing for an award of half the amount recovered. The Federal False Claims Act provides a broad definition of 'knowingly' with regard to billing Medicaid or Medicare for services which were not provided, not provided according to requirements for receiving payment, or were unnecessary.
        (2) 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; and, to authorize the attorney general to investigate alleged violations of this act.
        (3) The Anti-Kickback Statute (1972). A criminal statute that prohibits transactions intended to induce or reward referrals for items or services reimbursed by federal health care programs.
        (4) HIPAA (1996). An act that 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 failing to give privacy notice, and/or not following security measures (e.g., sharing passwords).
        (5) The Physician Self-Referral Law (1989). A law commonly referred to as the "Stark Law" that prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or their immediate family member has a financial relationship, unless an exception applies.
        (6) The Eliminating Kickbacks in Recovery Act ("EKRA") (2018). A criminal statute that prohibits accepting or paying anything of value for referring individuals to recovery homes, clinical treatment facilities, or laboratories with respect to services covered by a health care benefit program, including for privately paid services. A "recovery home" is shared living environment centered on peer support and connection to services that promote sustained recovery from substance use disorders (18 U.S.C. § 220(e)(5)). A "clinical treatment facility" is a medical setting, other than a hospital, that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for substance use (18 U.S.C. § 220(e)(2)). Michigan

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healthcare providers found to violate the EKRA may be subject to disciplinary actions under Section 16221 of the Public Health Code.

b. The violation of any regulations implementing the Balanced Budget Act of 1996 with respect to regulations which impact rates, claims, and payment issues.

I. Retaliation: When an individual is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against for engaging in Protected Activity.

J. Waste: Overutilization of services, or other practices, that result in extraneous costs and not usually considered to be caused by criminal negligence but rather the misuse of resources.

K. Whistleblower: A person who reports a violation or suspected violation of local, state, or federal law.

IV. STANDARDS:

A. All staff are required to conduct themselves in a manner that promotes the SCCCMHA Board's Mission, Vision, and Values, and Code of Ethics.

B. All staff are required to follow the SCCCMHA Corporate Compliance Program Plan. Personnel may be subject to discipline for failing to participate in compliance efforts.

C. All staff are empowered and responsible for reporting any compliance or ethics concerns, inappropriate behavior, or suspected violations of laws, rules, or regulations. The process for reporting potential noncompliance will be posted at all sites.

D. Federal and state laws provide protections for Whistleblowers and this policy expressly prohibits any form of Retaliation against an individual who engages in Protected Activity. Whistleblower provisions include:

1. Protection to employees or others who report a violation or suspected violation of local, state, or federal law.
2. Protection to employees or others who participate in hearings, investigation, legislative inquiries, or court actions.
3. Awards, remedies, and penalties prescribed under federal and state law.

E. An individual making a compliance report or complaint may request to anonymous when submitting a report or complaint to the SCCCMHA Corporate Compliance Office and such anonymity will be provided to the reporting person to the extent possible under the circumstances. Anonymity may slow down the investigation and delay its completion. Furthermore, anonymity may affect the success of a possible later prosecution.

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E. Detection of noncompliance will occur through already established reviews, including audit of claims data, record reviews, in addition to the observations and reports or complaints made by staff, individuals served, providers, or others.

F. Each contracted provider agency shall investigate its own complaints and report compliance issues to the SCCCMHA Corporate Compliance Office on a quarterly basis (or more frequently if desired). The report may include requests from the provider for the SCCCMHA Corporate Compliance Office to assist in the investigation. The SCCCMHA reserves the right to investigate possible compliance issues within its Provider Network agencies.

G. Plans of correction shall address remediation of the specific allegations and may include a plan for change in policy designed to prevent recurrence of similar findings in the future.

H. Possible findings - the following is only a sample of findings that could result in a determination of fraud, abuse, or non-fraudulent activities:

1. Altering a medical record
2. Providing a service, but using the wrong date or time
3. Billing for a service that was not medically necessary
4. Billing for non-covered services
5. Double billing (billing for the same service twice)
6. Timesheet falsification
7. Unbundling an all-inclusive service that is resubmitted as separate services
8. Lying about or falsifying credentials
9. Under billing (not billing for otherwise billable medically necessary services)
10. Unexplained entries and/or altered records
11. Inadequate or missing documentation
12. Delays in producing requested documentation
13. Unauthorized transactions
14. Unusual patterns and trends of contracting and procurement
15. Offers of gifts, money, or other gratuities from contractors, grantees, or other individuals
16. Providing false or misleading information
17. Missing signatures and credentials
18. Missing files, reports, data, and invoices (both electronic and paper)
19. Missing, weak, or inadequate internal controls
20. Billing for services that were performed by an employee who has been excluded from participation in federal healthcare programs
21. Billing for low-quality services
22. Collusion among providers, e.g., providers agreeing on minimum fees they will charge and accept

Findings of the above examples could result in discipline/corrective action, a larger sample of claims review, possible payback of inappropriate payments, and reporting to Michigan Department of Health and Human Services (MDHHS), Office of Attorney General, and/or Medicaid Fraud Unit.

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With respect to all areas of risk, the magnitude of the risk, changes in the risk from previous periods, and recommendations for remediating the risk shall be made.

