Van Buren Community Mental Health

FY25 Compliance Training

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Compliance Specialist

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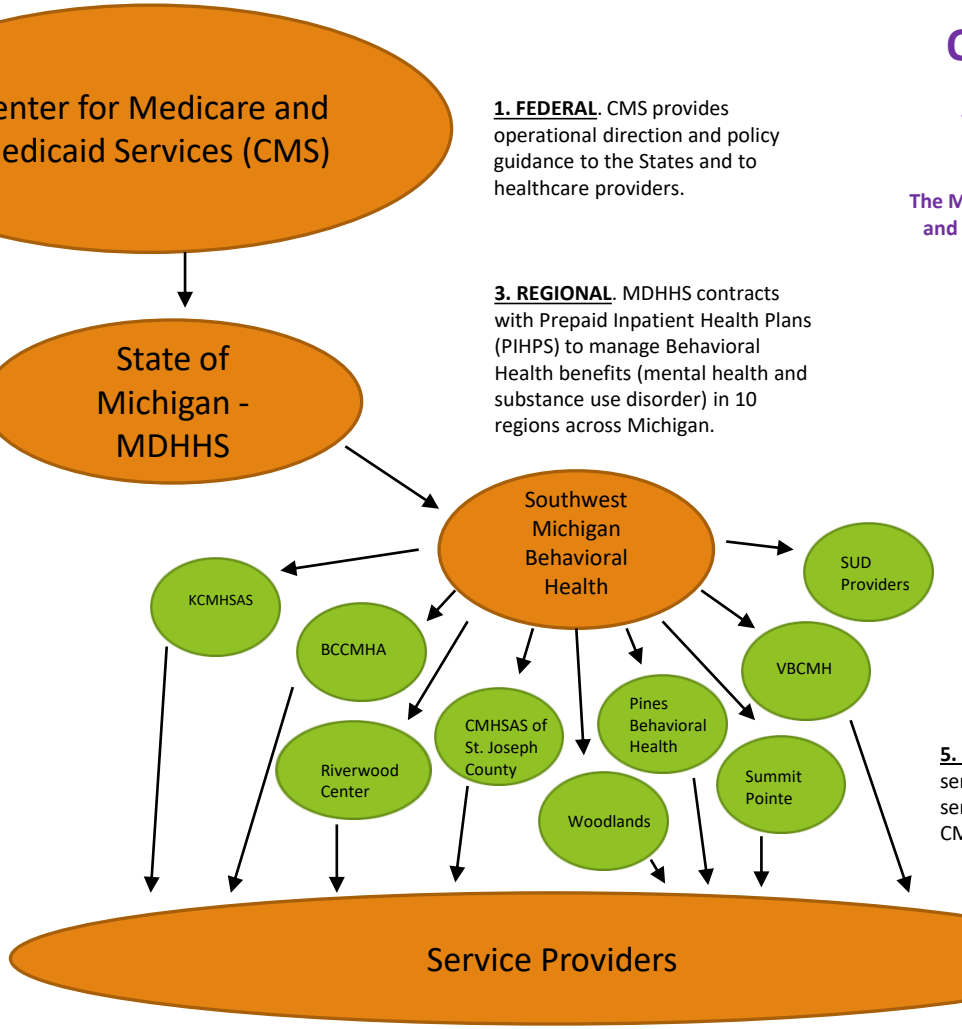
Corporate Compliance Officer

Overview of Medicaid Program Administration for Behavioral Health Services

The Medicaid Program is funded by both the federal and state governments and is directly administered by the States with approval and oversight by CMS.



1. FEDERAL. CMS provides 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 (mental health and substance use disorder) in 10 regions across Michigan.

4. COUNTY. Southwest Michigan Behavioral Health contracts with SUD Providers and with each of the CMHSPs in Region 4 to provide Mental Health and SUD services to Region 4 customers.

5. LOCAL. Each CMHSP contracts with various service providers to provide mental health services to the customers located in that CMHSP's county.

