

# NMRE~Compliance Training



This training provides general compliance guidance and does not replace current statutes, regulations, payer contracts, or legal advice

# COMPLIANCE CONTACT INFORMATION

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# Overview of Medicaid Program Administration for Behavioral Health Services

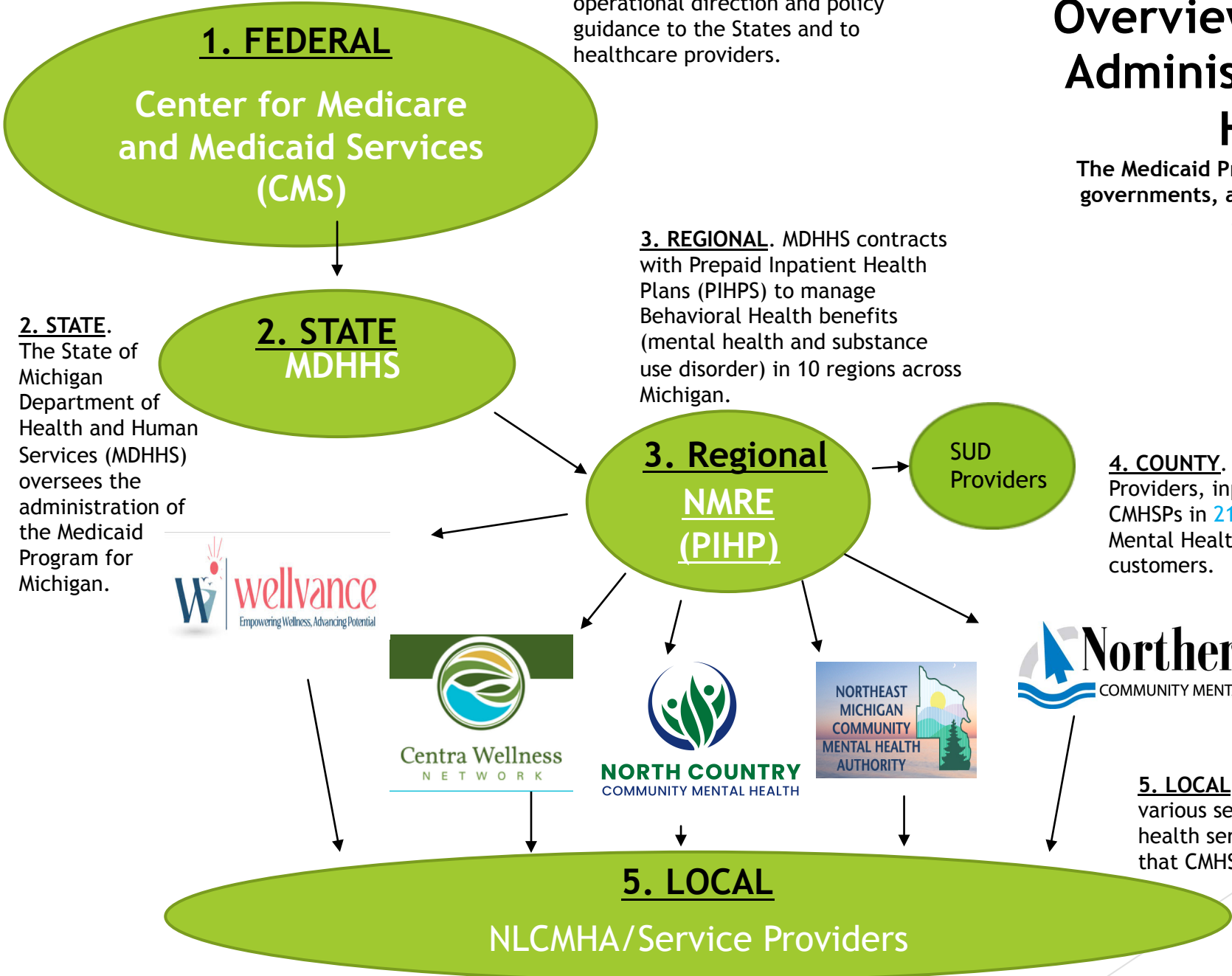
The Medicaid Program is funded by both the federal and state governments, and is directly administered by the States with approval and oversight by CMS.

