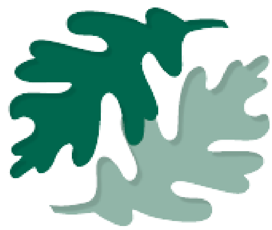

SHIAWASSEE
Health & Wellness

Corporate Compliance Plan

2023

Corporate Compliance Officer

Revised: 1/17/2023; Approved by CC Committee on: 2/13/2023, Approved by SHW Board on: 2/27/2023

Mission Statement:

Our mission is "to promote health, wellness and recovery."

Values:

- Dignity, respect, and courtesy for all individuals
- Upholding the public trust with integrity and accountability
- A well trained and culturally sensitive workforce that uses Evidence Based Practice.
- Being a leader in Shiawassee County for behavioral health by acting as a safety net to our community and giving individuals opportunities to reach their potential.

Scope of Plan:

The Shiawassee Health and Wellness (SHW) Compliance Plan encompasses the activities of all SHW board members, employees, and contractual independent practitioners. It is the expectation that the Provider Network will attest to following the Regulatory Standards identified in the SHW Compliance Plan or develop their own Compliance Plan that minimally meets the standards identified by SHW and in accordance with the Code of Federal Regulations, Title 42, Part 438.608: Program Integrity Requirements.

Definitions: Within the context of this Corporate Compliance Plan, these terms have the following meaning.

- Abuse: Generally, encompasses incidents or practices that are inconsistent with sound fiscal, business or medical practices, that may result directly or indirectly in unnecessary program costs, improper payment, or payment for services that fail to meet professionally recognized standards of care or that are medically unnecessary.

- Auditing: Formal comprehensive reviews of compliance using a specific set of attributes as a base measure. Audits will include a written report of findings, recommendations and if necessary, proposed corrective actions. Individuals performing the audit are independent of the department being audited.

- CMHSP: Community Mental Health Services Provider.

- Fraud**:** The knowing and willful execution or attempt to execute a scheme to defraud a health care benefit program to obtain, by means of false or fraudulent representation or promise, any money, benefits or other property owned by a health care benefit program. This includes any act that constitutes fraud under applicable federal and state laws.

- Legal Counsel: The attorney or law firm designated by SHW to provide legal advice and assistance regarding concerns or issues surrounding the CCP.

- Monitoring: Regular reviews as part of normal operations to confirm ongoing compliance. Monitoring is frequently performed by employees within said department and is used to determine if procedures are working as intended.

- MSHN-Mid-State Health Network: The Pre-Paid Inpatient Health Plan that Shiawassee Health and Wellness is an affiliate member.

- Payer: The operation of providing payment for services and operating as a Community Mental Health Service Program, within the context of a Medicaid Prepaid Inpatient Health Plan (PIHP) and a Substance Abuse Coordinating Agency.

- PAHP: Prepaid Ambulatory Health Plan.

- PCCM: Medicaid Primary Care Case Management

- Privacy Officer: The individual assigned the responsibility for overseeing the ongoing development of privacy related operations.

- Provider Network: A panel of the doctors, Behavior Health/Substance Use Disorder providers, direct care providers and hospitals that Shiawassee Health and Wellness has contracted with to provide MDHHS covered services to its consumers.

- Security Officer: The individual assigned the direct or indirect responsibility for research, development, implementation, testing and review of an organization's information security in order to prevent unauthorized access and protect information. This responsibility can be contracted out at which point the Security Officer will be responsible of over-site to ensure the vendor's adhere to identified standards that support "reasonable security measures."

- Subcontractor: An individual, who has an independent contract agreement with SHW to provide goods or services to SHW or its consumers, or who owns, is employed by, or otherwise works for an organization with such a contract, and in performance of the contract, has direct contact with any employee and/or consumer.

- Waste**:** A reckless or -negligent act that causes funds to be spent in a manner that represents a significant inefficiency and needless expense. Generally not caused by criminal actions, but rather the careless use of resources

Overview:

Shiawassee Health and Wellness is committed to using good faith efforts to comply with applicable health care laws, regulations, and third-party payer requirements as they apply to the requirements of State and Federal governmental programs. In order to ensure that appropriate legal business standards and practices are maintained and enforced throughout the organization, SHW has implemented a Corporate Compliance Program. This Corporate Compliance Program has been approved by the Chief Executive Officer (CEO) of SHW and fully disclosed to the SHW Board of Directors. The non-inclusive list of applicable legal and regulatory standards to be considered is located in the references section of this Corporate Compliance Plan.

SHW recognizes that complete perfection in the area of compliance may not be truly attainable in practice; however, it is the goal of SHW to strive for excellence and use good faith efforts in its compliance activities.

In 2022 the U.S. Department of Health & Human Services, Office of Inspector General (OIG) announced several changes to its standard Corporate Integrity Agreement (CIA). These changes not only impact those entities entering CIAs but will also lead to changes in all healthcare compliance programs. This current plan reflects some of those changes to:

- Compliance officer's responsibilities,
- Compliance committee's role and responsibilities,
- Reaffirming the need for ongoing Risk assessment/evaluation,

To that end, the Corporate Compliance Program (CCP) ensures the integrity of the system in which SHW operates. It is preserved and maintained within a culture driven by the highest level of business and professional excellence. The SHW CCP adheres to conduct compliant with federal, state, and local laws, the promotion of good corporate citizenship and prevention and early detection of misconduct.

To provide the framework for SHW to comply with applicable laws, regulations and program requirements, the organization will maintain a Corporate Compliance Plan. The key principles of the Compliance Plan are:

- Minimize organizational risk and improve compliance with billing requirements of Medicare, Medicaid, and all other applicable federal health programs.
- Maintain adequate internal controls (paying special attention to those areas identified in the Annual Monitoring and Audit Work Plan [Attachment D]).
- Reduce the possibility of misconduct and violations through prevention and early detection.
- Being proactive in Compliance to reduce exposure to civil and criminal sanctions.
- Encourage the highest level of ethical and legal behavior from all employees, contractual providers, and board members.
- Educate employees, contractual providers, board members, and stakeholders of their responsibilities and obligations to comply with applicable local, state, and federal laws and regulations including credentialing requirements, as well as accreditation standards.
- Promote a clear commitment to compliance by taking actions and showing good faith efforts to uphold such laws, regulations, and standards.

