Region 10 PIHP

FY 2018

Corporate Compliance Program Plan

Mission

The purpose of the Region 10 Corporate Compliance Program Plan is to provide quality care for all the individuals it serves by acting as an internal control. This encourages services that are provided by persons acting in good faith, with a duty of care and safety to the consumers, and promotes honesty, integrity, and high ethical standards.

Region 10 wants to defer 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 provider, for the right services.

The following mnemonic expresses the PIHP's commitment at the very basic level.

- **C**ommit to doing what is right
- **O**bey regulations and policies
- **M**ake compliance awareness part of everyone's job
- **P**ractice good conduct
- **L**earn about compliance
- **I**f in doubt, call the Corporate Compliance office
- **A**ttend training
- **N**otify supervisors of possible wrongdoing
- **C**ommunicate openly and honestly
- **E**thics is part of all the activities within Region 10

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 in Medicaid State Plan monies. Program basics include:

- Designation of a Corporate Compliance Officer;
- Written standards, policies and procedures;
- Implementation of compliance and practice standards;
- Conducting effective training and education;
- Ongoing and effective lines of communication;

- Responding to detected offenses, implementing corrective action, and issuing discipline as appropriate;
- Conducting monitoring and auditing; and
- Staying current with the law/regulations.

Corporate Compliance Office and Committees

The Region 10 PIHP Board has established a Regulatory Compliance Committee to oversee the organization's Compliance Program. Members include PIHP Board members as well as the PIHP Chief Executive Officer (Privacy Officer), Chief Financial Officer, Chief Information Officer (Security Officer) and Corporate Compliance Officer.

Region 10 PIHP has responsibility for approving and monitoring the region's Quality Assessment and Performance Improvement Program (QAPIP). To implement the QAPIP (QI Program), Region 10 PIHP's Board has established the Quality Improvement Committee which has designated the Corporate Compliance Committee to address Region 10's Compliance goals. Members include PIHP Corporate Compliance Officer and Administrative Staff, representation from each CMH Provider within the region and a representative for the regional SUD Provider Network.

Committee functions are further outlined in the PIHP Corporate Compliance Program Policy.

The PIHP Board has designated a Corporate Compliance Officer as the individual, within Region 10, who is responsible for overall development, implementation and administration of Region 10's Corporate Compliance Program Plan including enforcement activities. The Corporate Compliance Officer reports directly to senior management and is responsible to ensure that:

- PIHP personnel are receiving education and training regarding the Corporate Compliance Program Plan and that such education and training is documented;
- 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 as a result of complaint investigations;
- The Regulatory Compliance Committee is appropriately informed of significant corporate compliance issues and risks. The CCO serves as Chairperson of the Corporate Compliance Committee – serving as a liaison between the Committees.

Policy and Procedure Development, Review and Revision

The Corporate Compliance Officer, with input from the regional 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 PIHP policies include:

- 01-02-01 Corporate Compliance Program
- 01-02-03 Conflict of Interest

- 01-02-05 Corporate Compliance Complaint, Investigation and Reporting Process
- 01-02-06 Disclosure of Information
- 01-05-01 Utilization Management Program
- 03-03-01 HIPAA Privacy and Security Measures
- 03-03-02 HIPAA Privacy Measures – Protected Health Information
- 04-03-02 Claims Verification

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): 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 PIHP to have a written and operable compliance program capable of preventing, identifying, reporting, and ameliorating fraud, waste and abuse across the PIHP's provider network. All programs funded by the PIHP including CMHSPs, sub-contract provider organizations and practitioners, board members and others involved in rendering PIHP 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 (whistleblower's); 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 PIHP policies referenced earlier.

<u>Training and Communication</u>

The PIHP maintains effective training and communications between the Corporate Compliance Officer and employees. Examples of this include reviewing the Corporate Compliance Plan with the PIHP Board and posting online, ongoing communication with all Region 10 staff members and providing updates whenever there are changes or new legal requirements.

<u>The Complaint Process</u>

Region 10 supports open lines of communication and, as such, a written compliance policy (Corporate Compliance Complaint, Investigation & Reporting Process (01-02-05)) 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 CMHs and SUD 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 and provider agencies via the ongoing and annual contact monitoring process.

The Corporate Compliance Officer shall take 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 plan if needed.

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