**1. FEDERAL.** CMS provides operational direction and policy guidance to the States and to healthcare providers.

**3. REGIONAL.** MDHHS contracts with Prepaid Inpatient Health Plans (PIHPS) to manage Behavioral Health benefits (mental health and substance use disorder) in 10 regions across Michigan.

**4. COUNTY.** NMRE contracts with SUD Providers, inpatient hospitals and 5 CMHSPs in 21 County region to provide Mental Health and SUD services to customers.

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



**2. STATE.** The State of Michigan Department of Health and Human Services (MDHHS) oversees the administration of the Medicaid Program for Michigan.





# What is Compliance?

## Doing the Right Thing!

- What does this look like in an ORGANIZATION'S BEHAVIOR?
  - A formal program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of laws and regulations.
- What does this look like in INDIVIDUAL BEHAVIOR?
  - Following laws and rules that govern healthcare;
  - Being honest, responsible, and ethical;
  - Preventing, detecting, and reporting unethical and illegal conduct;
  - Preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA) of Federal and/or State funds;
  - Auditing and Monitoring to make sure funds are being used correctly.

# The Seven Elements of an Effective Compliance Program

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## 1. Standards of Conduct, Policies and Procedures

Code of Conduct; Corporate Compliance Plan; Policies & Procedures located on the T-drive

## 2. Compliance Administration

NMRE Compliance Officer-Brie Blauw-Molaison, NMRE Compliance Committee, Regional Compliance Coordinating Committee

## 3. Conducting effective training and education

Education Plan: at hire; annually via computer

## 4. Developing effective lines of communication

Open-door policy to Compliance Officer; Anonymous reporting; Whistleblower protections

## 5. Conducting internal monitoring and auditing

Annual FY Compliance Audit & Monitoring Plan; Provider Network Reviews; IT Audit Plan

## 6. Enforcing standards through well-publicized disciplinary guidelines

Contained in Employee Handbook, Code of Conduct, Corporate Compliance Plan, and Policies & Procedures

## 7. Responding promptly to detected offenses and undertaking corrective action

All reports of wrongdoing will be promptly and confidentially investigated, and appropriate remedial action taken (can include Corrective Action Plans, repayments, notification to outside government agencies, training, etc.).

# NLCMHA STANDARDS OF CONDUCT

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## Code of Conduct

- ▶ Confidentiality: Protect the privacy of those we serve
- ▶ Alcohol & drug free environment
- ▶ Free of harassment of any kind
- ▶ Avoidance of conflict of interest
- ▶ Report any suspected or actual FWA
- ▶ Do not solicit or accept gifts
- ▶ Safe, respectful work environment: all employees will be treated with dignity and respect
- ▶ Political contributions will not be made with agency funds or resources

## Ethics

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

## INTERSECTION OF COMPLIANCE AND ETHICS

# Organizational Ethics

### What is the role of compliance when it comes to ethics?

Support the organization toward an ethical culture. OIG Compliance Guideline states one purpose of compliance program is to, “..increase the likelihood of preventing, identifying, and correcting unlawful and unethical behavior at an early stage”

### What does this look like?

Establishing policies, procedures, and business processes that support and encourage employees to act in conformity with the organization’s values. **Examples** include a Code of Conduct, and other standards that encourage transparency and open communication.

