St. Clair County Community Mental Health
Providing Opportunities for Health, Wellness, & Connection

# Board Policy

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| **Policy Title:** | **Corporate Compliance Complaint, Investigation, and Reporting Process and Non-Retaliation** |
| **Policy #:** | **01-002-0020** |
| **Effective Date:** | 03/13/2025 |
| **Approved by:** | SCCCMH Board |
| **Functional Area:** | Administrative |
| **Responsible Leader:** | Telly Delor, Chief Operating Officer |
| **Policy Owner:** | Joy Vittone, Corporate Compliance Supervisor |
| **Applies to:** | SCCCMH Board, SCCCMH Staff, Direct Operated Programs, Contract Network Providers, Community Agency Contractors |

**Purpose:** To document the process for filing corporate compliance complaints and outline investigation steps, reporting obligations, and protections against retaliation.

## I. Policy Statement

It is the policy of the St. Clair County Community Mental Health (SCCCMH) to maintain compliance with all applicable laws, rules, and regulations in order to prevent and reduce the risk of misconduct and fraud, waste, and abuse wherever it may occur in our organization.

St. Clair County Community Mental Health (SCCCMH) is committed to cultivating a culture of compliance and ethics by adopting a Corporate Compliance Program that promotes honesty, integrity, and high ethical standards in the work environment and empowers individuals to comply with all federal, state, and local statutes and regulations and other legal and ethical obligations. Components of the Corporate Compliance Program include written policies and standards, designation of a Compliance Officer, oversight by a Corporate Compliance Committee, a compliance plan; education and training for staff; a process for receiving and investigating complaints; monitoring and auditing activities, corrective action and mitigation of identified risks, and reporting on compliance activity.

SCCCMH expressly prohibits any form of *Retaliation* against an individual for reporting a compliance or ethics concern, a suspected violation, or an inappropriate behavior; for participating in an investigation; or for refusing to participate in inappropriate or wrongful activity.

This policy is intended to address matters relating to the Federal False Claims Act (1863), Michigan Medicaid False Claims Act (1977), The Anti-Kickback Statute (1972), The

Physician Self-Referral Law (commonly called "The Stark Law")(1989), Health Insurance Portability & Accountability Act (HIPAA) (1996), the Balanced Budget Act (1996), the Deficit Reduction Act (Medicaid Integrity Program) (2006), and the Eliminating Kickbacks in Recovery Act (2018), as well as any other circumstance in which the potential for or actual occurrence of Medicaid fraud, waste, or abuse is involved.

## II. Standards

**A.** All staff are required to conduct themselves in a manner that promotes the SCCCMH Board's Mission, Vision, and Values, and Code of Ethics.

**B.** All staff are required to follow the SCCCMH Corporate Compliance Program Plan. Personnel may be subject to discipline for failing to participate in compliance efforts.

**C.** All staff are empowered and responsible for reporting any compliance or ethics concerns, inappropriate behavior, or suspected violations of laws, rules, or regulations.

**D.** Information about accessing the Corporate Compliance Office, including the process for reporting concerns or complaints of noncompliance must be posted at all sites.

**E.** Federal and state laws provide protections for *Whistleblowers* and this policy expressly prohibits any form of Retaliation against an individual who reports a violation or suspected violation of a policy or a law. Whistleblower protections include:

1. Protection to individuals who report a violation or suspected violation of local, state, or federal law.
2. Protection to individuals who participate in hearings, investigation, legislative inquiries, or court actions.
3. Provision of awards, remedies, and penalties.

**F.** An individual making a compliance report or complaint may remain anonymous when submitting a report or complaint to the SCCCMH Corporate Compliance Office and such anonymity will be provided to the reporting person to the extent possible under the circumstances. Note that anonymity may slow down a prompt and complete investigation.

**G.** Reportable events are any incidents, either an isolated event or series of events, where there is a reasonable concern or suspicion that activities violate the legal basis of the SCCCMH Corporate Compliance Program, due to a policy violation or a legal violation, with a focus on the following laws:

1. The Federal False Claims Act (1863). An act permitting individuals to bring action against parties which have defrauded the government and providing for an award of half the amount recovered. The Federal False Claims Act provides a broad definition of 'knowingly' with regard to billing Medicaid or

Medicare for services which were not provided, not provided according to requirements for receiving payment, or were unnecessary.