VBCMH Compliance Program

VBCMH is committed to conducting business in an ethical & legal manner. In order to accomplish this, we have a Corporate Compliance Program, accompanying policies & procedures, and the agency's vision, mission & values to provide guidance for our business practices.

What is Compliance?

Doing the right thing!

- Following laws and rules that govern healthcare
- Being honest, responsible, and ethical
- Preventing, detecting, and reporting unethical and illegal conduct
- Preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA) of Medicaid Funds
- Auditing and Monitoring to make sure funds are being used correctly

Basically, it is about **prevention**, **detection, collaboration & enforcement.**

Southwest Michigan Behavioral Health
STANDARDS OF CONDUCT

Code of Conduct

Confidentiality: Protect the privacy of those we serve

Alcohol & drug free environment

Free of harassment of any kind

Avoidance of conflict of interest

Report any suspected or actual Fraud, Waste and Abuse

Do not solicit or accept gifts

Safe, respectful work environment: all employees will be treated with dignity and respect

Political contributions will not be made with agency funds or resources

Ethics

- Carefully read and understand the Code of Ethics associated with your professional license (MSW, LLP, LPC, etc. all have a different Code of Ethics)
- Establish and maintain healthy boundaries with consumers, families, and colleagues
- Avoid using your workplace as a way to promote personal interests or paid endeavors
- Immediately warn if a consumer discloses intent to harm self or others
- Ensure continuity of treatment and services (transfer and discharge responsibilities)
- Avoid sexual impropriety
- Adequately document services/billings/communications
- Treatment should be suitable to condition (amount, scope, duration matches the need)

Laws Impacting Healthcare

Deficit Reduction Act 2005

- Education and training for employees, contractors and agents that contains detailed information about the Federal False Claims Acts, whistleblower provisions, and information about preventing and detecting Fraud, Waste, and Abuse in the Federal health care programs.
- Written policies that include detailed provisions consistent with State and Federal False Claims Acts, whistleblower provisions, and other applicable laws.
- Employee Handbook must include State and Federal laws, rights of employees to be protected as Whistleblowers, and any related policies and procedures.

It's about Education, Written Standards, and creating increased joint oversight between Federal and State governments.

Deficit Reduction Act

Requires Van Buren CMH to:

- Establish written policies for all employees including management, contractors & agents providing detailed information about the False Claims Act (FCA); administrative remedies; state laws pertaining to false claims; whistleblower protections under the FCA & state law; and the role of such laws in detecting & preventing fraud & abuse.

- Include detailed provisions regarding the organization's policies for detecting & preventing fraud & abuse.

Medicaid Integrity Program

- The Deficit Reduction Act also created the first national Medicaid provider audit program.

- Directed the Centers for Medicare and Medicaid Services (CMS) to enter into contracts to review claims, identify overpayments & educate providers, states & managed care entities.

- At the direction of CMS, Medicaid Integrity Contractors (MICs) will audit Medicaid providers & managed care entities throughout the country looking for overpayments (e.g., were services provided, properly billed & documented).

Laws Impacting Healthcare

Anti-Kickback Statute

- Health care providers and suppliers MAY NOT give or receive "remuneration" in exchange for the referral of patients or services covered by Medicaid or Medicare.
- Fines can include up to $100,000 per violation and up to 10 years in prison per violation

Exclusion Authorities

- Providers must ensure that no Federal Funds are used to pay for any items or services furnished by an individual who is debarred, suspended or otherwise excluded from participation in any federal health care program. This includes salary, benefits, and services furnished, prescribed, or ordered.
- Federal exclusions are imposed under the Social Security Act, 42 USC § 1320a-7. They are mandatory and permissive. Examples of mandatory exclusions are: conviction of a crime relating to patient neglect or abuse, felony conviction of health care fraud, etc. Examples of permissive exclusions are: misdemeanor conviction relating to health care fraud, conviction relating to fraud in a non-health care program, etc.
- Examples of Mandatory Exclusions:
  - Conviction of program related crimes
  - Conviction relating to patient abuse
  - Felony conviction related to health care fraud
  - Felony conviction related to controlled substance

Civil Monetary Penalties Law

- Allows the Office of the Inspector General (OIG) to impose civil penalties (MONEY) for violations of the Anti-Kickback Statute and other violations including submitting false claims and making false statements on applications or contracts to participate in a Federal health care program.

