CMHA-CEI Corporate Compliance Training

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Updated 10/2025

What is Compliance?

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Compliance is doing the right thing!

- In an organization, this looks like:
  - A formal compliance program that defines policies and procedures to guide behavior, conducts training and education to support staff in understanding legal and ethical obligations, and prevents and detects violations of laws and regulations.
  - A culture of ethics and integrity throughout the organization that promotes and supports responsible behavior.

- As an individual, this looks like:
  - Being honest, responsible, and ethical.
  - Knowing and following applicable laws, regulations, and agency policies and procedures.
  - Reporting unethical and illegal conduct.

The Seven Elements of an Effective Compliance Program

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1. Written Policies and Procedures
    a. Policies and procedures are available in PolicyStat.
2. Compliance Leadership and Oversight
    a. Corporate Compliance Officer, Emily Ryan.
3. Training and Education
    a. Annual compliance and privacy trainings; Job specific trainings provided by the Compliance Office.
4. Effective Lines of Communication with the Compliance Officer and Disclosure Programs
    a. Open door policy to Compliance Officer; Anonymous reporting options; Whistleblower protections.
5. Enforcing Standards: Consequences and Incentives
    a. Consequences are applied equally across staff at all levels; Activities such as Compliance and Ethics Week.
6. Risk Assessment, Auditing, and Monitoring
    a. Risk Management Plan overseen by Quality and Compliance.
7. Responding to Detected Offenses and Developing Corrective Action Initiatives
    a. All reports are responded to and investigated promptly; appropriate remedial action is taken and may include training, changes to internal processes, and recommendations for disciplinary actions. The Compliance Office does not have the authority to impose disciplinary action or termination.

Ethical Standards

Code of Ethics

Each member of the organization's behavior must be guided by the values of:

- Dignity
- Self-Determination
- Justice
- Service
- Compassion

For more information, see Ethical Standards Procedure, 1.1.15:
https://ceicmh.policystat.com/policy/17915677/latest

Other Ethical Responsibilities

1. Employees, consumers, and visitors are treated in a professional, friendly, competent, and efficient manner, regardless of their economic status, race, religion, age, gender, sexual orientation, or disability.
2. Read and understand the Code of Ethics associated with any professional license you may have.
3. Consumers receive treatment that is suitable to their condition.
4. Consumers will not be denied access to needed mental health care because of an inability to pay.
5. Consumer information is shared in accordance with confidentiality policies.
6. Consumers are informed about their rights, right to appeal, and grievance procedures.
7. Employees report any suspected or actual fraud, waste, and abuse.
8. Employees do not solicit or accept gifts.
9. Employees are responsible for thorough documentation as defined by agency standards for completion of paperwork.
10. Employees establish and maintain healthy boundaries with consumers, families, and colleagues.
11. Avoid conflicts of interest and disclose potential conflicts as they arise.
12. Avoid using your workplace to promote personal interests or paid endeavors.
13. Immediately warn if a consumer discloses intent to harm self or others.
14. Avoid sexual impropriety.
15. Political contributions will not be made with agency funds or resources.

Service Documentation Requirements

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Michigan Medicaid Provider Manual requirements (non-exhaustive list) (Medicaid Provider Manual Section 15: Record Keeping)

- The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed.
- All documentation must be signed and dated by the clinician rendering the service.
  - Documentation, including signatures, must be legible.
  - If the signature is not legible, the clinician's name and credentials should be printed below.
- For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service.
- Progress notes must include the following:
  - Goal(s) and/or Objective(s) of the Plan of Service addressed.
  - Progress/lack thereof toward desired outcome.