## INTERSECTION OF COMPLIANCE AND ETHICS

# Organizational Ethics

### Steps for Approaching An Ethical Dilemma

- E - Examine relevant values (yours, consumer's, organization's)
- T - Think about relevant law, practice, policies
- H - Hypothesize about different paths and imagine the consequences
- I - Identify who will be helped or harmed in each possible scenario. Ask yourself  
“Who is most vulnerable in this situation?” “Who is my client?”
- C - Consult with supervisor and other colleagues to evaluate options before acting,  
then your actions document well

(ETHIC Model by Dr. Elaine P. Congress)

## PRACTICE

# Which of the following are actual or potential Conflicts of Interest that should be reported to your supervisor or HR?

1. You accepted paid outside employment at a contracted provider entity, but it is only part-time and will not interfere with your normal work schedule for your entity.
2. Your spouse works for a vendor that is seeking to contract with your entity.
3. Your job includes referring consumers to providers and your daughter works at a provider organization.
4. You are completing a Master's Degree Program and are performing your internship at a contracted provider entity.

**ALL OF THE ABOVE!!** Actual, potential, and even the appearance of a Conflict of Interest should be disclosed to your supervisor or HR. This supports transparency and integrity in your organization.

# Laws Impacting Healthcare

## Deficit Reduction Act 2005

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

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

# Laws Impacting Healthcare

## **FEDERAL FALSE CLAIMS ACT**

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- ▶ Federal statute that covers fraud involving any federally funded contract or program, including the Medicaid program.
- ▶ Establishes civil liability for certain acts, including:
  - ▶ Knowingly presenting a false or fraudulent claim to the government for payment;
  - ▶ Knowingly making, using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved;
  - ▶ Conspiring to defraud by getting a false or fraudulent claim allowed or paid;
  - ▶ Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
- ▶ “Knowingly” means:
  - ▶ Actual knowledge of the information;
  - ▶ Acting in deliberate ignorance of the truth or falsity of the information; or
  - ▶ Acting in reckless disregard of the truth or falsity of the information.
  - ▶ **\*\*No proof of specific intent to defraud!!\*\***

# Laws Impacting Healthcare

## **FEDERAL FALSE CLAIMS ACT**

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### ▶ Examples:

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

### ▶ Penalties:

- ▶ “Civil monetary penalties adjusted annually for inflation per false claim, plus treble damages.”;
- ▶ Treble damages - three times the amount of damages incurred by the federal government related to the fraudulent or abusive conduct;
- ▶ Exclusion from participation in State and Federal programs;
- ▶ Federal criminal enforcement for intentional participation in the submission of a false claim.

## PRACTICE

# Laws Impacting Healthcare

## FEDERAL FALSE CLAIMS ACT

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

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

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

PROBLEMS??

# Laws Impacting Healthcare

## FEDERAL FALSE CLAIMS ACT

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Problems identified on the previous slide:

- Medicaid was charged for a claim for a 60 minute psychotherapy service when Dr. Smith only saw her for 5 minutes.
  - ❑ Appears to be intentional - fraud
- Dr. Smith instructed receptionist to create Progress note for 60 minutes for an audit.
  - ❑ Documenting a service not provided; intentional - fraud
- Receptionist created a note and Dr. Smith signed and back dated. Receptionist and Dr. intentionally created, signed and presented note to auditors to support a service that was not provided but billed.
  - ❑ Falsifying documentation for payment; intentional by both the receptionist and Doctor - fraud.



# Laws Impacting Healthcare

## **MICHIGAN FALSE CLAIMS ACT**

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- ▶ Mirrors the Federal False Claims Act, with expanded definition of “knowledge”
- ▶ MCL 400.602
  - ▶ “Knowing” and “knowingly” means that a person is in possession of facts under which he or she is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the payment of a Medicaid benefit. Knowing or knowingly includes acting in deliberate ignorance of the truth or falsity of facts or acting in reckless disregard of the truth or falsity of facts. Proof of specific intent to defraud is not required. (Emphasis added)
  - ▶ Allows for constructive knowledge. This means that if the course of conduct “reflects a systematic or persistent tendency to cause inaccuracies” then it may be fraud, rather than simply a good faith error or mistake.

# Laws Impacting Healthcare

## **OTHER APPLICABLE LAWS**

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### Anti-Kickback Statute

- ▶ Health care providers and suppliers MAY NOT give or receive “remuneration” in exchange for the referral of patients or services covered by Medicaid or Medicare. This applies when remuneration is offered or accepted knowingly and willfully to induce referrals.”

