COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY AND PROCEDURES MANUAL				
Chapter **Program Quality**	**Section** **Compliance**	**Chapter** **05**	**Section** **04**	**Subject** **05**
Subject **Reporting/Investigating Improper/Illegal Conduct**	**Authorization**		**Approved: 12/27/05** **Replaces: None**	

Reviewed/No Updates: May 2022

I. PURPOSE: To establish a process for reporting and investigating improper/illegal conduct. The purpose of an investigation is to identify those situations in which the laws, rules and/or standards of federal programs, state programs, and/or Community Mental Health Authority (CMHA) policy may not have been followed, and/or issues related to fraud, waste, and/or abuse. This includes, but not limited to:

1) Identifying processes or individuals who may have knowingly or inadvertently caused services to be provided or coded and/or claims to be submitted or processed in a manner which violated federal, state, and/or local laws, rules, or standards.

2) Facilitating the correction of any practices not in compliance with federal, state, and/or local laws, rules, or standards.

3) Ensuring necessary procedures are implemented for future compliance.

4) Protecting CMHA in the event of civil or criminal enforcement actions.

5) Preserving and protecting CMHA's assets.

II. APPLICATION: All programs of CMHA regardless of funding source.

III. POLICY: Every employee has the responsibility to report any suspected or known fraud, waste, abuse, or violations of laws, rules, regulations, or organizational policies.

IV. DEFINITIONS:

A. **Compliance Investigation**: the observation or study of suspected fraud, waste, abuse, or reported violations of applicable laws and regulations for all covered services (Medicaid, General Fund, etc.) by close examination and systematic inquiry.

B. **Abuse** (CMS): means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program (or any funding source), 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).

C. **Fraud** (CMS/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 him/herself 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).

D. **Waste** (CMS): means overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

V. PROCEDURE: In addition to following procedures in the Compliance Plan (exhibit to policy 05-04-01), the following procedures will be followed:

A. An employee may contact their supervisor, the Compliance Liaison, or the Chief Executive Officer with any questions they have regarding compliance issues.

B. If an employee, in good faith, suspects or knows that fraud, waste, abuse, and/or laws, rules, regulations, or organizational policies have been violated, they should report the violation to their supervisor, the Compliance Liaison, a Program Director, the Chief Executive Officer, the Recipient Rights Officer/Privacy Officer, or the Security Officer. Additionally, as CMHA is a member of the NorthCare Network, reports of violations or suspected violations may be made to the NorthCare Compliance Officer and/or anonymously to NorthCare's confidential Compliance Hotline; contact information for both NorthCare and the Compliance Hotline is listed on the Reporting Illegal or Unethical Conduct poster (see exhibit).

1) Reports may be made in person, via phone, mail, e-mail, or anonymously (i.e., via suggestion box, internal mail, etc.) to the employee's supervisor, the Compliance Liaison, a Program Director, the Chief Executive Officer, the Recipient Rights Officer/Privacy Officer, the Security Officer or as noted above, NorthCare's Compliance Officer. If any one of the prior staff as listed above are unable to be contacted, reports can be made to any supervisor.

2) Copies of written reports made directly to a supervisor must be forwarded to the Compliance Liaison or to the CEO.

3) Written reports can be made using the Compliance – Suspected Violation Report form (see exhibit).

4) Employee should furnish as much information as possible, including:

- **a)** Date suspected violations occurred.
- **b)** Individuals involved (i.e., employees, recipients, contract providers, etc.).
- **c)** Location where suspected violation occurred.
- **d)** Description of suspected violation.
- **e)** Whether or not this is an initial report of the suspected violation; if not initial report, indicate when and to whom the suspected violation was previously reported.
- **f)** How the suspected violation violates laws, rules, regulations, or policies.
- **g)** Any additional important information the employee feels is important.
- **h)** Any and all supporting documentation should be attached to the report.

5) Individuals will not be subjected to retaliation, retribution, harassment, etc., for making a good faith report; reporting individuals are protected by the Whistleblowers' Protection Act 469 of 1980.

C. Upon receipt of a complaint or other information which suggests fraud, waste, abuse, and/or a violation of compliance policies, laws, rules, or regulations occurred, the Compliance Liaison will schedule a meeting with the Compliance Committee, comprised of the Compliance Liaison, Chief Executive Officer, and Program Directors to conduct an investigation; the CMHA Board Chairperson may also be invited to be a member of the Committee, as applicable. The investigation may also include the Recipient Rights Officer/Privacy Officer if it appears that there was also a violation of recipient rights and/or the Security Officer, as appropriate. If the matter involves a

member of the Compliance Committee, that member shall be excluded from meetings pertaining to the investigation.