The Program is designed to incorporate what is viewed as the Eight Key Elements for Compliance and Ethics Programs.

When the United States Sentencing Commission (USSC) modified the "Federal Sentencing Guidelines," this included identifying the elements for an effective corporate compliance and ethics program. These guidelines have become an important barometer used by federal prosecutors and regulators in determining whether a company should be charged with a crime at the conclusion of an investigation, and if so, the severity of the civil enforcement action.

Beyond the potential benefits related to prosecution and conviction, the key elements within the

"Guidelines" have become widely used by organizations seeking to proactively establish effective compliance and ethics programs. Satisfying the requirements for an effective compliance and ethics program is now widely believed to create a number of additional benefits including protection of the organization by reducing the likelihood of -detrimental events and minimizing the consequences should those events occur.

Effective ethics and compliance programs are key to achieving a culture of integrity within a healthcare organization. In addition, establishing ethical and compliant behavior and regulating against noncompliance, these programs, as expressed by the Office of Inspector General (OIG), are, "a major initiative in engaging the private health care community in combating fraud and abuse."

Eight Elements of an Effective Compliance Program

1. Oversight; Designating a Compliance Officer and Corporate Compliance Committee
2. Implementing Policies, Guidelines and Standards; the organization must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards, laws and regulations.
3. Conducting Appropriate Training and Education: the organization must provide effective training and education for the Board of Directors, Compliance Officer, and the organization's employees.
4. Developing Open Lines of Communication: Effective lines of communication must be established between the Compliance Officer and the organization's employees.
5. Conducting Internal Auditing and Monitoring: The organization must take reasonable steps to achieve compliance with defined standards by utilizing reasonably designed monitoring and auditing systems and practices.
6. Enforcement of Disciplinary Standards of the Program: Standards must be enforced through well-publicized disciplinary guidelines.
7. Responding Appropriately to Detected Offenses and Developing a Corrective Action; after an offense *(non-compliance)* has been detected, the organization must take reasonable steps to respond appropriately to the offense and to develop corrective action initiatives and performance improvement. This includes follow-up monitoring and review to ensure the performance improvement plan is effective.
8. Environmental Evaluation/Risk Assessments: Risk Management is defined as the ability to identify, assess, prevent, monitor, and remediate risk for the organization. The goal of this specific element is to mitigate risk and reduce the severity of a loss if an event were to occur.

Oversight and Structure:

SHW Board of Directors:

The SHW Board of Directors has responsibility for formally adopting the agencies commitment to a Corporate Compliance Program and approving the necessary resources to accomplish an

atmosphere conducive to Corporate Compliance. The SHW Board of Directors is responsible for the review and approval of the Compliance Plan, related policies, review of the Annual Compliance Report, and review of matters related to the Compliance Program. The SHW Board of Directors has the highest level of responsibility for the oversight of the Compliance Program.

Effective compliance programs include the designation of a Corporate Compliance Officer and a Corporate Compliance Committee to oversee the operations of the Corporate Compliance Program. SHW supports the position of Corporate Compliance Officer and has also designated the establishment of a Corporate Compliance Committee.

Corporate Compliance Officer:

The Corporate Compliance Officer is responsible for the development, implementation, and management of the Corporate Compliance Program for SHW. To increase the effectiveness and integrity of the Program, the Corporate Compliance Officer shall have the cooperation of, and access to, all members of the organization. The SHW Board of Directors and senior management shall provide the Corporate Compliance Officer with appropriate resources to effectively manage and satisfy the elements of the Program. The Corporate Compliance Officer shall also have the authority to inquire into any matters arising or appearing to arise within the scope of the Corporate Compliance Program.

The Compliance Officer may appoint staff as necessary to assist in the performance of his/her responsibilities. In the event this occurs, those individual/s will be treated as the Corporate Compliance Officer for purposes of cooperation with his/her efforts to perform Corporate Compliance program functions. Competent Legal Counsel will be made available to the Corporate Compliance Officer in managing the Corporate Compliance Program in the event that fraudulent or abusive practices are discovered through reported complaints, audits or compliance investigations.

The authority given the Compliance Officer will include the ability to review all documents and other information relevant to compliance activities, including, but not limited to, consumer records, billing records, employee records, and contracts and obligations of SHW.

The Compliance Officer will be given sufficient authority and control to oversee and monitor the Compliance Program, activities and staffing used to support the program, as well as related Policies and Procedures. This includes, but not limited to the following:

Coordinating internal and external provider network audits and monitoring activities outlined in the Annual Monitoring and Audit Work Plan.

Directs and is accountable for the implementation and enforcement of the Compliance Plan.

Serves as chair of the Corporate Compliance Committee and provides leadership and consultative support to the organization’s employees.

Responsible for oversight of SHW efforts to maintain compliance with federal and state regulations and contractual obligations.

- Ensures that effective systems are in place, by which, actual or suspected compliance violations are reported in a timely manner to appropriate governing bodies.
- Reviews all reports of actual or suspected compliance violations received by SHW from any source and ensures that effective investigation and/or other action is taken.
- Monitors changes in federal and state health care laws and regulations and, as needed, implements necessary actions to effectively address those requirements within the Corporate Compliance Program.
- Works collaboratively with the PIHP to not only ensure that auditing and monitoring protocols are designed to detect and deter potential compliance violations, but in a consultative capacity for guidance as needed.
- Ensures that performance improvement plans are adequate to ensure compliance and assures effective implementation of corrective action occurs to reduce risk of future occurrences.
- Oversees the processes for on-going Inherent Risk Evaluation for the organization. This will be used to not only identify future organizational risk factors, but also as a means of designing systems which could mitigate current risk factors.
- Prepares and delivers an annual compliance report to the SHW Board covering the fiscal year, including:
  - A summary of trends in the frequency, nature and severity of substantiated compliance violations, this will include an annual summary of the OIG/PIHP quarterly reports.
  - A review of any changes to the Compliance Plan or program.
  - An objective assessment of the effectiveness of the Compliance Plan and Program.
  - Overview of the activity taken on identified Risk Management Action items.

