I.M.P.A.C.T.

CORPORATE COMPLIANCE PROGRAM

2005
Revised
2007
2009
2011
2013
2015
2016
2017
2018
2019
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2021

I.M.P.A.C.T.

CORPORATE COMPLIANCE PROGRAM

1. INTRODUCTION

This document describes I.M.P.A.C.T.'s Corporate Compliance Program. This compliance program covers the specific compliance principles and components and activities the Agency performs as a healthcare entity.

Establishing the Program is a response to the federal initiatives to improve compliance with federal regulations governing the Medicaid and Medicare programs.

Efforts to uncover fraudulent practices in the health care industry and to encourage public reporting of them were mandated in the 1996 Health Insurance Portability and Accountability Act (HIPAA) revised. Following findings of fraud in several locations by the Office of the Inspector General (OIG), the components of a Corporate Compliance Program acceptable to the Federal government were articulated in several OIG Advisories.

Compliance Plans are now required of providers receiving more than $5,000,000 in Medicaid State Plan monies. Programs basics include:

- Implementing written policies, procedures
- Standards of conduct;
- Designating a compliance officer;
- Conducting effective training and education;
- Developing effective lines of communication;
- Enforcing standards through disciplinary guidelines;
- Conducting internal monitoring and auditing; and
- Responding promptly to detected offenses and developing corrective action.

2. FOUNDATION AND LEGAL BASIS OF THE PROGRAM

The Program is founded on a) the ethical principles that are the basis of the corporate culture of the Agency, b) a body of laws which defines actions that constitute criminal behavior and establish civil and criminal penalties and c) on regulations which implement federal and state law and prescribe financial sanctions, and/or civil and criminal penalties for violations.

A. Ethical Foundation and Principles**:**
The Agency subscribes to the Unified Code of Ethics. Compliance with the ethical foundation is initiated at staff orientation and reinforced through the annual staff evaluation process.

B. Legal Foundations – Federal Statutes

1. The *False Claims Act* (1863). This act permits individuals to bring action against parties which have defrauded the government and provides for an award of ½ the amount recovered. The Act contains protection from recrimination against those who report, testify or assist in investigation of alleged violations 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 not necessary.
2. The *Anti-Kickback Statute* 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 consumer service delivery.
3. *Self Referral Prohibitions (Stark Laws)* prohibits referral by physicians to entities in which the physician or immediate family has a financial interest. This includes referrals to a second place of employment.
4. *HIPAA (1996) revised* expands the definition of "knowing and willful" conduct to include instances of "deliberate ignorance" such as failure to understand and correctly apply billing codes.
5. T*he 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 ac; to provide for civil actions to recover money received by reason of fraudulent conduct; to prohibit retaliation (Whistleblower's Act); to provide for certain civil fines; and to prescribe remedies and penalties.

C. Federal and State Regulations:
1. Regulations implementing the Balanced Budget Act of 1996 with respect to the management of Medicaid Managed Care Programs;
2. Social Security Act 1903 (m)(95)(i);
3. Medicaid Integrity Program developed pursuant to the Deficit Reduction Act of 2006
4. Advisories issued by the HHS Office of the Inspector General for the conduct of fraud and Abuse Compliance Programs;
5. Guidelines for addressing Medicaid fraud and abuse in managed care, issued by the MDHHS; and
6. Michigan Mental Health Code (1974; 1996) and the Mental Health Administration Rules, as promulgated by the State.

3. COMPLIANCE PROGRAM PURPOSE

A. To prevent noncompliance with applicable law, whether accidental or intentional
B. To detect noncompliance which may occur
C. To discipline individuals involved in noncompliance
D. To prevent reoccurrence of noncompliance

4. SCOPE OF PROGRAM AND DELEGATION OF FUNCTIONAL REPONSIBILITY

The scope of the Corporate Compliance program extends to all activities. Each staff, volunteer and contractor are expected; through its direct employment or contractual agreement, to initiate corporate compliance activities that are consistent with the purpose and activities of the Agency.

Agency Compliance Responsibilities:

As a healthcare organization a compliance structure is needed. The Agency has a Corporate Compliance Team, made up of Agency Management staff, that reports quarterly at the management team meetings, quarterly at Quality Improvement Committee and annually to the Board of Directors.
The Corporate Compliance Team reports regularly at the management team meetings to review and resolve compliance issues, as well as advising on program policy, policy development, training and other issues.
The management team is charged with developing and recommending an Annual Quality Improvement Plan which includes specific goals and compliance improvement/assessment activities to be undertaken. The annual plan is approved by the Agency Board of Directors.

