ADAPT, INC.

CORPORATE COMPLIANCE PLAN

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1. **10 U.S. Code 1095**
2. **10 U.S. Code 1079b**
3. **32 Code of Federal Regulations Part 220**
4. **Southwest Michigan Behavioral Health Corporate Compliance Plan**

INTRODUCTION

This Corporate Compliance Plan documents Adapt's approach to assuring honest and responsible conduct, decreasing the likelihood of unlawful and unethical behavior at an early stage, and to encourage employees to report potential problems to allow for appropriate internal inquiry and corrective action. In addition to the cooperative effort of all Adapt personnel, compliance will be monitored through the regular occurrence of audits. The Corporate Compliance Plan is structured to meet the guidelines as set forth by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS). For the purpose of educating all covered individuals, as well as other agency stakeholders (parents, guardians, AFC Providers, natural supports, etc.), the plan will be accessible on the organization's website (www.adaptinc.org).

ORGANIZATIONAL STRUCTURE

Adapt contracts with Barry, Branch and St. Joseph County Community Mental Health agencies to provide a variety of community services to individuals with chronic mental illness and intellectual and developmental disabilities. All three counties are part of the eight-county Medicaid Prepaid Inpatient Health Plan (PIHP), Southwest Michigan Behavioral Health (SWMBH). Adapt's Compliance Plan will conform to the standards set forth by SWMBH.

ADAPT'S MISSION

The purpose of ADAPT is to provide residential services, day programs, Clubhouse, and/or vocational training and experiences. ADAPT serves developmentally disabled individuals, persons suffering from mental illnesses, and persons in need of vocational skills and employment. It is the desire of this organization to assist individuals in maximizing their growth and to become as self-sufficient as possible.

ADAPT'S VALUES

- Consumer Focus
- Consumer Choice
- Honesty
- Integrity
- Quality
- Cost-Efficiency
- Competency
- Citizenship
- Accountability

PURPOSE OF COMPLIANCE PLAN

The purpose of the Corporate Compliance Plan is to provide uniform guidance for ADAPT billing and accounting activities, thereby minimizing organizational risk of fraud, waste, and abuse (FWA). This plan outlines collection compliance

guidance for the Medical Services Account (MSA), Third Party Collection Program (TPCP), and Medical Affirmative Claims (MAC). The ADAPT Compliance Plan is a comprehensive strategy to ensure:

a. **That claims submitted to all payers, including private, government (Medicare and Medicaid), and other Federal agencies and individuals are consistently accurate.**
b. **That accounting of collections is consistently accurate.**
c. **That ADAPT employees comply with the applicable laws, policies and regulations, and payer requirements relating to its participation in these programs.**
d. **An environment for all Adapt personnel that promotes honesty, accountability, and high ethical standards.**
e. **The education and training of all employees, contract employees, and board members on their responsibilities and obligations to comply with all applicable laws.**
f. **That oversight and monitoring through internal audits occurs at regular intervals.**

DEFINITIONS OF TERMS

Covered individual: Refers to all Adapt employees and board members. All covered individuals are expected to follow the Compliance Plan.
Fraud: Means an intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. Michigan law permits a finding of Medicaid fraud based upon the discovery of a systematic or persistent tendency to cause inaccuracies (rather than simply being construed as a good faith error). It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and Michigan False Claims Act. If the OIG is unclear of the provider's intent, a finding of fraud could occur vs. Abuse.
Abuse: Means provider practices are inconsistent with sound fiscal, business, or clinical practices, and result in the unnecessary cost to the Medicaid program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. Abuse is viewed as unintentional. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
Waste: Means the overutilization of services, or other practices, resulting in unnecessary costs; the misuse of resources.

BASIS OF COMPLIANCE PLAN

Adapt's compliance is based on numerous laws as outlined in SWMBH's Corporate Compliance Plan. As found in the *SWMBH Corporate Compliance Plan (p. 6-7),* the four key laws and statutes of the Compliance Plan are:

- **The Affordable Care Act (2010) - This Act requires the PIHP (SWMBH) to have a comprehensive Corporate Compliance plan. Adapt, as part of the**

SWMBH provider network, falls under the "purview and scope" of the PIHP's plan. The Adapt Corporate Compliance plan must comply with SWMBH's plan.