### Exclusion Authorities

- ▶ Providers must ensure that no Federal Funds are used to pay for any items or services furnished by an individual who is debarred, suspended or otherwise excluded from participation in any federal health care program. This includes salary, benefits, and services furnished, prescribed, or ordered.

### Civil Monetary Penalties Law

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

### Criminal Health Care Fraud Statute

- ▶ Makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment of up to 10 years, and fines of up to \$250,000. Specific intent is not required for conviction.

# Laws Impacting Healthcare

## **WHISTLEBLOWER PROTECTION**

### ▶ Federal Statute

- ▶ Designed to protect against the fraudulent use of public funds by encouraging people with knowledge of fraud against the Government to “blow the whistle” on wrongdoers.
- ▶ Individuals can file a “Qui tam” lawsuit on behalf of the government. The law provides for a reward in the form of a share of the recovery.
- ▶ Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the False Claims Act to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation.

### ▶ Michigan Statute

- ▶ Provides protection for employees who report a violation or suspected violation of a State or Federal law, rule, or regulation to a public body; unless the employee knows the report is false.
- ▶ Employers may not discharge, threaten, or otherwise discriminate against an employee regarding the employee’s compensations, terms, conditions, location, or privileges of employment.

# Laws Impacting Healthcare

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Offering to pay someone to make referrals to your entity, or accepting payment for making referrals violates what law?

Placing an employee on a corrective action plan because they reported suspected fraud occurring within the agency would be a violation of this law.

Using federal funds to pay the salary and benefits of a person who is barred from participating in Medicare and Medicaid would violate this law.

Identifying that your provider has received an overpayment, but failing to repay that overpayment amount within 60 days of quantifying the amount violates what law?

Increased Federal resources to fight Medicaid fraud, waste, and abuse.

- Federal False Claims Act
- Whistleblowers Protection Act
- Anti-kickback Statute
- Exclusion Authorities
- Deficit Reduction Act

# FRAUD, WASTE, & ABUSE

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## FRAUD

An intentional deception or misrepresentation by a person with the knowledge the deception could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.

Can include billing for services not rendered, performing medically unnecessary services solely to obtain payment, altering documentation to obtain higher payment (upcoding), and deliberate duplicate billing.

### Example

Dr. Smith's submission of a claim for a service not rendered, and creation of a fake progress note to support that claim.

# FRAUD, WASTE, & ABUSE

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## WASTE

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.

Can include healthcare spending that can be eliminated without reducing the quality of care, redundant testing

### EXAMPLE

Consumer received an Assessment from Provider A last month. There has been no significant change in Consumer's condition, nor any change in the treatment being delivered. Provider A performs another Assessment and submits a claim for payment.

# FRAUD, WASTE, & ABUSE

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## ABUSE

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

Can include submitting claims that do not comply with billing guidelines, providing services that are not medically necessary or do not meet professionally recognized standards, submitting bills to Medicare/Medicaid instead of the primary insurer.

**CAUTION** - Abuse can develop in to Fraud if there is evidence that the individual knowingly and willfully (on purpose) conducted the abusive practices.

### EXAMPLE

Provider A has multiple sites and determined it made billing easier if all claims were submitted listing a single location of service, and a clinician associated with that location of service, rather than the claims reflecting the clinician who actually furnished the service, and the location where it was actually furnished.

# Service Documentation Requirements

## Michigan Medicaid Provider Manual requirements (non-exhaustive list)

### Medicaid Provider Manual Section 12: Record Keeping

- ▶ The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed.
- ▶ All documentation must be legibly signed with credentials and dated by the rendering health care professional and signed by the customer
- ▶ For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service
- ▶ Progress notes must include a Description of Service that describes:
  - ▶ Presenting problems, treatment modality, customer response to treatment
  - ▶ Goal(s) and/or Objective(s) of the Plan of Service addressed
  - ▶ Progress/lack thereof toward desired outcome
  - ▶ Current status of the customer/Future treatment recommendations
  - ▶ Specific clinician/staff interventions offered during the service contact