5. FUNCTIONS

The functions of the compliance program include activities in the following areas:

A. Assessment of Risk

The Compliance Team is responsible for ensuring that practices within the Agency's programs and its contracts are such that the risk of fraud and abuse is understood and minimized. This function involves assessment of both existing and planned activities to identify potential risks and the level of that risk. Many areas of risk begin as failures to adequately perform under existing policies; however, if not stopped or when combined with other undesirable practices, they may be considered fraud. Major areas of potential risk include;

- Staffing and subcontract issues, including the potential that staff or subcontractors have inadequate or falsified credentials or financial reports, engage in bid rigging or collusion among service providers or violate standards related to conflict of interest. The Agency is also at risk of having a service array which has inadequate capacity to provide the scope, intensity and duration of services required or of paying for services at rates which have inadequate economic justification.
- Inappropriate Utilization issues. When practices result in a pattern of denying eligible persons necessary services on a timely basis, it may be considered fraud. Examples include delay in providing services, defining appropriate care in a manner not consistent with standards of care, inappropriate Utilization review guidelines, inhibiting the appeal process for consumers, an ineffective grievance process, and provider's incentives to limit care.
- Claims Submission and Billing Procedures. Examples include up coding or inflating claims, double-billing, billing for ineligible consumers or for services not rendered, and billing for unnecessary services.
- Failure to meet other requirements of Federal or State law and regulations, including the Balanced Budget Act and HIPAA.

Although embezzlement and theft are clear violations of law, they are generally not within the scope of activity of the compliance program, unless one of the risk areas defined herein is the mechanism for carrying out the embezzlement/theft.

B. Policy and Procedure Development, Review and Revision

The Compliance Team has developed policies to augment practices already in place to help ensure legal compliance. A complaint and investigation policy are key. This includes but is not limited to Business Associate Agreements (BAA) with; referral sources, contractors and services providers.

C. Prevention Activities/Training

All employees, direct and contractual, are to be trained; each new employee of the Agency is provided with written information and discussion on an individual basis as part of the new employee orientation or other procedure depending on the Department. Each employee will receive re-certification training annually.

D. Ensuring that information regarding current law and regulation is disseminated
The management team is responsible for reviewing all new compliance related law and regulation and official interpretation of law and regulation which is issued by State and Federal agencies. Administration of information to employees or policy changes will be issued as appropriate.

E. Detection Activities
The system for detecting noncompliance has two components. The first is a body of auditing and review mechanisms conducted by the Agency where the Compliance Team ensure that audits include issues of regulatory concern and that monitoring tools are regularly updated to reflect both existing and new issues. Reviewers will report the presence of issues that require investigation from a compliance perspective.
Second is a mechanism for confidential reporting of suspected incidents of noncompliant behavior. In this regard all individuals must know that failure to report suspected fraudulent behavior is unethical and thus itself is noncompliant. Individuals are also assured that allegations will be held in confidence to the limit allowed by law and that they will not be penalized for reporting suspected incidents and that fair and objective investigation of all allegations will be conducted prior to any action. All corporate compliance complaints, and alleged Medicaid fraud, waste and abuse must also be reported to the Region 10 PIHP.

F. Investigation, Disciplinary Action, Disclosure Activities
The annual assessment and evaluation of the compliance program will determine whether the required elements have been implemented as well as whether activities have resulted in meeting goals established. Methods that can be used to assess and evaluate the program include;

- Analysis of reports generated as part of the utilization review processes to identify potentially abusive claims payment and service provisions practices as well as the financial audit.
- Analysis of consumer complaints and appeals to identify potential areas of abuse related to over or under utilization, denial of access or denial of choice.
- A baseline and annual follow-up review of agency employees to determine change in the level of understanding and sensitivity to compliance issues.
- Analysis of all allegations of financial abuse and fraud.

The Compliance Team shall take the lead to ensure the compliance report is included as part of the Annual Plan.

G. Assessment and Evaluation of Compliance Program
The annual assessment and evaluation of the Compliance Program will determine whether the required elements have been implemented as well as whether activities have resulted in meeting the goals established. Methods used to assess and evaluate the Compliance program include the following:

- ∨ Claims Payment reviews and Utilization Review processes to identify potentially over and/or under payments and service provision practices.
- ∨ An analysis of consumer complaints and Grievances/Appeals to identify potential areas of abuse related to over or under utilization, denial of access or denial of choice.
- ∨ An analysis of all allegations of abuse and/or fraud.

The Compliance Team shall develop a Year-end Compliance Report as part of the annual plan which assesses the overall effectiveness of the compliance program during the past year, including recommendations for the next **Compliance Plan** review**.** The development of the year-end report should include the following activities:

1. The Team will analyze and as needed, develop new methods for promoting compliance and identifying potential violations and for soliciting, evaluating and responding to complaints and reports of alleged non-compliance.

2. The Team will periodically review the resources assigned to compliance efforts to assess their adequacy for maintaining the Compliance Program's ongoing effectiveness.

3. The Team will provide recommendations for Compliance Program improvement to the Board as part of the annual Report.