Criminal Health Care Fraud Statute

- 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.

Stark Law

- U.S. federal laws that prohibit physician "self-referral", specifically, a physician may not refer a Medicare or Medicaid patient to an entity providing designated health services ("DHS") if the physician or an immediate family member of the physician has a financial relationship with that entity.

Hot Areas

Areas of Review by Investigators:

Residential Setting and/or Appropriate Level of Services

Poor Quality of Care/Under Utilization of Care

Overpayments/Credit Balances/ Third Party Liability & Waiving of Payment

Services lacking documentation to address medical necessity

Federal False Claims Act

- Federal statute that covers fraud involving any federally funded contract or program, including the Medicaid program.

- Establishes civil liability for certain 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; or
  - Acting in reckless disregard of the truth or falsity of the information.

  No proof of specific intent to defraud is required!!

Federal False Claims Act

Examples:

- Upcoding
- Billing for unnecessary services
- Billing for services or items that were not rendered
- Billing for items or services performed by an excluded individual
- Failing to repay overpayments within 60 days of identification

Penalties:

- Civil monetary penalties ranging from $5,500 to $11,000 for EACH false claim
- Treble damages – three times the amount of damages incurred by the federal government related to the fraudulent or abusive conduct
- Exclusion from participation in State and Federal programs
- Federal criminal enforcement for intentional participation in the submission of a false claim

Michigan False Claims Act

MCL 400.602

- "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. (Emphasis added)
- Allows for constructive knowledge. This means that if the course of conduct "reflects a systematic or persistent tendency to cause inaccuracies" then it may be fraud, rather than simply a good faith error or mistake.

Fraud is:

An intentional deception or misrepresentation by a person with the knowledge the deception could result in unauthorized benefit to him/herself or some other person. In other words:

- It is intentionally attempting to deceive or execute a scheme to falsely obtain money or other benefit from a healthcare program and/or
- Providing information to someone or some entity that you know is false.

Example of Fraud:

Patient Sally B. was scheduled for 60 minutes of psychotherapy with Dr. Smith. Sally arrived for her appointment extremely distraught and in crisis. The receptionist immediately contacted an ambulance. While waiting for the ambulance, Sally never left the waiting room. Dr. Smith interacted with Sally for approximately 5 minutes until the ambulance arrived and transported her to a nearby hospital.

Dr. Smith had 60 minutes scheduled for Sally B. and was unable to schedule other patients during that time block. He also saw Sally B., even if it was for 5 minutes. Dr. Smith submitted a claim for Sally B.'s visit, for 60 minutes of psychotherapy. The claim was paid out of Medicaid.

A month later, as part of a routine Medicaid Services Verification audit, Sally B.'s claim was selected as part of the audit sample. When auditors contacted Dr. Smith's office to obtain documentation to support the service billed, he instructed his receptionist (the one who called the ambulance) to create a Progress Note for 60 minutes of Psychotherapy, furnished to Sally B. on the day she went to the hospital. The receptionist created the note, Dr. Smith signed it and dated it the day Sally B. went to the hospital, and the Progress Note was provided to the auditors to support the service billed.

Abuse is:

Practices that are inconsistent with sound fiscal, business or medical practices & result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare.

CAUTION – Abuse can develop into Fraud if there is evidence that the individual knowingly and willfully (on purpose) conducted the abusive practices.