# Medicaid Services Verification

- ▶ Code is approved under the contract
- ▶ Eligibility of the beneficiary on the date of service
- ▶ Service is included in the beneficiaries individual plan of service
- ▶ Date/time of service on progress note
- ▶ Service provided by a qualified practitioner and falls within the scope of the code billed/paid
- ▶ Amount billed does not exceed the payer (PIHP or CMHSP) contracted amount
- ▶ Amount paid does not exceed the payer (PIHP or CMHSP) contracted amount
- ▶ Any additional elements to support the PIHP quality improvement efforts with claims/encounters data

# PRIVACY & CONFIDENTIALITY

## Behavioral Health Records

### Governing Rules

Health Insurance  
Portability and  
Accountability Act  
(HIPAA)

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

42 CFR Part 2

Michigan Mental  
Health Code

# PRIVACY & CONFIDENTIALITY

## Behavioral Health Records

# Substance Use Disorder (SUD) Records

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

- ▶ “Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized...”
- ▶ Provides heightened protections for SUD records. While disclosure rules have been partially aligned with HIPAA following patient consent, Part 2 still imposes stricter requirements than HIPAA, including limits on re-disclosure.”
- ▶ Requires a very specific, detailed Release of Information (ROI)/Consent
- ▶ Requires information that is disclosed include a Prohibition on Re-disclosure
- ▶ No information regarding a client should be released without a valid, 42 CFR Part 2-compliant ROI/Consent

# PRIVACY & CONFIDENTIALITY

## Behavioral Health Records

### Mental Health Records - HIPAA

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

HIPAA Security Rule - “Covered entities must ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits.”

- ▶ The Security Rule applies to safeguarding electronic PHI (PHI stored on computers, sent via email, access permissions to PHI)
- ▶ Requires covered entities to protect against any reasonably anticipated threats or hazards, and reasonably anticipated unpermitted uses or disclosures, to the security or integrity of ePHI
- ▶ Entities must have Administrative, Physical, and Technical safeguards.
  - ▶ Administrative: Policies and procedures regarding how staff use electronic media that stores ePHI, policies regarding changing of Passwords
  - ▶ Physical: Limited access to locked server room, sign in/out logs
  - ▶ Technical: Use of encrypted devices, automatic logouts after inactivity

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

# PRIVACY & CONFIDENTIALITY

## Behavioral Health Records

# Mental Health Records - HIPAA

HIPAA Privacy Rule - “A covered entity may not use or disclose protected health information, except as permitted or required...”

- ▶ “Use” means internal review or use of PHI (training, customer service, quality improvement)
- ▶ “Disclose” means release of PHI externally (faxing records to a provider)
- ▶ The “Minimum Necessary” information should be disclosed when use or disclosure is permitted or required. This means only the least amount of information that is necessary to accomplish the intended purpose of the use or disclosure should be requested.
  - ▶ EXAMPLE: External Provider receives a request for Consumer A’s records from [NLCMHA](#), for the purpose of auditing a single date of service. External Provider should provide only the information necessary for [NLCMHA](#) to perform the audit.
- ▶ “Need to know”
- ▶ The most common use or disclosure of PHI is for “TPO”, or Treatment, Payment, or Operations
  - ▶ HIPAA allows for the use or disclosure of PHI for the purpose of TPO without consumer consent
  - ▶ HOWEVER, the Michigan Mental Health Code is **MORE RESTRICTIVE** and allows disclosure of PHI for Treatment, Payment, and Coordination of Care without consumer consent. When in doubt, consult Compliance before sharing PHI under coordination of care.

PRIVACY & CONFIDENTIALITY  
Behavioral Health Records

# Mental Health Records – MI Mental Health Code

## Michigan Mental Health Code - Confidentiality (MCL 330.1748)

- ▶ “Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section or section 748a.”
- ▶ **Amended effective April 10, 2017 to allow for disclosure of PHI for Treatment, Payment, and Coordination of Care in accordance with HIPAA.**
- ▶ While not always legally required, obtaining an ROI is a best practice to reduce risk and avoid misunderstanding. If you have questions regarding exceptions to this rule, contact the NLCMHA Compliance Officer.

