Origination:	*02/2018*
Last Approved:	*02/2018*
Last Revised:	*02/2018*
Next Review:	*02/2019*
Owner:	*Eric Doeh: Compliance Officer*
Policy Area:	*Compliance*
References:	

Compliance Plan

POLICY

The Detroit Wayne Mental Health Authority ("DWMHA") has instituted an ongoing Compliance Program, which includes the DWMHA's Standards of Conduct and Conflict of Interest Policy. This Compliance Plan is intended to implement Compliance Program procedures.

PURPOSE

The DWMHA, and its Board of Directors ("Board") are committed to providing services for Wayne County individuals diagnosed with severe mental illness, developmental disabilities and/or substance use disorders, in compliance with all applicable state, federal and local laws and regulations governing the provision of these services and the pursuit of business goals by governmental agencies.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWMHA Board, DWMHA Staff, Contractual Staff, Access Center, MCPN Staff, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI/SEI, SED, SUD, Autism
3. This policy impacts the following contracts/service lines: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

STANDARDS

There shall be effective adherence to compliance standards through the DWMHA's Standards of Conduct, Conflicts of Interest Policy, and other applicable written policies and procedures.

1. *Chief Compliance Officer.* Administration of the DWMHA's compliance activities shall be primarily vested in the Chief Compliance Officer.
    a. If any questions arise concerning whether any particular action is proper under this Compliance Plan, or other DWMHA compliance policies, they should be brought to the Chief Compliance Officer for clarification. If for any reason an individual is uncomfortable in bringing his or her compliance issue or question to the Chief Compliance Officer (e.g., the questioned conduct involves the Chief

Compliance Officer or someone under the Chief Compliance Officer's direct supervision) the issue may be reported through use of the DWMHA's Compliance Hotline (313-833-3502), or otherwise brought directly to the attention of the General Counsel, the President/CEO, or the Board chair.

b. The Chief Compliance Officer shall report to President/CEO and the DWMHA's Board. The Chief Compliance Officer is expected to maintain frequent and direct communication with respect to compliance matters with the Board, specifically, the Program Compliance Committee, senior management and the Office of General Counsel. In addition, the Chief Compliance Officer shall provide quarterly reports to the Program Compliance Committee.

c. To the extent deemed feasible and necessary for the maintenance of DWMHA compliance, the Chief Compliance Officer shall also be responsible for overseeing the coordination of compliance activities between the designated compliance officers of the DWMHA's Contracted Providers.

2. *Compliance Committee*. The Compliance Committee is an organization-wide operations compliance committee. The Compliance Committee consists of (i) the Chief Compliance Officer who chairs the Committee; (ii) the Chief Financial Officer; (iii) the Chief Medical Officer; (iv) the Chief Operating Officer; and (v) the Chief Strategic Officer. The Compliance Committee shall:

   a. Assist the Chief Compliance Officer with risk assessment and the need for and design of compliance reviews within the organization;

   b. Advise the Chief Compliance Officer on compliance training needs within the organization and assist in arranging for and conducting such compliance training;

   c. Assist the Chief Compliance Officer with developing organizational policies supporting the Compliance Plan;

   d. Assist the Chief Compliance Officer with implementation of the Compliance Plan;

   e. Assist the Chief Compliance Officer with evaluation of the effectiveness of the Compliance Plan;

   f. Meet, at a minimum, on a bi-annual basis during the fiscal year; and

   g. Refer all matters to the Program Compliance Committee and the Board for review that relate to the following:

      1. Violations that require notification to federal, state, and/or local agencies;

      2. Violations that have an economic impact (i.e. budgetary) on the DWMHA and/or require funds to be returned to federal or state agencies; or

      3. Any other information that the Compliance Committee deems appropriate for Board notification.

3. *Education and Compliance Training Program.* Comprehensive training and education of DWMHA Staff shall be conducted regarding compliance policies and procedures. The Chief Compliance Officer shall have oversight responsibility for initial and periodic Staff compliance training. New Staff shall review and acknowledge the DWMHA's Standards of Conduct contemporaneous with their initiation of providing services on behalf of the DWMHA, and shall be provided with training regarding this Compliance Plan and other DWMHA policies and procedures within sixty (60) days of their start date. Such initial training should be documented. Thereafter, Staff shall receive refresher training on an annual basis, or as the Chief Compliance Officer deems appropriate. Training will be conducted under the supervision of the Chief Compliance Officer, however, at the discretion of the Chief Compliance Officer, and with the approval of the President/CEO, portions of compliance training may be outsourced to appropriate outside vendors.