To ensure the delegated compliance activities of the PIHP are carried out and efficiently managed by SHW, the Corporate Compliance Officer will serve directly, or delegate as needed, a representative to serve on the MSHN Regional Corporate Compliance Committee.

Based on recent OIG recommendations that have been built into Corporate Integrity Agreements (CIA), the Corporate Compliance Officer shall not have any non-compliance job responsibilities that may interfere or conflict with the Officer’s ability to perform compliance duties.

Corporate Compliance Committee:

The Corporate Compliance Committee has been established to advise the Corporate Compliance Officer and assist in the implementation of the Compliance Program. The Committee reviews and evaluates compliance activities and reports to and consults with the Board of Directors and its appropriate ad hoc committees, as necessary.
Based on recent OIG recommendations that have been built into Corporate Integrity Agreements (CIA), the Corporate Compliance Committee shall be expected to take on additional responsibilities within their role in the Compliance Program.

The duties of the Compliance Committee shall include but are not limited to:

- review the Policies and Procedures at least annually and update the Policies and Procedures, as necessary. Any new or revised Policies and Procedures shall be made available to all employees, contractual providers, board members, and stakeholders,
- shall review the Board training at least annually and update the Board training as necessary,
- shall provide oversight of the risk management plan and internal review of the risk management process,
- analyze the effectiveness of the compliance program and make recommendations accordingly,
- providing a forum for discussion of compliance related issues.

The Corporate Compliance Committee must be comprised of no less than six members of which must include the CEO and the Corporate Compliance Officer. Membership consideration will be operationally and clinically based. Consideration may be given to include the Director of Clinical Services, Director of Strategic Services, Financial Services Supervisor or Chief Finance Officer, the Recipient Rights Officer, HIPAA Privacy Officer, Security Officer, Representative/s from Nursing and/or Medical Department, and other agency leaders as determined by the CEO. Additional members may be added as ad hoc. The frequency of meetings is based on identified organizational need; however, the Corporate Compliance Committee must meet no less than twice per year, but any member of the Committee may call a special meeting.

Regional (PIHP) Corporate Compliance Committee:

The Regional Corporate Compliance Committee, operating under the auspices of the Mid-State Health Network (MSNH) Quality Improvement Council, is comprised of designated representatives from each of the Community Mental Health Service Providers, as well as the Corporate Compliance Officer of MSHN. This committee meets in accordance with the PIHP Corporate Compliance Charter and Plan.

The purpose of the group is to provide a forum for education on changes in federal and/or state laws and regulations applicable to compliance initiatives. It offers regional Corporate Compliance representatives an opportunity for ongoing exchange of information to ensure a standardized method exists for policy and procedure review and comparison of local processes. In that the regional CMHSP's assume various delegated functions from the PIHP it is beneficial that all affiliate members carry out these processes in a uniformed manner. Emphasis is on promoting continuity between the Corporate Compliance Programs of the affiliate CMHSP's, while allowing the framework and processes for each organization to remain intact. Information derived from these meetings may be incorporated into the SHW Compliance Program. The Corporate Compliance Program of SHW will adhere to any MSHN policies or procedures developed through the regional committee. This can be achieved by authoring or revising existing SWH policies and procedures, or through implementation of SHW Board Governance Policy and Procedure 13, Applicability of Regional Policies of the Mid-State Health Network.

Ethics Committee:

Behavioral HealthCare Organizations have a dual responsibility for advocating for the consumers while promoting ethical business practices in a time of audit and monitoring. A system of readiness

and compliance is essential to develop a plan to respond appropriately and timely to prevent and detect violations of law.

The Ethics Committee is a Sub-Committee of the Corporate Compliance Committee. The Ethics Committee has three primary functions: education by providing information and resources to behavioral health staff about issues in ethical decision making; policy formulation on ethical issues affecting consumer care; and case consultation in response to a request from a staff person, consumer, or guardian.

The Ethics Committee will include members representing multi-disciplines and/or professional areas. Members are appointed by the CEO for a two-year term.

A representative of the Ethics Committee shall report on their activities to the Corporate Compliance Committee at least twice per year.

The committee will meet at least once quarterly, with ad hoc meetings held as often as necessary in order for the committee to perform its responsibilities, as well as respond to specific ethical concerns. Due to the importance of diversity of opinion in the discussion of ethical concerns, at least five members (including the committee chair or designee) must be present for a meeting of the Ethics Committee to be held. The Committee shall keep such records of its meetings as it deems appropriate.

The Ethics Committee is:

- Responsible for the organization’s development and implementation of an ethical code
- Oversee implementation of ethics related policies and procedures
- Develop and implement a plan for monitoring tools in use throughout SHW ethics related policies and procedures
- Serve as forum for case review
- Responsible for making recommendations to the sponsoring Corporate Compliance Committee for changes in staff educational practices, organizational policies and procedures, and/or process improvements.
- Serve as a resource for planning content and format for periodic staff development educational experiences

Ad-Hoc Committees:

Ad-hoc committees may be formed, if deemed necessary, to address specific substantive compliance issues or to implement self-review and audit projects. An employee of SHW may be appointed to an “ad-hoc” committee for purposes of obtaining their expertise in a particular area. However, their appointment to any “ad-hoc” committee must first be approved by the CEO or designee.