- **The Federal False Claims Act** – "This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; conspires with others to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal government (or its designated entity)."
- **The Michigan False Claims Act** – "This Act prohibits fraud in the obtaining of benefits or payments in conjunction with the MI Medical assistance program; to prohibit kickbacks or bribes in connection with the program to prohibit conspiracies in obtaining benefits or payments; and to authorize the MI Attorney General to investigate alleged violations of this Act."
- **The Anti-Kickback Statute** – "This Act prohibits the offer, solicitation, payment or receipt of renumeration, in cash or kind, in return for or to induce a referral for any service paid for or supported by the Federal government or for any good or service paid for in connection with consumer service delivery."

Additional federal and state regulations affecting the Adapt Compliance Plan include, but are not limited to, the following:

- The Balanced Budget Act of 1997
- The Deficit Reduction Act of 2005
- Social Security Act of 1964 (Medicare & Medicaid)
- Privacy and Security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)
- Michigan Whistleblowers Act, Act 469 of 1980
- Michigan Mental Health Code and Administrative Rules
- Michigan State Licensing Requirements
- Michigan Medical Records Act
- Civil Monetary Penalty Law of 1981
- Americans with Disabilities Act of 1990

II. COMPLIANCE PROGRAM ELEMENTS 1 – 7

Element 1: Written Policies and Procedures

A. Code of Conduct

The following general principles apply to every *covered individual* relative to their respective roles within the organization. Where a situation is not covered

by the standards set forth, covered individuals shall apply the principles set forth in this plan in determining whether their conduct is proper. Each covered individual is expected to abide by the following general principles:

- **Serve the public, and treat all persons employed by or associated with the organization with respect, concern, courtesy, and responsiveness.**
- **Proactively market the organizations services in a manner which is fiscally and morally responsible, enables potential consumers to become a part of ADAPT services, and promotes the organization locally and in the larger arena of human services.**
- **Protect the privacy of all consumers.**
- **Promote a culture free of harassment based on gender, race, color, religion, national origin, citizenship, age, sexual orientation, or any other condition.**
- **Support equal treatment of all consumers, employees and other persons associated with the organization, or obtaining or providing services to the organization, without regard to race, gender, color, age, religion, national origin, veterans' status, marital status, sexual orientation, or individual disabilities.**
- **Avoid actual or potential conflicts of interest including the appearance of a conflict of interest, except as allowed by this policy or other policies of the organization.**
- **Promptly report to your supervisor any situation in which a covered individual reasonably feels that they may be or may become involved in a conflict of interest, whether or not such situation is specifically described in this policy.**
- **Recognize that personal gains from employment or service to the organization are limited to respect, recognition, salary, and normal employee benefits.**
- **Demonstrate the highest standards of personal integrity in all actions related to or affecting the business of the organization.**
- **Not use your relationship with the organization to bestow any benefit on anyone related to the person by family, business, or social relationship.**
- **Not disclose or use or allow others to use confidential information, including the use of individual consumer information, obtained as the result of your relationship with the organization, for private gain or private purposes.**
- **Respect the right to informed consent of potential and current consumers and ensure all applicable service information is provided. (Refer to Adapt's policy on Consumer Informed Consent.**

- **Be aware of each consumer's legal decision-making status and maintain open communication with the legal decision-maker, as appropriate to the covered individual's role in the organization.**
- **Witness the legal decision-maker's signature on documents, for the purpose of facilitating medical treatment and Adapt services, when requested.**
- **Not serve as a witness for the legal decision-maker's signature on legal documents such as guardianship, Power of Attorney, DNR, etc., unless an exception is made by the Executive Director.**
- **Not accept any fee, compensation, gift, payment of expense, or any other thing of monetary value except as authorized by policies of the organization.**
- **Not engage in outside employment except as authorized by policies of the organization. No covered individual shall hold a public office or employment that is incompatible with their duties and obligations.**
- **Not use the organization's time, property, equipment, supplies, or support services for private gain, or private purposes, except such limited use as authorized by policies of the organization.**
- **Follow the standards set forth in this Compliance Plan, as well as all applicable laws.**
- **Not make, file, or use any false, fictitious, or fraudulent statements or documents in connection with the delivery of, or payment for, health care benefits, items, or services.**
- **Not falsify, conceal, or cover up a material fact in the performance of duties.**
- **Report suspected fraud, waste or abuse, or any other violation of the Compliance Plan, to their immediate supervisor or the Compliance Officer, without fear of retaliation by any employee or board member.**

B. Potential Risk Areas

The following areas have been identified as potential vulnerabilities of the organization.