2. The Michigan Medicaid False Claims Act (1977). An act to prohibit fraud in the obtaining of benefits or payments in connection with the Medicaid medical assistance program; to prohibit kickbacks or bribes in connection with the program; to prohibit conspiracies in obtaining benefits or payments; and, to authorize the attorney general to investigate alleged violations of the act.
3. The Anti-Kickback Statute (1972). A criminal statute that prohibits transactions intended to induce or reward referrals for items or services reimbursed by federal health care programs.
4. HIPAA (1996). An act that expands the definition of 'knowing and willful conduct' to include instances of 'deliberate ignorance' such as failure to understand and correctly apply billing codes, failing to give privacy notice, or not following security measures to protect health care information.
5. The Physician Self-Referral Law (1989). A law commonly referred to as the "Stark Law" that prohibits physicians from referring patients to entities with which the physician or their immediate family member has a financial relationship unless an exception applies.
6. The Eliminating Kickbacks in Recovery Act ("EKRA") (2018). A criminal statute that prohibits accepting or paying anything of value for referring individuals to recovery homes, clinical treatment facilities, or laboratories with respect to services covered by a health care benefit program, including for privately paid services. A "recovery home" is a shared living environment centered on peer support and connection to services that promote sustained recovery from substance use disorders (18 U.S.C. § 220(e)(5)). A "clinical treatment facility" is a medical setting, other than a hospital, that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for substance use (18 U.S.C. § 220(e)(2)). Michigan healthcare providers found to violate the EKRA may be subject to disciplinary actions under Section 16221 of the Public Health Code.
7. The violation of any regulations implementing the Balanced Budget Act of 1996 with respect to regulations which impact rates, claims, and payment issues.

**H.** The SCCCMH Corporate Compliance Office must respond promptly to reports of activity which may be contrary to the SCCCMH Corporate Compliance Plan.

**I.** Detection of noncompliance will occur through already established reviews, including audit of claims data, record reviews, as well as observations and/or complaints made by staff, individuals served, providers, or others.

**J.** Each contracted *provider* agency shall investigate its own complaints and report compliance issues to the SCCCMH Corporate Compliance Office on a quarterly basis (or more frequently if desired). The report may include requests from the provider for the SCCCMH Corporate Compliance Office to assist in the investigation. The SCCCMH reserves the right to investigate possible compliance issues within its Provider Network agencies.

**K.** Plans of correction shall address remediation of the specific allegations and may include a plan for change in policy designed to prevent recurrence of similar findings in the future.

**L.** Possible findings - the following is only a sample of findings that could result in a determination of *fraud* or *abuse*:

1. Altering a medical record
2. Providing a service, but using the wrong date or time
3. Billing for a service that was not medically necessary
4. Billing for non-covered services
5. Double billing (billing for the same service twice)
6. Timesheet falsification
7. Unbundling an all-inclusive service that is resubmitted as separate services
8. Lying about or falsifying credentials
9. Under billing (not billing for otherwise billable medically necessary services)
10. Unexplained entries and/or altered records
11. Inadequate or missing documentation
12. Delays in producing requested documentation
13. Unauthorized transactions
14. Unusual patterns and trends of contracting and procurement
15. Offers of gifts, money, or other gratuities from contractors, grantees, or other individuals
16. Providing false or misleading information
17. Missing signatures and credentials
18. Missing files, reports, data, and invoices (both electronic and paper)
19. Missing, weak, or inadequate internal controls
20. Billing for services that were performed by an employee who has been excluded from participation in federal healthcare programs.
21. Billing for low-quality services

22. Collusion among providers, e.g., providers agreeing on minimum fees they will charge and accept

Findings of the above examples are a basis for discipline and corrective action, a larger sample of claims review, payback of inappropriate payments, and reporting to Michigan Department of Health and Human Services (MDHHS), Office of Attorney General, or Medicaid Fraud Control Unit.

With respect to all areas of risk, the magnitude of the risk, changes in the risk from previous periods, and recommendations for remediating the risk shall be made.

## III. Procedures, Definitions, and Other Resources

### A. Procedures

#### Responsibilities

| Position | Responsibilities |
|---|---|
| All Staff | 1. Endeavor at all times to contribute to a culture of compliance by acting in accordance with SCCCMH Mission, Vision, and Values and the Corporate Compliance Plan.<br>2. Report to Corporate Compliance Office any observed or suspected compliance concerns or potential violations.<br>3. Cooperate with Corporate Compliance Office investigations. |
| Corporate Compliance Office | 1. Investigate observed or reported compliance concerns or potential violations.<br>2. Report probable incidents of fraud, waste, or abuse to Region 10 PIHP Compliance Officer. |

#### Actions – Complaint Process

| Action Number | Responsible Stakeholder | Details |
|---|---|---|
| 1.0 | Any Staff/Individual Served/Provider /Other | 1. Observe or identify concerning, improper, or illegal conduct by an individual, program, or provider.<br>2. Notify SCCCMH Corporate Compliance Office immediately by any of the reporting methods, including SCCCMH's anonymous report it application in ADP or at reportit.com.<br>3. When requested, complete form #1352 Complaint of Noncompliance.<br>4. Request assistance from the Corporate Compliance Office, when needed. (Note: Recipient Rights complaints will be referred to the SCCCMH Recipient Rights Office. Concurrent investigations may be conducted, if appropriate). |