4. *Monitoring and Audits.* The DWMHA is committed to an ongoing auditing and monitoring program to ensure the success of its Compliance Program. Primary responsibility for this auditing and monitoring

program is vested in the Chief Compliance Officer, who shall formulate specific auditing and monitoring tools. In designing and implementing this ongoing auditing and monitoring program, the Chief Compliance Officer shall focus particular attention on the following areas:

a. Policies and Procedures. It shall be the responsibility of the Chief Compliance Officer to ensure that all policies and procedures necessary for the ongoing effectiveness of the Compliance Program are in place. This will include responsibility for conferring with the General Counsel, and, as necessary, the Compliance Committee, in the drafting of new compliance policies and procedures, when they do not exist, and periodically reviewing and updating existing compliance policies and procedures. The updating of compliance policies and procedures will require awareness and understanding of changes in laws, regulations, rules and guidelines, which the Chief Compliance Officer will be expected to have.

b. At a minimum, the Chief Compliance Officer shall develop:

    1. This Compliance Plan (which shall be reviewed on an annual basis and revised as necessary);
    2. A simple and readily accessible procedure to process reports of possible fraudulent or erroneous conduct (e.g., a telephone Hotline), including a process that maintains the confidentiality of the persons involved in the alleged fraudulent or erroneous conduct and the person making the allegation, to the extent possible;
    3. A procedure for periodic compliance audits; and
    4. A Record Retention, Storage, Retrieval and Scheduled Disposal Policy.

c. Periodic Compliance Audits. The DWMHA is committed to full compliance with federal and state law, regulations, rules and applicable guidelines. It shall be the Chief Compliance Officer's responsibility to arrange and perform periodic compliance audits to ensure such compliance by the DWMHA.

d. Provider Audits. The DWMHA may conduct audits of its Contracted Providers, when such action is determined by the Chief Compliance Officer to be necessary to ensure DWMHA compliance with applicable law and regulations.

5. *Lines of Communication and Reporting.* The DWMHA is committed to open communication as an essential component of proper implementation of its Compliance Program.

    a. It shall be the responsibility of the Chief Compliance Officer to develop a process, or processes, to ensure effective communication of suspected fraudulent or abusive behavior. The Chief Compliance Officer shall make himself or herself available to communications regarding compliance issues received from Consumers, Staff, Contracted Providers and other vendors through discussions at Staff meetings regarding fraudulent or erroneous conduct issues, and shall maintain community bulletin boards to keep DWMHA Staff updated regarding compliance activities and the various means by which Staff may report perceived problems (e.g., via the compliance Hotline).

    b. Pursuant to the terms of the Standards of Conduct, all Staff are expected and required to report any conduct that they, in good faith, reasonably believe may be fraudulent or erroneous. If in doubt as to whether a "reasonable person" would consider the conduct in question to be fraudulent or erroneous, it is the DWMHA's expectation that it be reported. The identity of an individual who raises a compliance issue shall remain anonymous to the extent possible and there shall be no retribution for reporting conduct that a reasonable person, acting in good faith, would have believed to be fraudulent or erroneous.

6. *Procedure for Investigation of Reports*. It is the DWMHA's policy that all suspected and reported violations of the mandates of the Compliance Plan, the Standards of Conduct, and the Conflict of Interest Policy will

be promptly investigated internally.

a. When a credible report of such a violation is received, the Chief Compliance Officer will first protect any relevant information that is needed to perform a thorough investigation. All document disposal practices will be stopped immediately. If, in the Chief Compliance Officer's determination, a reasonable suspicion exists that Staff may destroy or remove documents, such individuals will be suspended or removed from sensitive areas until completion of the investigation.

b. After evidence of the violation is protected, the DWMHA will interview the Staff members involved, as necessary, to learn the extent of the potential violation and the identities of responsible parties. Extensive document review will also be performed. At the conclusion of the investigation, responsible Staff members will be disciplined (as described below), and this Compliance Plan may be altered or amended, as necessary, to reduce the likelihood of future violations.

c. If the alleged violation is covered by the DWMHA's Human Resource Policy Manual, the Chief Compliance Officer may solicit the assistance of the Human Resources Department to investigate the alleged violation.

d. For alleged violations that are reported to the Office of Recipient Rights, the Chief Compliance Officer may assist (if requested) with the investigations since the state Mental Health Code assigns the primary authority for all consumer neglect and abuse investigations to be conducted by the Office of Recipient Rights.

e. The Chief Compliance Officer shall report any substantiated violation or suspicion or knowledge of fraud (in certain cases) to the appropriate federal, state, local, and/or contracting agency (i.e. Integrated Care Organizations) as required by law or contract.