- **Billing for procedures, items or services that were not provided;**
- **Billing for procedures, items or services that are not documented;**
- **Submitting duplicate claims:**
    - **More than one claim for the same service;**
    - **Claim is submitted to more than one primary payor at the same time;**

- **Up-coding: Using a billing code that provides a higher payment rate than the billing code that accurately reflects the service furnished to the consumer.**
- **Unbundling: the practice of submitting bills in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced cost;**
- **Inappropriate balance billing;**
- **Inadequate resolution of overpayments;**
- **Incorrectly or improperly recording receivables;**
- **Failing to implement or follow marginal internal fiscal controls, including separation of duties;**
- **Failure to maintain the confidentiality of information/records;**
- **Lack of integrity in computer systems;**
- **Alteration of documentation;**
- **Destroying records/documentation without proper authority.**
- **Blocking investigations;**
- **Administration overlooking, disregarding, defending, or affirmatively concealing illegal billing practices.**

C. Claim Development and Submission Process. ADAPT will:

- **Provide a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the clinical and coding staff.**
- **Possess the necessary skills, quality assurance processes, systems, and appropriate procedures to ensure that all billing for government and commercial insurance programs are accurate and complete.**
- **Provide for proper and timely documentation of all services prior to billing to ensure that only accurate and properly documented services are billed.**
- **Emphasize that claims will be submitted only when appropriate documentation supports the claims and only when such documentation is maintained, appropriately organized in legible form, and available for audit and review. The documentation, which may include patient records, should record the time spent in conducting the activity leading to the record entry and the identity of the individual providing the service.**
- **Ensure notes used as a basis for a claim submission are appropriately organized in a legible form so they can be audited and reviewed.**
- **Ensure that services reported on the reimbursement claim are based on the medical record and other authorized documentation.**

- **Establish a process for pre- and post-submission review of claims to ensure claims submitted for reimbursement accurately represent services provided, are supported by sufficient documentation and are in conformity with any applicable coverage criteria for reimbursement.**
- **Ensure all billings to government and private insurance payers reflect true and accurate information and conform to all pertinent Federal and State laws and regulations.**
- **Implement a periodic manual review to determine the appropriateness of billing each service claim, to be conducted by one or more appropriately trained individuals familiar with applicable billing rules.**

D. <u>Heath Insurance Portability and Accountability Act of 1996 (HIPAA)</u>. Covered individuals will comply with requirements as mandated by HIPAA. Adapt personnel will complete HIPAA training upon hire and annually. There are essentially three areas of HIPAA Compliance of concern to ADAPT personnel:

- ***Privacy***
  - **ADAPT personnel may not use or disclose protected health information unless the patient has authorized or consented, or unless HIPAA specifically permits or requires.**
  - **HIPAA permits ADAPT personnel to use or disclose Patient Health Information (PHI) without patient consent only for Payment and Healthcare Operations.**
- ***Security***
  - **ADAPT personnel will ensure that they do not disclose information that compromises the security, confidentiality, or integrity of Personally Identifiable Information (PII).**
  - **ADAPT personnel will adhere to established policies and procedures and administrative, physical, and technical controls to ensure protection of PII.**
- ***Standard Electronic Transactions***
  - **ADAPT personnel with adhere to the HIPAA requirement that providers doing business electronically will use the same standardized health care transactions, code sets, and identifiers.**
  - **Standard transactions for Electronic Data Interchange (EDI) to transmit health care data include: Claims and encounter information, payment and remittance advice, and claims status and inquiry.**

E. Credit Balances. Credit balances occur when payments, allowances, or charge reversals posted to an account exceed the charges to the account. The appropriate manager will diligently review the claims/account reports for credit balances and determine the reason for occurrence and required action.

F. Integrity of Data Systems Procedures. To ensure and maintain the accuracy and integrity of electronic data systems used for claims submission, collections, credit balances and other relevant reports, ADAPT will:

- Ensure data is backed up either by diskette, restricted system, or tape on a regular basis.
- Ensure regularly scheduled virus checks are performed.
- Ensure electronic data is protected against unauthorized access or disclosure by limiting access to data systems to only authorized personnel (password protected).

G. Retention of Records.

- Each employee is responsible for the integrity and accuracy of ADAPT's documents and records, not only to comply with regulatory and legal requirements, but also to ensure that records are available to defend business practices and actions.
- No one may tamper with, alter, or falsify information on any record or document.
- Medical and business documents and records are retained in accordance with the law and service specific records retention policy.
  - Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities.
  - This also includes:
    a. All records and documentation required by either Federal or State law and the program requirements of Federal, State and private health plans (for billing companies, this will include all documents related to the billing and coding process).
    b. Records listing the persons responsible for implementing each part of the compliance plan.

c. All records necessary to protect the integrity of the billing office's compliance process and confirm the effectiveness of the program.