## Actions – Investigation Process

| Action Number | Responsible Stakeholder | Details |
|---|---|---|
| 1.0 | Corporate Compliance Office | 1. Observe an incident or situation which may lead to a compliance issue or receive a Complaint of Noncompliance.<br>2. Determine if an allegation of noncompliance can be identified as a *reportable event*, consulting with others as necessary.<br>3. Assign the complaint a number using a fiscal year numbering system: 25-01, 25-02, 25-03, etc., and record complaint in SCCCMH Corporate Compliance Complaint Log.<br>4. Categorize the complaint and provide notification to SCCCMH Chief Executive Officer and others (e.g., SCCCMH Recipient Rights Office), as appropriate.<br>5. Acknowledge receipt of report/complaint to reporter/complainant (within 5 business days), when applicable.<br>6. Investigate and gather supporting documentation related to the allegation.<br>a. For allegations related to Medicaid fraud, waste, or abuse: conduct a preliminary evaluation and notify Region 10 Pre-Paid Inpatient Health Plan (PIHP) Corporate Compliance Office whether there is a suspicion of fraud, waste, and abuse. The investigation will be coordinated by Region 10 PIHP Corporate Compliance Office.<br>b. For allegations unrelated to Medicaid fraud, waste, or abuse, conduct full investigation and document findings and make a determination to substantiate or not substantiate the complaint.<br>7. Complete Noncompliance Investigative Report (Exhibit A) within 30 days (unless extenuating circumstances exist) and provide notification to SCCCMH Leadership Team and others, as appropriate.<br>8. Recommend, as appropriate, corrective action, disciplinary action, and improvements to operational processes to reduce risk of future non-compliance. |
| 2.0 | Designated Leadership Staff | 9. Review the complaint and report.<br>10. Make determination and agree or disagree with the findings and recommendations.<br>11. Forward findings to the SCCCMH Chief Executive Officer |

| Action Number | Responsible Stakeholder | Details |
|---|---|---|
| | | for review, as necessary. |
| 3.0 | Corporate Compliance Office | 12. Follow up on recommendations, as appropriate.<br>13. Consult, as needed, with Region 10 PIHP Corporate Compliance Office to ensure all reportable events are reported to the appropriate legal and federal health care program authorities as required.<br>14. Incorporate findings into SCCCMH Corporate Compliance Committee reports. |

### Actions – Reporting Process

| Action Number | Responsible Stakeholder | Details |
|---|---|---|
| 1.0 | Corporate Compliance Office | 1. Complete monthly SCCCMH Corporate Compliance reports and forward to SCCCMH Quality Improvement Committee (QIC) on a quarterly basis.<br>2. Complete monthly PIHP Corporate Compliance Complaint Report and Program Integrity Report and submit to PIHP Corporate Compliance Office on a quarterly basis.<br>3. Review and update the SCCCMH Corporate Compliance Plan at least annually and provide to the SCCCMH.<br>4. Review and analyze complaint data for trends or risk areas.<br>5. Provide recommendations to Leadership Team, for corrective or follow-up action, as necessary.<br>6. Forward SCCCMH Corporate Compliance Plan for SCCCMH Board approval on an annual basis. |

## B. Related Policies

N/A

## C. Definitions

1. *Abuse:* Means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an 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).
2. *Alleged Illegal Conduct:* Conduct which appears to be in conflict with what is required by law.

3. *Alleged Improper Conduct:* Conduct which includes behaviors such as intimidation, harassment, and other unethical behavior.
4. *Fraud (per Federal False Claims Act):* Means an 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).
5. *Fraud (per Michigan statutes 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." Errors or mistakes do not necessarily 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."
6. *High Probability:* Considered to exist whenever one of the following circumstances is present:
    a. When the allegation arises as a result of regular review of claims, case review, or other routine monitoring and detection activities, and the number of improprieties exceeds the level a reasonable person would categorize as a mistake.
    b. When the allegation arises as a result of routine detection and monitoring activities, and the same impropriety continues after a warning has been issued.
    c. Whenever a specific allegation of improper or illegal activity has been brought to the SCCCMH Corporate Compliance Office or SCCCMH Quality Improvement Committee (QIC) by a credible person.
7. *Protected Activity*: Protected Activity means the good faith reporting of a compliance or ethics concern, inappropriate behavior, or suspected violations of laws, rules, or regulations; participating in an investigation; or refusing to participate in inappropriate, wrongful, or illegal activity.
8. *Provider:* SCCCMH providers, individuals, or corporations, or any SCCCMH subcontracted provider or practitioner, individual, or corporation.
9. *Waste:* Overutilization of services, or other practices, which result in extraneous costs and not usually considered to be caused by criminal negligence but rather the misuse of resources.
10. *Whistleblower*: A person who reports a violation of suspected violation of local, state, or federal law.

### D. Forms

#1352 Complaint of Noncompliance

### E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

Exhibit A: Noncompliance Investigative Report

### F. References

N/A

## IV. History

- Initial Approval Date: 11/2006
- Last Revision Date: 02/2025 BY: Joy Vittone
- Last Reviewed Date: 09/2023
- Non-Substantive Revisions: N/A
- Key Words: compliance, privacy, report, complaint, violation, fraud, waste, abuse, investigation, retaliation