Standards of Conduct - Compliance Policy & Procedure Development

Standards, Policies, and Procedures are crucial to an organization’s ability to create a culture of consistency and integrity. The following documents are used by SHW to convey Standards of Conduct:

- Corporate Compliance Plan
- Organizational Plans that address Risk Management, Privacy, or Security
- Policies and Procedures
- Standards of Conduct, Code of Ethics

This Corporate Compliance Plan provides the framework of the Compliance Program. However, an effective Corporate Compliance Program requires detailed standards, policies, and procedures designed to reduce unethical or noncompliant behavior. The Corporate Compliance Officer in conjunction with both the Corporate Compliance Committee and Ethics Committee is responsible for developing and maintaining detailed policies and procedures that govern and offer guidance to the operations of the Corporate Compliance Program. On an annual basis, policies will be reviewed by the Corporate Compliance Officer (or designee) and presented to the Compliance Committee for their review and final approval. This ensures the policies adhere to industry best practice and current regulatory standards. Refer to Attachment F, Index of Policies and Procedures that are part of the Compliance Program.

Ethics related procedures will be reviewed by the Ethics Committee, with any revisions reported bi-annually to the Corporate Compliance Committee. Any changes to Corporate Compliance or Ethics related policies will be approved by the Corporate Compliance Committee and the SHW Board of Directors. Appropriately, management team members are integral to creating new policies, as well as reviewing and revising current policies that may impact compliance issues that affect respective departments. This includes issues that could fall within the Environmental Evaluations/Risk Assessment section of this plan.

SHW is committed to conducting the delivery of services and business operations in an honest and lawful manner, consistent with its Vision, Mission, Values, and Operating Principals. SHW's Standards of Conduct and Code of Ethics (Attachment A) provides guidance to employees in carrying out their daily activities within appropriate ethical and legal standards. Following the Standards of Conduct and Code of Ethics is one means by which to facilitate compliance. All new employees are provided with a copy of the Staff Code of Ethics as part of the hiring process.

Additionally, in order to safeguard the ethical and legal workplace standards of conduct, SHW shall endorse policies and procedures that address employee behaviors and activities within the workplace setting, including but not limited to the following:

- Confidentiality: SHW is committed to protecting the privacy of its consumers. SHW Board members, employees, and contractual providers are to comply with the Michigan Mental Health Code, Section, 330.1748, Code of Federal Regulations (CFR), Title 42 and all other privacy laws as specified under the Confidentiality section of this document.
- Drug and Alcohol: SHW is committed to providing a drug-free work environment that is both safe for our employees and visitors, as well as conducive to efficient and productive work standards.
- Harassment: SHW is committed to maintaining a work environment free of harassment for Board members, employees, and contractual providers. SHW will not tolerate harassment based on sex, race, color, religion, national origin, disability, citizenship, chronological age, sexual orientation, union activity, or any other condition, which adversely affects the work environment.
- Conflict of Interest: SHW Board members, employees, and contractual providers shall avoid any action that conflicts with the interest of the organization and the

consumers we serve. All Board members, employees, and contractual providers must disclose any potential conflict of interest situations that may arise or exist in accordance with established policies and procedures.

- Reporting Suspected Fraud or Abuse: SHW Board, employees, and contractual providers shall report any suspected or actual "fraud, abuse or waste" of any funds, including Medicaid funds, to the organization.
- Solicitation and Acceptance of Gifts: SHW Board members, employees, and contractual providers shall not solicit gifts, gratuities, or favors. SHW Board members, employees, and contractual providers will not accept gifts, gratuities, or favors of any kind from any individual, consumer, or organization doing business or seeking to do business with SHW.
- Workplace Bullying: SHW defines bullying as "repeated" inappropriate behavior, either direct or indirect, whether verbal, physical, or otherwise, conducted by one or more persons against another or others, at the place of work and/or during the course of employment. Such behavior violates SHW's Code of Ethics, which clearly states that all employees will be treated with respect.
- Workplace Violence and Weapons: SHW takes violence and threats of violence extremely seriously. Any act or threat of violence by or against any employee, customer, supplier, partner, or visitor is strictly prohibited.
- Political Contributions: SHW shall not use agency funds or resources to contribute to political campaigns or activities of any political party or candidate.
- Credentialing and Licensure: SHW will ensure that the credentials and licenses are verified as appropriate to the clinician's practice level to ensure that consumers receive the highest quality of care. Processes will be established for the verification of all required credentials and practitioner eligibility requirements per regulatory statutes for clinical and direct care services.

Conducting Appropriate Training and Education

SHW Employees:

Proper education and training is a significant element of the Corporate Compliance Program. It is important that all members of SHW's workforce are not only knowledgeable about the Corporate Compliance Program but applicable statutes and regulations that are the basis for documentation, billing, and service delivery practices. All new employees are required as part of new hire orientation to review and sign an acknowledgment of receiving the "Code of Ethics." A copy of this form is placed in the employee file.

Additionally, new employees, as part of an organizational orientation, will receive an onboarding presentation of the Corporate Compliance Program to understand their role in compliance. Additionally, within 30 days of hire, and on an annual basis thereafter, each employee will be required to complete training on Corporate Compliance/Deficit Reduction, False Claims, and HIPAA. The SHW Training Department retains documentation for all workforce members who complete compliance training. In addition, managers and employees working in areas at high-risk for compliance violations will receive additional education and training as necessary.

Training of employees, as well as contracted providers, is not limited to increased awareness to Corporate Compliance and applicable regulations. It also requires training to those elements contained within the MSHN Minimum CMHSP Training Requirements (Attachment B), as well as predetermined training modules. Clinical program supervisors will emphasize the quality of clinical documentation as it provides validity that the service was provided in accordance with the Person-Centered Plan as well as Medicaid standards for clinical eligibility. Improper payments primarily fall into 4 main categories with the most frequent being unsupported services (e.g., poor or incomplete documentation, no documentation, unclear documentation), as well as medically unnecessary services. Quality of documentation is of utmost importance.