Examples of Abuse:

- Charges in excess for services & supplies
- Submitting claims not in compliance with billing guidelines
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Submitting bills to Medicare/Medicaid instead of the primary insurer

Abuse vs. Fraud:
Understanding the Difference

- Abuse results from practices that directly/indirectly result in unnecessary cost.
- Abusive billing practices may not result from “intent” or it may be impossible to prove that the intent to defraud existed.
- Abuse may develop into fraud if there is evidence of the subject knowingly & willfully conducting an abusive practice.
- Fraud requires evidence of intent to defraud (e.g. acts were committed knowingly, willfully & intentionally).

Waste is:

Improper practices that are inconsistent with sound fiscal, business, or clinical practices & result in unnecessary cost or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards of care.

Examples of Waste:

- Healthcare spending that can be eliminated without reducing the quality of care, such as overuse and/or underuse or ineffective use of treatments or medication.
- Inefficiency in redundant testing, delays in treatment & making processes unnecessarily complex.

Whistleblower Protection

Federal Statute

- Designed to protect against the fraudulent use of public funds by encouraging people with knowledge of fraud against the Government to "blow the whistle" on wrongdoers.
- Individuals can file a "Qui tam" lawsuit on behalf of the government. The law provides for a reward in the form of a share of the recovery.
- 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.

Michigan Statute

- Provides protection for employees who report a violation or suspected violation of a State or Federal 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 compensations, terms, conditions, location, or privileges of employment.

Seven Elements of Compliance

1. Implementing written policies, procedures, and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

Your Responsibility

- Know the policies/procedures – especially the code of conduct, privacy/confidentiality procedures, documentation procedures, and billing procedures.
- Report any activities in violation *or believed to be in violation* of procedures or known laws/regulations.
- Ask questions if you are unsure of the proper/ethical procedure for anything.
- Become familiar with not only the compliance procedures, but all other procedures as well.
- Know and follow your professional code of ethics if you are licensed or certified.

*It is **not** your responsibility to know if wrongdoing has occurred – just to alert someone that it might be.

Compliance Investigations

- Every issue that is brought to the attention of the compliance office is investigated to make sure that rules, regulations, policies or procedures are not being violated.
- Any complaints or issues about the Compliance Officer or the CEO would also be investigated without bias by an outside party, if necessary.
- All compliance audits are completed annually for every person that provides services to consumers. These audits are completed by an unrelated, unbiased party.
- Recipient rights investigations where there might be a perceived bias are investigated by a recipient rights officer from another CMH.

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Major Governing Rules

Health Insurance Portability and Accountability Act (HIPAA)

Health Information Technology for Economic and Clinical Health Act (HITECH)

42 CFR Part 2

Michigan Mental Health Code

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Substance Use Disorder (SUD) Records

42 CFR Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records

- "Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized…"
- Prohibits even acknowledging an individual as a patient
- Requires a very specific, detailed Release of Information (ROI)
- Requires information that is disclosed include a Prohibition on Redisclosure
- No information regarding a client should be released without a valid, 42 CFR Part 2-compliant ROI

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Mental Health Records - HIPAA

HIPAA is a federal law that provides data privacy and security provisions for safeguarding Protected Health Information (PHI). It has two main parts, the Privacy Rule and the Security Rule.

HIPAA Security Rule – "Covered entities must ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits." The Security Rule applies to safeguarding ***electronic*** PHI (PHI stored on computers, sent via email, access permissions to PHI).

Requires covered entities to protect against any reasonably anticipated threats or hazards, and reasonably anticipated unpermitted uses or disclosures, to the security or integrity of ePHI.

Entities must have Administrative, Physical, and Technical safeguards.

- Administrative: Policies and procedures regarding how staff use electronic media that stores ePHI, policies regarding changing of Passwords
- Physical: Limited access to locked server room, sign in/out logs
- Technical: Use of encrypted devices, automatic logouts after inactivity

HITECH Act – Extended these requirements to covered entities' Business Associates.