Overview of Medicaid Program Administration for Behavioral Health Services

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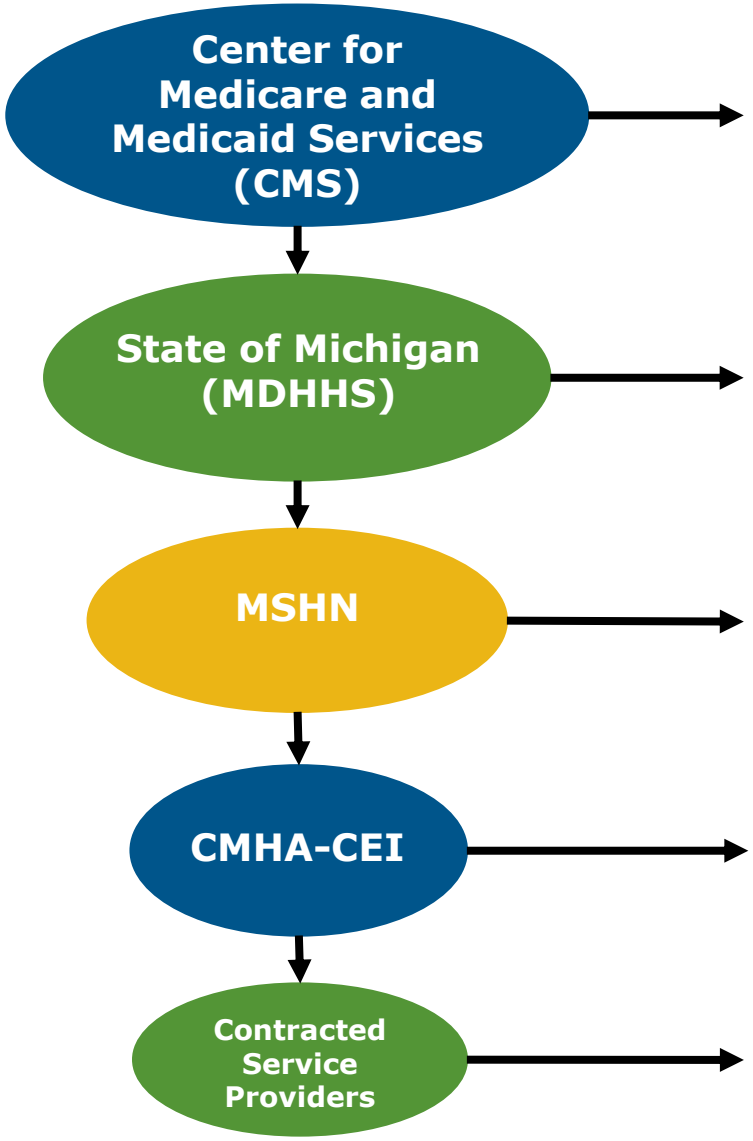

1. Federal
CMS provides approval, oversight, operational direction, and policy guidance to the states and to healthcare providers.

2. State
The Michigan Department of Health and Human Services (MDHHS) oversees the administration of the Medicaid Program for Michigan.

3. Regional
MDHHS contracts with Prepaid Inpatient Health Plans (PIHPs) to manage behavioral health benefits in 10 regions across Michigan.

4. County
MSHN contracts with SUD providers and each of the Community Mental Health Service Providers (CMHSPs) in Region 5 to provide behavioral health services to Region 5 consumers.

5. Local
Each CMHSP contracts with various service providers to provide behavioral health services to the consumers located in that CMHSP's county.

Laws Impacting Healthcare: Deficit Reduction Act of 2005

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The Deficit Reduction Act of 2005 (DRA) requires entities that receive $5 million or more in Medicaid payments annually to establish:

- A compliance program.
- Training for employees, contractors, and agents that contains detailed information about federal and state False Claims Acts, administrative remedies for false claims, and whistleblower protections.
- Written policies and procedures that include detailed information about federal and state False Claims Acts, whistleblower protections, and preventing and detecting fraud, waste, and abuse of Medicaid funds.
- An employee handbook that includes applicable state and federal laws, rights of employees to be protected as whistleblowers, and related policies and procedures.

The DRA ensures that staff receive sufficient education and training, that written standards are in place, and encourages joint oversight between federal and state governments.