V. PROCEDURES:

A. Complaint Process

Any Staff/Individual Served/Provider/Other

1. Identifies an alleged act of illegal or improper conduct either by an individual, program, or provider.

2. Notifies SCCCMHA Corporate Compliance Office immediately of such conduct by in-person report, telephone, email, or formal written complaint.

3. May completes the Complaint of Noncompliance form (form #1352, available on the SCCCMHA Forms Index) while maintaining anonymity when requested, if possible. If needed, assistance is available from an SCCCMHA-identified staff/Corporate Compliance Office for the complainant in filing the complaint. (Note: Recipient Rights complaints should be referred to the SCCCMHA Recipient Rights Office. Concurrent investigations may be conducted, if appropriate).

B. Investigation Process

Corporate Compliance Office

1. Observes an incident or situation which may lead to a compliance issue or receives a reported concern or Complaint of Noncompliance.

2. Determines if an allegation of noncompliance can be identified as a reportable event (see Definitions section), consulting with others as necessary.

3. Assigns the complaint a number using a fiscal year numbering system: 24-01, 24-02, 24-03, etc., and records complaint in SCCCMHA Corporate Compliance Complaint Log.

4. Categorizes the complaint from the type given and description offered. Provides notification to SCCCMHA Chief Executive Officer and others (e.g., SCCCMHA Recipient Rights Office), as appropriate.

5. Acknowledges receipt of complaint to complainant (within 5 business days) if not originally observed and/or reported by SCCCMHA Corporate Compliance Office.

6. Gathers supporting documentation for allegations related to Medicaid fraud, waste or abuse, conducts preliminary evaluation, and submits notification to Region 10 Pre-Paid Inpatient

Health Plan (PIHP) Corporate Compliance Office. The investigation will be coordinated by Region 10 PIHP Corporate Compliance Office.

7. Researches and reviews allegations unrelated to Medicaid fraud, waste or abuse, and conducts interviews, as necessary, to investigate the complaint (brings in outside sources as appropriate).

8. Makes a determination to substantiate or not substantiate the complaint. Completes Noncompliance Investigative Report (Exhibit A) within 30 days (unless extenuating circumstances exist), and provides notification to SCCCMHA Leadership Team and others, as appropriate.

9. Recommends action, as appropriate, for all substantiated complaints (e.g., corrective action, disciplinary action). May also make recommendations for improvement opportunities identified as a result of unsubstantiated complaint investigations.

Designated Leadership Staff

10. Reviews the findings and recommendations of the SCCCMHA Corporate Compliance Office.

11. Makes determination and agrees or disagrees with the findings and recommendations.

12. Forwards findings to the SCCCMHA Chief Executive Officer for review, as necessary.

Corporate Compliance Office

13. Follows up on recommendations/corrective action, as appropriate.

14. Consults, as needed, with Region 10 PIHP Corporate Compliance Office in the case of a substantiated reportable event, to ensure all reportable events are reported to the appropriate legal and federal health care program authorities as required.

15. Incorporates findings into SCCCMHA Corporate Compliance Committee report.

C. Reporting Process

Corporate Compliance Office

1. Completes monthly SCCCMHA Corporate Compliance reports and forwards to SCCCMHA Quality Improvement Committee (QIC) on a quarterly basis.

2. Completes monthly PIHP Corporate Compliance Complaint Reports and submits to PIHP Corporate Compliance Office on a quarterly basis.

3. Reviews the SCCCMHA Corporate Compliance Plan at least annually and updates as necessary.

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4. Reviews and analyzes the complaint data for trends or problem areas.

5. Recommends, to Leadership Team, changes and/or follow up action as necessary.

6. Forwards SCCCMHA Corporate Compliance Plan for SCCCMHA Board approval on an annual basis.

VI. REFERENCES:

Form #1352 Complaint of Noncompliance

VII. EXHIBITS:

A. Noncompliance Investigative Report

VIII. REVISION HISTORY:

Dates issued 11/06, 09/07, 01/10, 08/11, 01/13, 03/14, 03/15, 01/16, 01/17, 01/18, 01/19, 01/20, 03/21, 3/22, 3/23.

EXHIBIT A

Region 10 PIHP Corporate Compliance Complaint Investigation Form

Complaint # _____ Date & Time Reported _____

Reported By _____ Received By _____

Self-Reported ☐ Yes ☐ No Anonymously Reported ☐ Yes ☐ No

Reported By ☐ Verbal ☐ Hotline ☐ Email ☐ Walk-In ☐ Complaint Form ☐ Other _____

Investigator 1 _____ Investigator 2 _____

Name of Person / Agency Alleged in Non-Compliance _____

Address of Person / Agency Alleged in Non-Compliance

_____

Type of Complaint ☐ Fraud ☐ Waste ☐ Abuse ☐ Policy Violation ☐ Ethical Violation
☐ HIPAA Privacy / Security ☐ Other _____

Names of Individuals Involved and/or interviewed	Organization	Title	Contact Information

Complaint Overview:

Investigation Actions (include dates):

Findings	Disposition
☐ Substantiated	
☐ Not Substantiated	
☐ Suspicious	
☐ Non-Suspicious	

Policy Violations:

Follow Up / Corrective Action / Recommendations:

_____ _____

Compliance Staff Signature and Title Date Closed