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Mental Health Records - HIPAA

HIPAA Privacy Rule – "A covered entity may not use or disclose protected health information, except as permitted or required…"

"Use" means internal review or use of PHI (training, customer service, quality improvement).

"Disclose" means release of PHI externally (faxing records to a provider).

The "Minimum Necessary" information should be disclosed when use or disclosure is permitted or required. This means only the least amount of information that is necessary to accomplish the intended purpose of the use or disclosure should be requested.

- EXAMPLE: External Provider receives a request for Consumer A's records from SWMBH, for the purpose of auditing a single date of service. External Provider should provide only the information necessary for SWMBH to perform the audit.

The most common use or disclosure of PHI is for "TPO", or Treatment, Payment, or Operations.

- HIPAA allows for the use or disclosure of PHI for the purpose of TPO without patient consent;
- HOWEVER, the Michigan Mental Health Code does NOT.

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Mental Health Records – MI Mental Health Code

Michigan Mental Health Code – Confidentiality (MCL 330.1748)

- "Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section or section 748a."

- **MORE RESTRICTIVE THAN HIPAA**

- **Amended effective April 10, 2017 to allow for disclosure of PHI for Treatment, Payment, and Coordination of Care in accordance with HIPAA.**

Best Practice: Always obtain a valid Release of Information to ensure compliance with the MI Mental Health Code. If you have questions regarding exceptions to this rule, contact the Compliance Department.

PRIVACY & CONFIDENTIALITY
Behavioral Health Records-MI MHC

TREATMENT: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or referral of a patient for health care from one health care provider to another.

PAYMENT: Activities undertaken by (1) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (2) A health care provider or health plan to provide reimbursement for the provision of health care.

- **Includes:** eligibility/coverage determinations; COB; adjudication of claims; billing; medical necessity review; utilization review activities including preauthorization, and concurrent and retrospective review.

Coordination of Care: Not specifically defined by HIPAA or the MI Mental Health Code.

- If PHI is being shared between health care providers, it may fall under the purpose of "Treatment".
- If PHI is being shared between entities that are not health care providers (ex. PIHP and MHP), then disclosure of PHI is limited to entities that have a current or past relationship with the consumer who is the subject of the PHI, and the PHI must pertain to such relationship (45 CFR 164.506(c)(4)).

PRIVACY & CONFIDENTIALITY
Behavioral Health Records
HIV/AIDS Information

Confidentiality of HIV/AIDS Information

MCL 333.5131

- "HIV-related information is confidential & cannot be released unless the consumer authorizes disclosure, or a statutory exception applies. This confidentiality statute applies to all reports, records & data pertaining to testing, care, treatment, reporting & research & information pertaining to partner counseling & referral services (formerly known as partner notification) under section 5114a, that are associated with the serious communicable diseases or infections of HIV & AIDS."
- The consumer must sign a release of information containing a SPECIFIC statement if the release is to cover HIV-related information in the records before the information can be released.

TEXTING AND HIPAA

- Almost 90% of mobile phone users send SMS (short message service) text messages.
- Texting is not secure for sending PHI or identifiable health information.
- Problems (why you should not use texting to communicate with a customer):
  - The text resides on the device and is not deleted.
  - Very easy to access.
  - Can be compromised in transmission relatively easily.
  - HIPAA Privacy Rule does not allow for texting.
  - Impossible to be confident in who will see the text.

Email

Verify Links PRIOR to Clicking

NEVER Open Unexpected Attachments

Security Tips

- No unauthorized people in your work area.
- Protect Information: papers, computer, media
- Passwords: Do not share, change them quarterly, don't use "easy" words – i.e. "password"
- Lock your computer when you step away
- Report suspicious activity

CYBER PLEDGE

PLEDGE to:

- Stop and Think (consider appropriateness and risk) before I connect to the Internet.
- Take personal responsibility for security, follow my organization's security policies, and adhere to sound security practices.
- Lock my computer whenever I leave my work area.
- Safeguard portable computing equipment when I am in public places.
- Create and use strong passwords, and never share my password(s) with anyone.
- Never leave a written password near my computer, or easily accessible.
- Promptly report all security incidents or concerns to my organization's security officer or other appropriate contact.
- Protect "sensitive data" as well as confidential and/or legally protected (Personally Identifiable Information and Protected Health Information) data from any inappropriate disclosure.
- Work to the best of my ability to keep my organization's staff, property and information safe and secure.
- Spread the message to my friends, co-workers and community about staying safe online.