Laws Impacting Healthcare: Federal False Claims Act

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- The False Claims Act (FCA) is a federal statute that prohibits individuals or entities from submitting false or fraudulent claims for payment from any federally funded contract or program, including the Medicaid program.
- The FCA establishes civil liability for acts including:
  - Knowingly presenting a false or fraudulent claim to the government for payment.
  - Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved.
  - Conspiring to defraud by getting a false or fraudulent claim allowed or paid.
  - Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
- "Knowingly" means:
  - Actual knowledge of the information.
  - Acting in deliberate ignorance of the truth or falsity of the information.
  - Acting in reckless disregard of the truth or falsity of the information.
  - Specific intent to defraud is not required.

Laws Impacting Healthcare: Federal False Claims Act

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- Qui Tam Lawsuits:
  - A whistleblower can file a lawsuit on behalf of the government against someone who has defrauded it.
  - A whistleblower who files a qui tam lawsuit has the possibility of receiving a portion of monetary recovery if the government is awarded any.
  - Qui tam lawsuits are filed under seal and only the government is aware of the case.
  - Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the False Claims Act to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation.
- Penalties:
  - Civil Monetary Penalties ranging from $14,308-$28,619 per claim.
  - Treble Damages: The government can recover three times the amount of damages incurred related to fraud, waste, and abuse.
  - Returning overpayments to the government for restitution.
  - Exclusion from participation in state and federal programs, including Medicare and Medicaid.
  - Criminal penalties such as probation or imprisonment.
  - Loss of professional license.
  - Entities can be required to comply with a Corporate Integrity Agreement.

Laws Impacting Healthcare: Federal False Claims Act

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- FCA Violation Examples:
  - Billing for services not rendered..
  - Falsifying documentation used to justify payment.
    - Examples: backdating documents, altering medical records, creating notes for services that were not rendered.
  - Billing for services outside of allowed billable time.
    - Example: billing for drive time to and from a service in the community when only face to face time is billable.
  - Overlapping services
    - Example: billing for Community Living Supports (CLS) while the consumer is attending an appointment with another provider.

Laws Impacting Healthcare: Michigan False Claims Act

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- The Michigan False Claims Act can be found at MCL 400.602.
- It mirrors the federal False Claims Act, but expands the definition of "knowledge".
  - "Knowing" and "knowingly" means that a person is in possession of facts under which he or she is aware or ***should be aware*** of the nature of his or her conduct and that his or her conduct is substantially certain to cause the payment of a Medicaid benefit. Knowing or knowingly includes acting in deliberate ignorance of the truth or falsity of facts or acting in reckless disregard of the truth or falsity of facts. Proof of specific intent to defraud is not required.
  - Allows for constructive knowledge. This means that if the course of conduct "reflects a systemic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

Laws Impacting Healthcare: Whistleblowers Protection Act

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- Federal Whistleblowers Protection Act
  - Protects employees from retaliation for reporting suspected violations of federal or state laws or participating in investigations or court actions related to suspected violations.
  - Retaliation is any type of action that would discourage a reasonable employee from reporting suspected violations of laws, rules, or regulations.
  - Examples of retaliation include:
    - Termination of employment.
    - Discrimination related to compensation, location, terms, conditions, or privileges of employment.
    - Threats towards the employee.
- Michigan Whistleblowers Protection Act
  - Provides protection for employees who report a violation or suspected violation of a federal or state law, rule, or regulation to a public body; unless the employee knows the report is false.
  - Employers may not discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment.

Laws Impacting Healthcare: Other Applicable Laws

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- Anti-Kickback Statute [42 USC § 1320a-7b(b)]
  - Health care providers and suppliers must not offer, pay, solicit, or receive anything of value in exchange for the referral of patients or services covered by Medicaid or Medicare.
  - Fines can include up to $25,000 per violation and up to 5 years in prison per violation.
- Stark Law
  - Prohibits physician self-referral; a physician may not refer a Medicaid or Medicare patient to an entity providing designated health services if the physician or an immediate family member of the physician has a financial relationship with that entity, unless an exception applies.
  - The Center for Medicare and Medicaid Services (CMS) issued a final rule effective in January 2021 that created new exceptions for value-based arrangements to improve quality of care.