7. *Disciplinary Guidelines*. Any individual who violates the Compliance Plan, the Standards of Conduct, the Conflict of Interest Policy or any applicable laws, regulations, policies or procedures, including a failure to report a known compliance violation, shall be subject to potential disciplinary action.

   a. Disciplinary action may result in any one, or combination, of the following possible actions:

      1. Oral or written warning;
      2. Oral or written reprimand;
      3. Probation;
      4. Demotion;
      5. Suspension;
      6. Termination (employment or independent contractor relationship);
      7. Restitution of damages; and/or
      8. Referral for criminal prosecution.

   b. The appropriate level of disciplinary action will be determined by the Chief Compliance Officer on an individual basis, as determined by the specific facts of the situation, a review of the DWMHA's Human Resource Policy Manual, and the respective collective bargaining agreement (as applicable).

   c. The DWMHA shall also respond to detected violations by taking steps to correct the problems discovered during investigation. Such steps may include, as appropriate, a corrective action plan, appropriate revisions to this Compliance Plan to help prevent such violations from recurring, the return of any overpayments, a report to the federal, state or local government and/or a referral to law enforcement authorities.

d. If a violation of civil or criminal federal or state law is detected, the DWMHA will report the violation to the appropriate government entity as soon as possible. The DWMHA will provide a report of its internal investigation and cooperate with the government's investigation. If the violation has resulted in an overpayment, the DWMHA will promptly return the overpayment in compliance with the applicable payer's required procedures.

8. *Provider Licenses and Certification.* The DWMHA requires that all entities and individuals providing community mental health services through independent contractor arrangements who are required to be licensed, certified or registered to perform such services, maintain such license, certification or registration without interruption while providing such services under contract with the DWMHA.
9. *Business Relationships.* The DWMHA is committed to a high standard of legal and ethical conduct in its business relationships, and the DWMHA, and its management and Staff, shall accurately and appropriately represent the DWMHA in business matters at all times. This includes the following practices:
    a. Honest Communication. The DWMHA requires all Staff to communicate honestly with respect to compliance activities, but also with regard to DWMHA activities in general.
    b. Proprietary Information. DWMHA Staff shall not misappropriate proprietary information belonging to another individual or entity. Proprietary information may include, but is not limited to, publications, documents and computer programs.
    c. Business Arrangements with Tax Exempt Hospitals and Other Tax Exempt Entities. The DWMHA is committed to compliance with all applicable federal and state laws, including applicable regulations, in its business arrangements with tax-exempt hospitals and other tax-exempt entities.
10. *Record Retention.* All DWMHA records, including treatment records, business records and compliance records shall be maintained and destroyed in compliance with the DWMHA's Record Retention, Storage, Retrieval and Scheduled Disposal Policy. Compliance-related records shall be kept in a separate file, which should be continuously updated. At a minimum, the records that are maintained in the compliance file shall include minutes of any compliance related meetings, records of compliance education activities and internal compliance audit results. Particular attention should be paid to documenting violations uncovered by investigations and audits, and what remedial action was taken. In addition, correspondence with government agencies (e.g., CMS, MDHHS, etc.) regarding compliance issues should be retained, particularly when the DWMHA has relied on advice from such agencies as provided in their correspondence. In the case of telephone consultations, notes should be taken, dated and placed in the compliance file.
11. *Conflicts of Interest***.** It is each individual Staff member's obligation to ensure that he or she remains free of conflicts of interest that could have an adverse effect on the DWMHA. DWMHA Staff may have outside interests and activities, as allowed by applicable employment contracts, policies and handbooks, however, whenever an outside activity might result in a conflict of interest relative to the DWMHA, the Staff member must report the situation to the Chief Compliance Officer, the Director of Human Resources and/or the Board, in compliance with the DWMHA's Conflict of Interest Policy and/or the corporate Bylaws, as applicable.
12. *Applicable Law and Regulations.* The DWMHA is committed to full compliance with all applicable federal, state and local laws, whether based upon statute, regulation, rule, ordinance or any other legal authority, and whether or not specifically addressed in the Compliance Plan, the Standards of Conduct, and/or other DWMHA policies and procedures. The DWMHA may be subject to mandatory surveys from regulatory agencies including, but not limited to, The Joint Commission, Centers for Disease Control (CDC), the