Finally, to further support the identification of ongoing training needs, the Corporate Compliance program will implement a Compliance and Ethics survey no less than once per year. It is still common to evidence the effectiveness of compliance programs based on implementation of basic program elements, such as the amount, attendance, and type of compliance training, as well as how effectively these elements are put into action. However, there is movement toward having other more convincing evidence of program effectiveness. To assess whether such an environment exists, it is becoming more common to implement employee perception and knowledge surveys. The OIG recommends that organizations should evaluate all elements of a compliance program through “employee surveys, management assessments, and periodic review of benchmarks established for audits, investigations, disciplinary action, overpayments, and employee feedback.”

Board Members and Advisory Council Members

Board members and Advisory Council members shall receive training on the SHW Compliance Plan at a minimum of every two years. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records shall be maintained on all formal training and educational activities. Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination.

SHW Provider Network

SHW shall ensure that all contractual arrangements with providers are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers served.

Through predetermined documentation submission intervals, the SHW Provider Network/Contacts Manager in collaboration with Corporate Compliance, will review and monitor the provider network to ensure adherence to the identified training requirements. Additionally, as a member of the PIHP’s Provider Network Committee, SHW Provider Network/Contacts Manager will update the Corporate Compliance Officer (or designee) on any updated training requirements recommended through the MSHN Annual Training Plan to assure and provide consistent training requirements throughout the provider network. Where viable, SHW will also offer related compliance training and educational materials to the Provider Network.

Open Lines of Communication

Open lines of communication are essential to an effective Corporate Compliance program. Shiawassee Health and Wellness has established a Compliance Helpline and confidential digital fax line that provides a venue for confidential reporting of potential compliance violations and noncompliant activity.

It is SHW's policy that employees can report potential compliance violations without fear of retaliation. This policy applies to the reporting of any perceived compliance violation, regardless of the methodology used for submitting the report. This non-retaliation policy also holds true to any report made regarding the activity of the CEO. The Corporate Compliance Officer has a direct line to the Board of Directors to report potential compliance violations and noncompliant activity should the need arise. Such as any activity that may involve C-Level Leadership positions. In addition, all reports submitted will be held confidential to the extent practical.

A Corporate Compliance Notification Poster (Attachment C) is used to provide information on how to report concerns of non-compliant activity by SHW Staff, contracted providers, or external entities. This contact information is posted on the organization's website, the agency's intranet site, and in key locations within all SHW facilities. The following numbers are available to reach the Compliance Helpline.

Local: 989-723-0750
Internal Extension: 4750
Fax: 989-723-0740

These numbers are available for use at any time by all individuals. The Hotline may be used to ask compliance related questions or report actual or potential noncompliant activities. The Helpline is staffed weekdays from 8:00 a.m. to 4:30 p.m. After 4:30 p.m., confidential voice mail is available. Paper based Regulatory Compliance Concern/Complaint Forms (Attachment E) are made available on the organization's website and the agency's intranet site. All messages left on the Helpline voice mail or written notifications will be followed up within 2 business days (or in accordance with voicemail instructions). The Corporate Compliance Officer or other designated individual will investigate all reports made to the Compliance Helpline in a prompt and reasonable manner as outlined in the MSHN Compliance Investigation, Resolution and Documentation Process (Attachment G).

Monitoring and Auditing

The Corporate Compliance Officer shall establish appropriate procedures for conducting such audits and utilize the various organizational risk evaluations, peer review activity, as well data mining processes to identify and prioritize the areas that pose inherent risks for compliance violations or litigation. Areas of high risk will be monitored more closely and will be considered for more frequent auditing activities should evidence from monitoring efforts validate the need.
The Corporate Compliance Officer (or Designee) shall develop an Annual Monitoring and Audit Work Plan (Attachment D) that lists possible risk areas that could be audited and monitored each year. Elements of the Office of Inspector General (IOG) Work Plan as well as any areas of focus identified by SHW or the MSHN Regional Compliance Committee can be incorporated into the audit

work plan based on relevance to the organization.

Monitoring and auditing of SHW operations is key to ensuring compliance and adherence to policies and procedures. Monitoring and auditing can also identify areas of potential risk and those areas where additional education and training is required. Results of the monitoring or audit activities identified in the Annual Monitoring and Audit Work Plan will be communicated primarily through the Corporate Compliance Committee. However, monitoring activities may also occur within the context of other agency committees, e.g. UM/PI, Ethics, etc. In which case, reporting will occur within the context of said committee or within the Annual QAPIP Summary Report.

The Corporate Compliance Officer and auditors, or reviewers acting on behalf of the Corporate Compliance Officer, shall have access to all documents necessary to perform corporate compliance functions, including those related to claim development and submission, business records, cost reports, patient records, pricing and cost data, employee records, schedules, e-mail, and the contents of computers.

Additionally, the SHW Corporate Compliance Program may be required to conduct audits in support of delegated responsibilities or strategic areas of focus originating from the PIHP or in accordance with the Michigan Department of Health and Human Services (MDHHS). SHW will report to the PIHP any suspicion or knowledge of fraud or abuse within the Medicaid program. Unless otherwise specified, SHW will use the MSHN “Compliance Investigation Report Form” issued by the PIHP for the reporting of such events to the PIHP.

List of Excluded Individuals and Entities:

The Corporate Compliance Program of Shiawassee Health and Wellness in collaboration with Provider Network Management will ensure that measures are implemented to adhere to 42 CFR 438.602(d)) which states: “Consistent with the requirements at § 455.436 of this chapter, the entity must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, or PCCM entity through routine checks of Federal databases. This includes but is not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it must promptly notify the MCO, PIHP, PAHP or PCCM entity and take action consistent with § 438.610(c).”