1) The investigation will begin as soon as reasonably possible, but no more than 10 business days following the receipt of a complaint regarding the potential issues of noncompliance. The investigation shall be complete within 90 days of receiving the complaint.

2) CMHA will make every effort to protect the confidentiality of the reporter. If confidentiality cannot be maintained because of the circumstances, the reporting employee will not suffer from any retaliation for good faith actions.

3) The investigators will have unimpeded access to employees and documents necessary to complete the investigation. The investigation may include but is not limited to:

- **a)** Identifying documents for review/creating document request.
- **b)** Identifying appropriate individuals to be interviewed.
- **c)** Identifying questions to be asked during interviews.
- **d)** Reviewing documents (i.e., ELMER, billing/claims, training records, state and federal laws, rules, regulations, etc.).
- **e)** Reviewing policies and procedures.
- **f)** Defining sampling methodology, if applicable.
- **g)** Collaborating with an internal oversight authority.
- **h)** Contracting with an external authority and documenting recommendations of legal counsel, if appropriate.
- **i)** In instances where the suspected violation was previously reported/investigated, the investigation will include a review of the details of the previous investigation and actions taken, if any.

4) Interviews, document reviews, and other investigative techniques will be conducted as appropriate.

5) The cause of the problem, the affected parties, the policies, laws, rules, regulations involved, and the potential regulatory impact will be identified.

6) Recommendations for corrective action will be provided as appropriate. Corrective action plans will be monitored by the Compliance Liaison.

7) Recommendations regarding self-reporting to outside organizations (i.e., law enforcement or regulatory agencies) will be considered, as appropriate.

8) Solicit the help of an outside agency/legal counsel, if appropriate, to assists if the situation warrants additional expertise.

9) A copy of the Compliance – Suspected Violation Report of each substantiated violation will be provided to NorthCare's Compliance Officer. If the substantiated violation is fraud, CMHA will also complete and submit the NorthCare Network Provider Fraud Referral form to NorthCare's Compliance Officer.

10) The Compliance Liaison will report to the CMHA Board of Directors regarding the compliance program, as applicable.

11) Per CMHA's retention schedule, documentation and records of the entire investigation and the outcome of such will be permanently retained in hard copy; documentation will be maintained by the Compliance Liaison.

D. Enforcement of corrective and/or disciplinary action for employees will be conducted in accordance with CMHA personnel policies, as applicable.

E. CMHA will report suspected and known violations consistent with the definitions of fraud, waste, and abuse as stated in this policy and/or those in which one of more of the reporting thresholds noted below are met. Reports are to be made within three (3) business days to NorthCare's Compliance Officer when one or more of the criteria are met:

1) If, during an inquiry by the NorthCare Network's Compliance Officer, there is determined to be fraud, waste, or abuse as defined by the federal statute, CMS, HHS, OIG, and applicable Michigan statute, regulation, or PIHP contract definition.

2) Prior to any self-disclosure to any federal or state of Michigan authority (in no way is this intended to, nor should it be interpreted as a requirement or request to violate the letter or spirit of federal or Michigan reporting and whistleblower statutes or related regulations).

3) When as a result of fraud, waste, or abuse, CMHA makes a material revision to prior reported financial statements to NorthCare Network.

4) When CMHA knows or should have known, that an action or failure to take action could result in improper application or improper retention of Medicaid funds.

5) When there is suspected or actual privacy breach of Protected Health Information (PHI).

6) When there is a suspected or actual security breach or threat to CMHA's information system where PHI is stored.

7) When there is a suspected or actual security breach or threat to NorthCare's information system where PHI is stored.

8) When there is a suspected or actual violation of NorthCare policy as it relates to fraud, waste, or abuse; contract requirements; or state or federal law.

CMHA's CEO has the ultimate responsibility and authority for determining whether the thresholds above have been reached; although, the CEO has the authority to delegate the determination.

CMHA may request technical assistance from NorthCare's Compliance Officer on any compliance issue at any time. Such contacts will not automatically be considered a "report of compliance issue" by NorthCare.

VI. REFERENCES AND LEGAL AUTHORITY: Medicaid False Claim Act - Act 72 of 1977; State of Michigan Enacted Medicaid False Claim Act 272 of 1977; Whistleblowers' Protection Act - Act 469 of 1980; Balanced Budget Act Section 438.608; NorthCare Network's Compliance Policies and Compliance Plan; CARF Behavioral Health Standards

VII. EXHIBITS: Reporting Illegal or Unethical Conduct poster; Compliance – Suspected Violation Report; NorthCare Network Provider Fraud Referral; also reference CMHA Compliance Plan (exhibit to policy 05-04-01)