Food and Drug Administration (FDA), the Department of Justice (DOJ), the Office of the Inspector General (OIG), the Office of Civil Rights (OCR), the Center for Medicare and Medicaid Services (CMS), and Michigan Attorney General (AG), as well as local courts and law enforcement agencies. Those specific areas of legal compliance listed in this or any other section of the Compliance Plan are included by way of example and are not meant to be all-inclusive. The listing of specific legal requirements herein does not set the limit of the DWMHA's compliance; as the DWMHA is committed to compliance with all applicable legal authority.

a. CMS 1915(b) Wavier Standards. CMS granted the State of Michigan a 1915(b) waiver of the freedom of choice requirements under the State Plan provisions of Title XIX of the Social Security Act. The 1915(b) waiver authorizes a mandatory Medicaid prepaid capitation plan for behavioral health services. The Authority is committed to adherence to standards that have been issued by CMS, and which must be followed to ensure compliance with the 1915(b) wavier requirements.

b. Medicaid and Medicare Laws, Regulations, Protocols and Standards. Title XIX of the Social Security Act and the Code of Federal Regulations parts 430 through 456 govern the Medicaid program, and including requirements for fee-for-service, prepaid capitation fee arrangements, and prepaid inpatient health plans. The Authority is, by definition, a prepaid inpatient health plan under 42 CFR 438.2 and is committed to compliance with all applicable Medicaid laws, regulations, protocols and standards. To the extent that the Authority's activities involve any Medicare beneficiaries, the Authority is committed to comply with all applicable provisions of Title XVIII of the Social Security Act and related Federal Regulations, which govern the Medicare program.

c. Prohibition on False Statements or Representations with Respect to Federal Healthcare Programs. Section 1128B(a) of the Social Security Act makes it a criminal violation to make certain false statements or representations of material facts with respect to benefits and payments made under federal healthcare programs.

d. Fraud and Abuse. The Authority is committed to full compliance with all applicable federal and state fraud and abuse laws including the federal and state anti-kickback statutes, federal and state false claims acts, and all other applicable federal and state fraud and abuse provisions.

e. Excluded Providers. The Authority is committed to not employ, or otherwise contract with, any individual or entity that it knows is an "Excluded Provider." The Authority will make reasonable efforts to ensure that no individuals or entities with which it contracts have been excluded from such programs, including searches of OIG's website (http://exclusions.oig.hhs.gov).

f. Limited English Proficiency. The Authority shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency.

g. Rights to Inventions Made Under a Contract or Agreement. Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government as the recipient in any resulting invention in accordance with 37 CFR part 401.

h. Discrimination. The Authority is committed to compliance with all federal, state and local anti-discrimination laws and shall not discriminate based upon a person's race, color, religion, sex, sexual orientation, national origin, age, disability or any other classification prohibited by law. No form of harassment or discrimination shall be tolerated and all allegations of harassment or discrimination shall be promptly investigated and dealt with in accordance with the Authority's policies and procedures.

QUALITY ASSURANCE/IMPROVEMENT

DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, MCPNs, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Mental Health Code, Act 258 of Public Acts 1974, as amended, MCL 330.1001, et seq. (the "Mental Health Code").
2. Michigan Administrative Rules, R 330.1001, et seq.
3. Michigan Constitution, Laws, Rules and local charters governing Governmental Agencies.
4. Chapter III of the Medical Services Administration Medicaid Manual.
5. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
6. Pro-Children Act.
7. Anti-Lobbying Act.
8. Hatch Political Activity Act and Intergovernmental Personnel Act.
9. Byrd Anti-Lobbying Amendment.
10. Davis-Bacon Act.
11. Contract Work Hours and Safety Standards Act.
12. Anti-Kickback Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a- 7b[b])
13. 42 CFR 455.2
14. False Claims Act 31 U.S.C. §3729

RELATED POLICIES

1. Compliance Reporting Policy
2. Standard of Conduct Policy
3. Conflict of Interest Policy
4. Fraud and Abuse Policy

RELATED DEPARTMENTS

1. Administration

2. Claims Management
3. Clinical Practice Improvement
4. Compliance
5. Customer Service
6. Information Technology
7. Integrated Health Care
8. Legal
9. Managed Care Operations
10. Management & Budget
11. Purchasing
12. Quality Improvement
13. Recipient Rights
14. Substance Use Disorders

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

No Attachments

Approval Signatures

Approver	Date
Dana Lasenby: Acting Chief Executive Officer	02/2018
Allison Smith: Project Manager, PMP	01/2018
Jean Alce: Interim Medical Director	01/2018
Corine Mann: Chief Strategic Officer/Quality Improvement	01/2018
Stacie Durant: CFO Management & Budget	01/2018
Eric Doeh: Compliance Officer	01/2018