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REGION 10 PIHP

SUBJECT		CHAPTER	SECTION	SUBJECT
Corporate Compliance Program		01	02	01
CHAPTER	**SECTION**			
Administrative	Compliance			
WRITTEN BY	**REVIEWED BY**	**AUTHORIZED BY**		
Lisa K. Morse	Kelly VanWormer	PIHP Board		

I. **APPLICATION:**

☒ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. **POLICY STATEMENT:**

Region 10 PIHP 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 PIHP activities. In furtherance of this commitment, the PIHP strives to promote honesty, integrity, and high ethical standards in the work environment and to comply with all applicable federal state statutes and regulations and other legal and ethical obligations.

This policy is intended to address matters relating to the Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statue, the Health Insurance Portability & Accountability Act (HIPAA), the Balance Budget Act (1996), the Deficit Reduction Act (Medicaid Integrity Program) (2006), as well as any other circumstance in which the potential for or actual occurrence of Medicaid fraud, waste or abuse is involved.

III. **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): 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 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."

Provider: CMHSP and SUD Providers, individual or corporation; any CMHSP 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.

IV. STANDARDS:

A. The PIHP and Providers shall maintain administrative and management arrangements or procedures for compliance with 42 CFR 438.608 including a Compliance Program and information about rights of employees to be protected as whistleblowers.

B. The PIHP and Providers shall cooperate with the implementation and ongoing administration of the Corporate Compliance Program Plan.

C. REGULATORY COMPLIANCE COMMITTEE

The Board has established a Regulatory Compliance Committee to oversee the organization's compliance program as referenced in 42 CFR § 438.608 Program Integrity Requirements.

The Committee shall provide compliance program oversight (including endorsement of the Annual Compliance Report and endorsement of the Annual Compliance Program Plan), review significant reportable events, review compliance policies and act as liaison to the PIHP Board.

Committee standards and procedures are further addressed in the PIHP Regulatory Compliance Committee Policy.

D. CORPORATE COMPLIANCE COMMITTEE

The Board has established a Quality Assessment & Performance Improvement Program (QAPIP) Oversight Committee which has designated a Corporate Compliance Committee to address the PIHP's compliance goals. Members shall minimally 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.

The Committee shall provide practical consultation regarding legal requirements, MDHHS and Office of Inspector General requirements, existing policies and procedures and training materials. The Committee shall review the Annual Compliance Report and Annual Compliance Plan. Members shall work with the PIHP Management Team and Corporate Compliance Officer in support of corporate compliance complaint reporting requirements and maintenance of policies and procedures which promote the PIHP's Corporate Compliance Program Plan.

E. CORPORATE COMPLIANCE OFFICER

The Board has designated a Corporate Compliance Officer as the individual who is responsible for overall development, implementation, and administration of the 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:

1. PIHP personnel receive education and training regarding the Corporate Compliance Program Plan and that such education and training is documented;
2. Competency is maintained as received through effective and ongoing training;
3. Prompt response to detected offenses and that complaints are initiated to report, investigate, and follow up on any suspected fraud, abuse, waste, and / or other improper conduct;
4. Appropriate reporting / referrals are made as a result of complaint investigations;
5. Notification is made to the MDHHS Office of Inspector General (OIG) regarding ongoing program integrity activities and allegations of Medicaid fraud, waste, and abuse;
6. Provide guidance on program integrity activities to subcontract entities and ensure requirements are included in any subcontracts;
7. Policy development and implementation;
8. Code of Conduct development and implementation;
9. Provisions for internal monitoring and auditing;
10. Dissemination of appropriate contact information for reporting.

All personnel are expected to cooperate with the Corporate Compliance Officer in the implementation and ongoing administration of the Corporate Compliance Program Plan.

The Corporate Compliance Officer shall be a member of and report to the Regulatory Compliance Committee. The Corporate Compliance Officer shall also serve as a liaison between the Regulatory Compliance Committee and the Corporate Compliance Committee.