Responding Appropriately to Detected Offenses and Developing a Corrective Action

The SHW Compliance Program includes methods for identifying compliance violations such as the Helpline and auditing and monitoring. Within the continuum there must be methods for responding to

and correcting such violations. While the precise method to investigate any alleged complaint may vary based on the nature of the complaint, SHW will follow the process outlined in the "MSHN Compliance Investigation, Resolution and Documentation Process" (Attachment G). The MSHN process is used to ensure adherence to the expectations of the PIHP and consistency among CMHSP affiliates.

In order to respond appropriately to and correct potential compliance problems, an investigation of any report or questionable practice should be conducted promptly. In conducting an investigation, judgment should be exercised and consideration should be given to the scope and materiality consistent with the nature of the concern. The SHW Corporate Compliance Program will use prudent judgment during the course of an investigation. Should the activity be outside the level of expertise, the investigation may be turned over to the Michigan Office of the Inspector General so as not to adversely impact more thorough investigations by regulatory or oversight organizations.

Each investigation must be carefully documented to include a report describing the disclosures, the investigative process, the conclusions reached, and the recommended corrective action, when such is necessary. No one involved in the process of receiving and investigating reports shall communicate any information about a report or investigation, including the fact that a report has been received or an investigation is ongoing, to anyone within organization who is not involved in the investigation process or to anyone outside of the organization without the prior approval of the SHW Compliance Officer. All SHW employees and subcontractors are expected to cooperate fully with investigation efforts.

After a violation has been detected and confirmed, the Corporate Compliance Officer (or designee) shall institute steps to prevent the reoccurrence of the violation. Shiawassee Health and Wellness will take appropriate corrective action, including but not limited to:

- Reasonable steps to modify SHW's policies, procedures, and processes as deemed necessary
- Education and training to all applicable employees and/or providers
- Prompt and proper restitution of any overpayment to the affected payer,
- evaluation, recommendations, and the carrying out of appropriate disciplinary action with the individual/s responsible for the violation; consistent with the severity of the violation as well as considerations of previous violations
- Steps necessary to evaluate the effectiveness of the interventions.

Corrective action will include reporting suspected violations to the PIHP through the quarterly monitoring report. If deemed necessary, reports will be submitted to appropriate government agencies. Additionally, SHW will inform in writing, the PIHP Chief Executive Officer (CEO) or designee of: "any notice to, inquiry from, investigation by any Federal, State or local human services, fiscal, regulatory, investigating, persecutory, judicial, or law enforcement agency or protection and/or advocacy organization regarding the rights, safety, or care of a recipient of Medicaid Services". Unless otherwise specified, SHW will use any form issued or delegated by the PIHP for the reporting of such events to the PIHP. Reporting suspected violations to the appropriate government agencies and PIHP shall/will involve consultation with SHW's legal counsel and upon review by the Chief Executive Officer or Board of Directors.

SHW will thoroughly document all corrective actions taken to demonstrate to government and regulatory agencies (if necessary), that SHW is committed to compliance with all applicable laws and regulations.

Enforcement of the Program

An effective compliance program requires enforcement. Willfully violating SHW's Corporate Compliance Program or external regulatory statutes will result in disciplinary action, which will be appropriate for the severity of the activity. Fraudulent and other illegal activities will not be tolerated and could result in immediate termination of employment or the end of a Network Provider Contract. Employees are expected to adhere to the Corporate Compliance Program as a condition of their employment at SHW. This is reflected in both Standards of Conduct and the Code of Ethics. Failure to do so will result in disciplinary action. Sanctions could range from oral warnings to suspension, privilege revocation (subject to applicable peer review procedures), and termination.

Environmental Evaluations/Risk Assessments

Risk Management is defined as the ability to identify, assess, prevent, monitor, and remediate risk for the organization. The goal of this specific element is to manage risk and reduce the severity of a loss if an event were to occur, while accomplishing our mission and core objectives in providing quality behavioral health care to the people of Shiawassee County. SHW maintains various formal governance and staff-level committees in which risk can be identified, addressed, managed, and abated.

The committees are made up of individuals who are responsible by position, level of authority, or level of expertise for continually assessing systems and activities within our organization. These committees include, but are not limited to, Finance Committee (Board of Directors), Credentialing, Corporate Compliance, Management and Leadership Teams, Departmental Staff meetings, Consumer Advisory Council, Utilization Management/Performance Improvement, Behavior Management, Health and Safety, etc. In addition, key staff participate in several PIHP committees or work groups that address risk issues. One of primary functions of a PIHP Committee is to ensure compliance to legal or contractual requirements through a delegated process. These committees include, but are not limited to, Quality Improvement Council, Staff Training, Clinical Leadership/Utilization Management, Provider Network, Finance, Operations Council, Customer Services/Recipient Rights, Corporate Compliance, and Information Technology Council. SHW is diligent in our efforts to comply with all applicable Federal, State and local laws, regulatory statutes, rules and regulations.

Much of the work identifying risks is the responsibility of these bodies that have an overall responsibility for risk identification and management. In addition to the Corporate Compliance Plan, risk management activities for the organization occur through the Strategic Plan, IT Security Plan, Utilization Management Plan, Quality Assessment and Improvement Plan (QAPIP), and numerous systems, policy and procedures.

Additionally, risk areas are often addressed by external quality and compliance reviews including those conducted by the Michigan Department of Health and Human Services (MDHHS), the Health Services Advisory Group (HSAG), the Commission on Accreditation and Rehabilitation Facilities, and Mid-State Health Network. External audits are performed by independent certified public accountants and firms that specialize in Information Technology security. All these activities service

to identify potential risk areas or practices, mitigate risk, monitor system performance, and remediate systems that may be prone to risk.

To aid in tracking and prioritizing elements for potential risk, the SHW Corporate Compliance Program has developed an analytics tool that calculates Inherent and Residual Risk Indexes. Inherent Risk is typically defined as the level of risk in place in order to achieve an entity's objectives and before actions are taken to alter the risk's impact or likelihood. Residual Risk is the remaining level of risk following the development and implementation of the entity's response.