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Breach Notification

- A breach occurs when there is an unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of that information.
- Depending on the circumstances, a breach may require notice to the customer that his/her information was inappropriately released, mitigation efforts such as credit monitoring, notification to local media, and/or notification to the Office for Civil Rights (OCR).
- If you suspect or know of any situation that involved a potential breach, it is your responsibility to report it to the Compliance Officer.
- Examples:
  - Sending a letter containing PHI to the wrong address
  - Medical records/laptop being lost or stolen
  - Posting about a customer on social media
  - Looking at information in a neighbor/friend's file

Enforcement Bodies

Center for Medicare and Medicaid Services (CMS)

- Federal Agency with the US Department of Health and Human Services (HHS) that administers the Medicare program and work in partnership with state governments to administer Medicaid programs.

Office of the Inspector General (OIG)

- Enforcement division of the Federal Health and Human Services (HHS) agency, and of the Michigan Department of Health and Human Services.
- In charge of investigating Fraud, Waste, and Abuse in the Medicaid/Medicare Programs, and pursuing civil judgments under the Civil Monetary Penalties Law.

Office for Civil Rights (OCR)

- In charge of enforcing HIPAA Privacy and Security Rules. Levy huge civil penalties against entities that violate HIPAA.
- Implement and monitor Corporate Integrity Agreements.

Department of Justice (DOJ)

- Federal enforcement agency in charge of criminally prosecuting individuals/entities under applicable Federal laws.
- Works collaboratively with the OIG.

Michigan Attorney General

- Health Care Fraud Division in charge of investigating Fraud, Waste, and Abuse in the Michigan Medicaid/Medicare Programs.
- Can prosecute individuals/entities criminally under applicable State laws.

Reporting Violations

If you are aware or are suspicious of any type of Compliance violation including, but not limited to:

- Fraud, Waste, or Abuse
- Violation of Whistleblower protections
- Violations of HIPAA/Michigan Mental Health Code/42 CFR Part 2 regarding the release of protected health information

It is your right and your responsibility to report it to the Compliance Officer.

You may not be intimidated, threatened, coerced, discriminated against, or subjected to other retaliatory action for making a good faith report of an actual or suspected violation.

We Believe
Our Compliance Program

Enables you to do the Right thing for the Right reason

Reporting Responsibilities
Questions, Concerns or Suggestions

It is your right, and your responsibility to report actual and suspected Compliance violations.

You may not be intimidated, threatened, coerced, discriminated against, or subjected to other retaliatory action for making a good faith report of an actual or suspected violation.

- **Talk to Liz Evans, Compliance Officer**
  269-655-3304 or levans@vbcmh.com

- **Talk to Sandy Sharp, Compliance Specialist**
  269-655-3323 or ssharp@vbcmh.com

- **Call the Anonymous Hotline: 1-800-292-5419**

- **Southwest Michigan Behavioral Health**
  Compliance Hotline 800-783-0914
  In person, by phone or email to
  Mila Todd swmbhcompliance@swmbh.org
  800-676-0423

- **Contact the Michigan Office of Inspector General**
  Office Hours: Monday - Friday, 8:00am to 5:00pm
  Phone: 855-MI-FRAUD (643-7283) (voicemail available for after hours)
  Send a letter to:
  Office of Inspector General
  PO Box 30062
  Lansing, MI 48909

Who is Responsible for Compliance?

Everyone

When in doubt,

point it out!!