PRIVACY & CONFIDENTIALITY  
Behavioral Health Records

# Mental Health Records – MI Mental Health Code

- ▶ **TREATMENT:** The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or referral of a patient for health care from one health care provider to another.
- ▶ **PAYMENT:** Activities undertaken by (1) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (2) A health care provider or health plan to provide reimbursement for the provision of health care.
  - ▶ **Includes:** eligibility/coverage determinations; COB; adjudication of claims; billing; medical necessity review; utilization review activities including preauthorization, and concurrent and retrospective review.
- ▶ **Coordination of Care:** Not specifically defined by HIPAA or the MI Mental Health Code.
  - ▶ If PHI is being shared between health care providers, it may fall under the purpose of “Treatment”.
  - ▶ If PHI is being shared between entities that are not health care providers (ex. PIHP and MHP), then disclosure of PHI is limited to entities that have a current or past relationship with the consumer who is the subject of the PHI, and the PHI must pertain to such relationship (45 CFR 164.506(c)(4)).

PRIVACY & CONFIDENTIALITY  
Behavioral Health Records  
**HIV/AIDS Information**

**Confidentiality of HIV/AIDS Information**

MCL 333.5131

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

# PRIVACY & CONFIDENTIALITY

## Behavioral Health Records

# Breach Notification

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

# PRACTICE

## PRIVACY & CONFIDENTIALITY Behavioral Health Records

### TRUE OR FALSE??

Behavioral health providers cannot ever share my records without my permission.

**FALSE**

HIPAA, the MI MHC, and 42 CFR Part 2 all contain specific exceptions for when PHI may be shared without first obtaining patient consent. Check with your Compliance Officer to verify if an exception applies.

Protected Health Information (PHI) cannot be shared by email.

**FALSE**

Before sending any PHI electronically, check your agency's policies and make sure that it is encrypted or otherwise protected, and that it is addressed to the correct recipient.

If your agency receives a request from a provider for a patient's most recent Treatment Plan (mental health only) to assist that provider in appropriately treating the patient, it is acceptable to send the provider the patient's entire record.

**FALSE**

Non-SUD PHI can be shared without an ROI for Treatment, Payment, and Coordination of Care purposes in accordance with HIPAA. HOWEVER, only the minimum amount of information necessary to accomplish the purpose of the disclosure may be disclosed.

# Enforcement Bodies

## Center for Medicare and Medicaid Services (CMS)

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

## Office of the Inspector General (OIG)

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

## Office for Civil Rights (OCR)

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

## Department of Justice (DOJ)

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

## Michigan Attorney General

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

# Historical Enforcement Examples

- ▶ Office of Civil Rights (OCR) began Phase II HIPAA audits in the Spring of 2016. 167 covered entities were selected from a larger pool of potential auditees for the desk audit portion of the audits, focusing on compliance with HIPAA's Privacy, Security, and Breach Notification Rules.
- ▶ June 2016 - Catholic Health Care Services of the Archdiocese of Philadelphia (CHCS) agreed to settle potential violations of HIPAA after the theft of a CHCS mobile device compromised the PHI of hundreds of nursing home residents. CHCS provided management and information technology services as a business associate to six skilled nursing facilities. The total number of individuals affected by the combined breaches was 412. The Resolution Agreement includes a monetary payment of \$650,000 and compliance with a Corrective Action Plan. (source: <http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/catholic-health-care-services/index.html> )

# REPORTING RESPONSIBILITIES

It is your right, and your responsibility to report actual and suspected Compliance violations to the CMHSP's Compliance Officer and/or NMRE Compliance Officer.

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

## NMRE Compliance Reporting

Compliance Hotline: 866-789-5774

In-person, by telephone, or via email to:

Brie Blaauw-Molaison

Compliance Officer

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## NLCMHA Compliance Reporting

In-person, by telephone, or via email to:

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