Laws Impacting Healthcare: Other Applicable Laws

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- Civil Monetary Penalties Law (42 USC § 1320a)
  - Allows the Office of the Inspector General (OIG) to impose monetary penalties for violations of the Anti-Kickback Statute, the False Claims Act, and other violations including making false statements on applications or contracts to participate in a federal health care program.
- Criminal Health Care Fraud Statute (18 USC 1347)
  - Makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment of up to 10 years, and fines of up to $250,000. Specific intent is not required for conviction.
  - With respect to violations of this statute, a person does not need to have actual knowledge of this section or specific intent to commit a violation of this section.

Laws Impacting Healthcare: Exclusion Authorities

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- Providers must ensure that no federal funds are used to pay for items or services furnished by an individual who is debarred, suspended, or otherwise excluded from participation in any federal health care program.
  - Includes salary, benefits, and services furnished, prescribed, or ordered.
- Federal exclusions are imposed under the Social Security Act, 42 USC § 1320a-7.
- Federal exclusions can be mandatory or permissive.
  - Examples of mandatory exclusions:
    - Conviction of program related crimes.
    - Conviction related to patient abuse or neglect.
    - Felony conviction related to health care fraud.
    - Felony conviction related to controlled substance.
  - Examples of permissive exclusions:
    - Conviction related to fraud.
    - Conviction related to obstruction of an investigation or audit.
    - Misdemeanor conviction related to controlled substance.
    - License revocation or suspension.
    - Exclusion or suspension under Federal or State health care program.
    - Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services.

Laws Impacting Healthcare: Exclusion Authorities

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- State exclusions are imposed under MCL 400.111a-f and the Medicaid Provider Manual (Section 6: Denial of Enrollment, Termination, and Suspension).
  - Reasons for state exclusions are the same as those for federal exclusions, as well as:
    - Federal exclusion from participation in federal healthcare programs.
    - Termination as a provider under Medicare, Medicaid or the Children's Health Insurance Program (CHIP) in any other state.

What is Fraud?

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Fraud occurs when someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program.

Can include billing for services not rendered, performing medically unnecessary services solely to obtain payment, altering documentation to obtain higher payment, and deliberate duplicate billing.

<u>Example:</u>
A consumer is scheduled for 60 minutes of psychotherapy. The consumer unexpectedly has to leave 30 minutes into the service. The clinician submits a service note and bills for 60 minutes.

What is Waste?

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Waste occurs when services are overused or other practices result in unnecessary costs. Waste is generally considered to be caused by misuse of resources, not criminally negligent actions.

Example:
A consumer received an assessment from their provider last month. There has been no significant change in the consumer's condition or treatment. The provider performs another assessment and submits a claim for payment.

What is Abuse?

Abuse occurs when health care providers or suppliers engage in practices that result in unnecessary cost to the payer, reimbursement for services that are not medically necessary, or do not meet appropriate standards for healthcare.

Abuse can become fraud if there is evidence that the individual or entity knowingly and willfully conducted the abusive practices.

<u>Example:</u>

The guardian of a recipient receives payment from Medicaid for services provided to the recipient.

Reporting Responsibilities

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It is your right and responsibility to report actual or suspected compliance violations to the CMHA-CEI Compliance Officer, the MSHN Compliance Officer, or the MDHHS Office of Inspector General.

CMHA-CEI Compliance Reporting:

Emily Ryan
Corporate Compliance Officer
Phone: (517) 346-8193

Virginia Kallweit
Compliance Specialist
Phone: (517) 237-7115

Email: Compliance@ceicmh.org
Address: 812 East Jolly Road Suite 108
Lansing, MI 48910
Fax: (517) 237-7333

MSHN Compliance Reporting:

Compliance Hotline: 844-793-1288
Kim Zimmerman, Chief Compliance and Quality Officer
Phone: 517-657-3018
Email: kim.zimmerman@midstatehealthnetwork.org

MDHHS Office of Inspector General:

Medicaid Fraud and Abuse Online Complaint Form:
https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/report-medicaid-fraud-and-abuse
Phone: (855) 643-7283
Address: Office of Inspector General
P.O. Box 30062 Lansing, MI 48909

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THANK YOU!

You have completed CMHA-CEI's Corporate Compliance Training.

You must complete the test to receive credit for this course.

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