F. COMPLIANCE POLICY AND PROCEDURES

The policies and procedures for each risk area specific to PIHP include, but are not limited to conflict of interest, Health Insurance Portability and Accountability Act (HIPAA) requirements,

billing, medical records, documentation, record access and retention, contracting, training and education, and monitoring.

G. TRAINING

The PIHP requires all PIHP personnel to participate in programs of training and continuing education as needed with respect to the Corporate Compliance Program Plan.

At minimum, the PIHP and each Provider shall ensure all employees receive Corporate Compliance training upon initial hire and annually thereafter in the format specified by the PIHP.

H. NOTICE

The PIHP shall post notice regarding access to the PIHP Corporate Compliance Office (including how to report a complaint).

The Provider shall post notice regarding access to the Provider and PIHP Corporate Compliance Offices (including how to report a complaint).

I. FINANCIAL REPORTING AND PAYMENTS

All financial reports, accounting records, research reports, expense accounts, time sheets, 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 PIHP may violate the Corporate Compliance Program Plan.

All overpayments identified or recovered known to the Provider shall be promptly reported to the PIHP.

J. DOCUMENATATION AND BILLING PRACTICES

The PIHP will develop standards and procedures to ensure compliance with all regulatory standards. Providers will ensure that services are fully documented and that all claims, bills, and other submissions for reimbursement to those served and third-party payers for services rendered by any Provider compiles with the Corporate Compliance Program Plan.

K. PIHP NETWORK PROVIDERS

The PIHP shall require Providers:

1. That make or receive at least $5,000,000 in payments under the contract to comply with section 6032 of the Deficit Reduction Act (DRA) of 2005;
2. To report to the PIHP when an overpayment has been received as specified in the contract;
3. Submit ongoing compliance and program integrity reports as specified in the contract;
4. Provide assistance to the PIHP with audits and investigations;
5. Ensure provisions for internal monitoring, prompt response to potential offenses, and implementation of corrective action plans;

6. Maintain appropriate and prompt reporting of fraud, waste, and abuse to the PIHP;
7. Maintain compliance with program integrity provisions specified in the contract as applicable.

L. MONITORING

The PIHP shall engage in monitoring and auditing activities of the Corporate Compliance Program Plan. Evaluation efforts may be addressed through contract monitoring, record reviews, claims verification (e.g., correct usage of procedure codes) and utilization review.

The Corporate Compliance Officer will conduct an annual evaluation of the Corporate Compliance Program Plan. This assessment shall be reviewed with the Corporate Compliance Committee and reported to the Regulatory Compliance Committee.

M. COMPLAINT INVESTIGATION AND REPORTING

It is the responsibility of all regional personnel, including PIHP employees and Board members as well as Providers and Provider subcontractors, to report to the Provider and / or the PIHP his or her good faith belief of any violation of the Corporate Compliance Program Plan.

All allegations involving fraud, waste, or abuse shall be investigated and reported appropriately as specified in contract requirements.

The PIHP shall report all appropriate overpayments, Medicaid fraud, waste, or abuse allegations, and referral data to the MDHHS OIG as applicable. Reporting additionally includes ongoing program integrity activities and appropriate referral data / review components.

Investigation reporting standards and procedures are further addressed in the PIHP Corporate Compliance Complaint, Investigation, and Reporting Process policy.

N. CODE OF CONDUCT

The PIHP shall develop and implement a Code of Conduct which details the fundamental principles, values, and framework of the PIHP. The Code of Conduct shall include standards which address compliance with statutes and regulations as well as set forth broad principles of compliance for its Board and employees. The Code of Conduct is reviewed annually.

V. **PROCEDURES:**

None.

VI. **EXHIBITS:**

None.

VII. **REFERENCES:**

A. MDHHS – PIHP Medicaid Contract
B. 42 C.F.R.§438.608
C. 42 C.F.R.§455.13-17
D. MCL 400.43b