Any risks identified by one of the listed groups or by any individual will be evaluated for remediation. Conducting an enterprise or compliance risk assessment will result in identifying opportunities for improvement. Key factors to consider include, but are not limited to:

- Business area most likely impacted,
- Description of the risk,
- Key determinants
  - Impact: If the risk were to occur, what would be the impact,
  - Likelihood: What is the frequency of the occurrence,
  - Assurance: What is current effectiveness of controls over the risk,
  - Inherent Risk: impact x likelihood, assessment score of risk not taking in current controls
  - Residual Risk: impact x likelihood x assurance assessment scores with current effectiveness of controls considered.

Improvements can be viewed in terms of revising or implementing policies and procedures, adding control activities, or the need for additional education or training or even increased awareness of issues. These opportunities will be formalized into a performance improvement plan (PIP) with assigned responsibilities and timelines. The status of each action plan will be reported to the Corporate Compliance Committee as a standing agenda item. Due to the availability of resources, SHW will not carry more than three risk assessment-based performance improvement plans at one time. As one PIP is remediated, a new PIP can be implemented based on the severity of the residual risk score.

For more detailed information on the Risk Management Plan for Shiawassee Health and Wellness please refer to the full Risk Management Plan which exists as a stand-alone document.

Additional Impact Areas

Contractual Relationships

In order to ethically and legally meet all standards, SHW shall ensure that all contractual arrangements with providers are structured in accordance with federal and state laws and regulations and are in the best interest of the organization and the consumers served. The Network Provider application and onboarding process will be reviewed on an ongoing basis to ensure compliance with ever-changing legal statutes.

Purchasing and Supplies

SHW shall ensure that all rental, lease, and purchasing agreements are structured in accordance with applicable federal and state self-referral and anti-kickback regulations as well as federal

guidelines regarding tax-exempt organizations. All agreements must be commensurate with the fair market value for equipment or space.

All contractor and supplier arrangements shall be managed in a fair and reasonable manner, consistent with all applicable laws and good business practices. Subcontractors, suppliers, and vendors shall be selected based on objective criteria including quality, technical excellence, price, delivery, adherence to schedules, services, and maintenance of adequate sources of supply.

Marketing

Marketing and advertising practices are defined as those activities used by SHW to educate the public, provide information to the community, increase awareness of services, and recruit employees or contractual providers. SHW will present only truthful, fully informative, and non-deceptive information in any materials or announcements.

The federal Anti-kickback Statute (section 1128B[b] of the Social Security Act) makes it a felony, punishable by criminal penalties, to offer, pay, solicit, or receive “remuneration” as an inducement to generate business compensated by Medicare or Medicaid programs.

Financial Systems Reliability and Integrity

SHW shall ensure the integrity of all financial transactions. Transactions shall be executed in accordance with established policies and procedures and with federal and state law and recorded in conformity with generally accepted accounting principles or any other applicable criteria.

SHW shall develop internal controls and obtain an annual independent audit of financial records; shall ensure that reimbursement for services billed is accurate, appropriate, and based on complete documentation; and shall maintain accountability of assets. The Federal Civil False Claims Act prohibits the knowing submission of false or fraudulent claims for payment to the federal or state government, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the federal or state government by having a false or fraudulent claim allowed or paid.

In accord with the 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005) SHW’s processes shall monitor for actions by contractual providers of Medicaid services to prevent fraud, abuse, and waste, or are likely to result in unintended expenditures.

Information Systems Reliability and Integrity/Cyber Security Liability

The SHW Information Technologies Manager shall serve as the Security Officer and shall ensure the reliability and integrity of the information systems utilized to support the effectiveness of the SHW compliance program.

Cyber Liability takes into account first- and third-party risks and addresses those risks associated with the use of e-business, the Internet, networks, and informational assets as well as the risks associated with the use of mobile devices. Risk categories include, but are not limited to, privacy issues, the infringement of intellectual property, virus transmission, or other factors that may adversely impact web-based transactions from first to third parties users.

Confidentiality and Privacy

SHW is committed to protecting the privacy of its consumers and shall strictly govern the disclosure of any information to anyone other than those authorized in compliance with applicable privacy laws, regulations, and contractual requirements. To ensure that all consumer information remains confidential, employees and contractual providers are required to comply with all confidentiality policies and procedures in effect, specifically to include the HIPAA Privacy Regulations, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2, 45 C.F.R. Part 160 & 164. To ensure adherence to the cited statutes, SHW will appoint a Privacy Officer and a Recipient Rights/Customer Services Director to oversee compliance to the above requirements.

Environmental Standards

SHW shall maintain a hazard-free environment in compliance with all environmental laws and regulations. SHW shall operate with the necessary security systems, permits, approvals and controls. Maintenance of a safe environment is the responsibility of all employees and contractual providers. In order to maintain a safe environment, SHW shall enforce policies and procedures (as needed) designed to protect consumers, employees, staff, providers, visitors, the environment, and the community.

The OIG, it's Role and Responsibilities;

The Office of the State Inspector General (OIG) investigates instances of fraud, waste, abuse, and corruption in all executive branch state agencies, departments, commissions, authorities, and any entity of state government that is headed by an appointee of the Governor. The American Reinvestment and Recovery Act of 2009 (ARRA) encourages the reporting and investigation of fraud, waste, abuse, and corruption that occurs in connection with the distribution of federal stimulus funds to state and local governments and to private contractors.

On a federal level, the foundation for the IOG is to protect the integrity of HHS programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal health care laws. Their mission encompasses more than 100 programs administered by HHS at agencies such as the Centers for Medicare & Medicaid Services (CMS), Administration for Children and Families (ACF), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Indian Health Service (IHS), and National Institutes of Health (NIH).

