VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
POLICIES & PROCEDURES

Title: Corporate Compliance
Originated: March 30, 2010
Revised: 10/03/18, 02/13/25

Number: I.06.01
Approved By: Board
Reviewed By: Executive Team

POLICY:

Van Buren Community Mental Health Authority (VBCMHA) is committed to conducting itself in accordance with the highest standards of business ethics and integrity and in compliance with all applicable federal and state laws, regulations, and legal standards. For this reason, a Corporate Compliance Plan has been written, a Corporate Compliance Officer has been appointed, and a Compliance Committee has been established and charged with the responsibility to formalize and monitor VBCMHA's Compliance Procedures to ensure that all VBCMHA directors, officers, managers, employees, independent contractors, agents, and volunteers ("VBCMHA Personnel") conduct themselves on behalf of VBCMHA in the highest ethical manner.

Compliance Plan: The formal Compliance Plan will be available for review on the VBCMHA website. VBCMHA personnel will be trained regarding the Compliance Plan upon hire and will be expected to adhere to the principles, standards, and procedures described in the Compliance Plan.

Procedures: All VBCMHA Personnel are responsible for reviewing and adhering to the principles, standards, and procedures that comprise the Compliance Plan, and to the principles, standards, policies and procedures included in the existing Van Buren Community Mental Health Authority Policy and Procedure Manuals. All VBCMHA Personnel will receive initial and annual Compliance training.

DEFINITION(S):

State Laws and Regulations: Michigan Mental Health Code (MCLA 330.1400) and Administrative Rules; (Michigan Medicaid False Claim Act (MCL 400.601 et/seq.) Michigan Public Health Code (MCLA 333.16226) other statutes related to municipal organizations and operations and Michigan Social Welfare Act (MCLA 400.111d).

Applicable Michigan statutes, in particular:

- The Michigan Medicaid False Claim Act (MCL 400.601 et/seq.), addressing such issues as:
    - Billing for services not rendered;
    - Billing without reporting other resources;

- Billing for a brand name drug not dispensed;
- Billing for unnecessary services resulting in inappropriate or otherwise excessive payment;
- Billing a date of service other than the actual date the service was rendered;
- Receiving kickbacks;
- Fraudulent cost reports

Federal Laws and Regulations: Section 1909 of Title 19 of the Social Security Act (SSA), as amended; The Medicaid Managed Care Final Rule, 42 CFR Parts 400 et al, Patient Protection and Affordable Care Act, HITECH HIPAA Omnibus Rule, 42 CFR Part 2, Health Care Fraud and Abuse legal prohibitions, as referenced in the above statutes, and including:

- The Federal Anti-Kickback statute at 42 USC 1320a-7b(b), prohibiting knowing and willful solicitation, receipt, offer, or payment of remuneration in return for referring a customer or services under a federal health program;
- The Stark Law at 42 USC Section 1395nn and as implemented by 42 CFR 411 and 424 relating to self-referrals by physicians;
- The Federal False Claims Act;
- The Deficit Reduction Act of 2005

Transferred from Board Policy (effective 8/9/04) to Agency Policy