OIG's funding that is directed toward oversight of the Medicare and Medicaid programs—including oversight of financial integrity and quality and safety of medical services—constitutes a significant portion of OIG's total funding (approximately 78 percent in FY 2016). The remaining share of OIG's efforts and resources are focused on other HHS programs and management processes, including key issues, such as efficient and effective operation of health insurance marketplaces and accuracy of related financial assistance payments.

OIG operates by providing independent and objective oversight that promotes economy, efficiency, and effectiveness in the programs and operations of HHS. OIG's program integrity and oversight

activities adhere to professional standards established by the Government Accountability Office (GAO), Department of Justice (DOJ), and the Inspector General community. OIG carries out its mission to protect the integrity of HHS programs and the health and welfare of the people served by those programs through a nationwide network of audits, investigations, and evaluations, as well as outreach, compliance, and educational activities, conducted by personnel in the following components.

- **The Office of Audit Services (OAS).** OAS conducts audits of HHS programs and operations through its own resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote the economy, efficiency, and effectiveness of programs and operations throughout HHS.

- **The Office of Evaluation and Inspections (OEI).** OEI conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.

- **The Office of Investigations (OI).** OI conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State, the District of Columbia, and Puerto Rico, OI coordinates with DOJ and other Federal, State, and local law enforcement authorities. OI also coordinates with OAS and OEI when audits and evaluations uncover potential fraud. OI's investigative efforts often lead to criminal convictions, administrative sanctions, or civil monetary penalties (CMP).

- **The Office of Counsel to the Inspector General (OCIG).** OCIG provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, self-disclosure, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry about the anti-kickback statute and other OIG enforcement authorities.

- **Executive Management (EM).** EM is composed of the Immediate Office of the Inspector General and the Office of Management and Policy. EM is responsible for overseeing the activities of OIG's components; setting vision and direction, in collaboration with the components, for OIG's priorities and strategic planning; providing specialized expertise in cross-cutting issues; ensuring effective management of budget, finance, information technology (IT), human resources, and other operations; and serving as a liaison to HHS,

Congress, and other stakeholders. EM plans, conducts, and participates in a variety of cooperative projects within HHS and with other Government agencies.

- **State Medicaid Fraud Control Units (FCU's).** The 50 State MFCUs, located in 49 States and the District of Columbia, investigate and prosecute Medicaid provider fraud as well as complaints of patient abuse or neglect in Medicaid-funded facilities and board and care facilities. OIG provides oversight for the MFCUs and administers a Federal grant award that provides 75 percent of each MFCU's funding. As part of OIG's oversight, they provide guidance to the MFCUs; assess their adherence to Federal regulations, policy, and performance standards; and collect and analyze performance data. They also provide technical assistance and training and identify effective practices in MFCU management and operations. They will perform on-site reviews of a sample of MFCUs.

Regulatory Standards:

State/Federal Laws and Rules

- Michigan Mental Health Code and Administrative Rules
- Other Statutes Related to Municipal Organizations and Operations
- Other requirements as identified in the MDCH contract
- Technical Assistance Advisories, as required
- Medicaid State Plan
- Waiver Applications
- Medical Services Administration (MSA) Policy Bulletins
- Michigan Whistleblowers Act, Act 469 of 1980
- Michigan Executive Order Reorganization 2015-4:
- Medicaid Managed Specialty Supports and Services Contract: Part III: Section 2.0 (Fraud and Abuse Reporting Responsibilities)

Federal Medicaid Law, Regulations and Related Items

- Social Security Act, Title XIX (Medicaid)
    - Balanced Budget Act of 1997
    - Deficit Reduction Act/Medicaid Integrity Program of 2005
    - Anti-kickback Statute
- Code of Federal Regulations
    - Title 42, Part 438.608
    - Title 42, Part 438.602(d)
    - Title 42, Part 455.17
- State Operations Manual
- Letters to State Medicaid Directors
- Technical Assistance Tools
    - Quality Improvement Systems for Managed Care (QISMC)
    - Guide to Encounter Data Systems
- Office of Management and Budget (OMB) Circulars
- Government Accounting Standards Board (GASB)

Other Relevant Legislation

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- False Claim Act
- Provisions from Public Act 368 of 1978 – revised – Article 6 Substance Abuse
- American Recovery and Reinvestment Act of 2009
- Office of Inspector General Annual Work Plan
- Stark Law
- HITECH Act

Hyperlinks to Regulatory Standards:

1. Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans, Medicaid Alliance for Program Safeguards, May 2002. **https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf.**

2. Anti-kickback Statute (section 1128B[b] of the Social Security Act)
http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm
https://oig.hhs.gov/compliance/safe-harbor-regulations

3. False Claims Act
https://oig.hhs.gov/fraud
http://www.legislature.mi.gov

4. 42 USC 139a(a); Section 1902(a) of the Social Security Act (AKA the Deficit Reduction Act of 2005)
https://www.cms.gov/regulations-and-guidance/legislation/deficitreductionact/downloads/checklist1.pdf

5. Michigan Mental Health Code
https://www.legislature.mi.gov/documents/mcl/pdf/mcl-chap330.pdf

6. Department of Health and Human Services, Office of Inspector General
https://oig.hhs.gov

7. Michigan Public Health Code
http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf

8. Code of Federal Regulations (Title 42, Part 2 and Title 45, Part 160 & 164)
https://www.ihs.gov/sites/privacyact/themes/responsive2017/display_objects/documents/PvcFR01.pdf

9. 42 CFR 438.602(d) Federal Database Checks
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-H/section-438.602

Attachments:

“A” SHW Employee Conduct and Code of Ethics

“B” MSHN Minimum CMHSP Training Requirements

“C” SHW Corporate Compliance Notification Poster

“D” SHW Annual Monitoring and Audit Work Plan 2016

“E” SHW Regulatory Compliance Concern/Complaint Forms

“F” SHW Index of Corporate Compliance Policies and Procedures

"G" MSHN Corporate Compliance Plan, Compliance Investigation, Resolution and Documentation Process
"H" MSHN Compliance Investigation Report Form