- No one may remove or destroy these documents prior to the specified destruction date.

H. **Compliance as an Element of a Performance Plan.** The promotion of and adherence to the elements of this compliance program will be a factor in evaluating the performance of all employees. All managers and supervisors involved in the claims submission, collection, auditing, etc., processes will:

- Discuss with all supervised employees and relevant contractors the compliance policies and legal requirements applicable to their function.
- Ensure employees are periodically trained in new compliance policies and procedures.
- Inform all supervised personnel that strict compliance with these policies and requirements is a condition of employment.
- Disclose to all supervised personnel that the organization will take disciplinary action up to and including termination for violation of these policies or requirements.
- Be sanctioned for failure to instruct adequately their subordinates or for failure to detect noncompliance with applicable policies and legal requirements, where reasonable diligence on the part of the manager or supervisor should have led to the discovery of any problems or violations.

Element 2: Designation of a Compliance Officer and a Compliance Committee. To ensure an effective Compliance program, the organization will designate a Compliance Officer.

A. The ADAPT **Compliance Officer**, Peggy DeLaFuente, 517-279-7531, will:

- Oversee and monitor implementation of the Compliance Program.
- Review the program to ensure relevance and compliance with current Federal laws, and Service policy.
- Ensure the components of the Compliance Program are implemented to reduce fraud, waste, abuse, and mismanagement within the business office and throughout the revenue cycle.
- Ensure that contractors, vendors, and agents who furnish medical services to the organization are aware of the compliance program and its respective coding and billing policies and procedures.
- Have the authority to review all documents and other information relevant to compliance activities.

- **Assist the business office and internal review activities in conducting internal compliance reviews, including reviews of departments involved in the revenue cycle within the facility.**
- **Investigate issues related to compliance.**
- **Take corrective action and document compliance issues as necessary.**
- **Encourage reporting of suspected fraud, waste, abuse, or mismanagement (without fear of retaliation) through training and other means of communication.**
- **Notify employees of applicable regulations, procedures, and guidelines.**
- **Report to the organization's Executive Director on a regular basis, the progress of the compliance program. Similarly, report the results of any audits, or fraud, waste, abuse, and mismanagement investigations.**
- **Work cooperatively with hiring personnel to ensure the proper initial training of employees occurs and is documented.**
- **Work cooperatively with the organization's Training Coordinator to ensure the proper annual training of employees occurs and is documented.**

B. The Compliance Committee will be chaired by the Compliance Officer and will meet at least quarterly. The Committee will review the Compliance plan and its effectiveness annually, and more often if deemed necessary. The Compliance Committee will assist the Compliance Officer with developing standards of conduct and policies, reviewing the effectiveness of compliance education and training practices, identifying potential areas of risk and providing recommendations for addressing risk areas. The Compliance Committee will consist of:

- ❖ **The Corporate Compliance Officer**
- ❖ **Branch County Director of Services**
- ❖ **St. Joseph County Director of Services**
- ❖ **Executive Director**

Element 3: Conducting Effective Training and Education.

- **Initial Compliance Training. All new employees of the organization will receive an initial training session that will cover the topics and guidance set forth in this plan before they begin their assigned duties. A statement acknowledging the employee's commitment to and receipt of the compliance plan and code conduct will be signed and dated, and retained in the employee's personnel file.**
- **Ongoing Compliance Training. All employees will review the Corporate Compliance plan on an annual basis, and a signed attestation form placed in the personnel file will provide evidence of review. The Corporate Compliance officer will share periodic messages, articles, etc., in an effort to keep compliance training relevant.**

Element 4: Developing Effective Lines of Communication.

- Access to the Compliance Officer: Access to the Compliance Officer is available through a scheduled appointment, phone call, mail or email. The compliance officer will make every attempt to be visible for any member of the organization that needs assistance in determining compliance issues and conduct. As an advocate of compliance-related issues and conduct, the Compliance Officer works and communicates closely with the chain of command to ensure the organization is operating within the State and Federal laws:
  - The ADAPT Compliance Officer, Peggy DeLaFuente 517-279-7531
  - The form, ***ADAPT COMPLIANCE COMPLAINT/INQUIRY INVESTIGATION***, should be completed by the complainant and submitted to peggy@adaptinc.org or at 202 Morse Street, Coldwater, MI 49036 either by mail or in person.
  - Complainants may submit complaints anonymously. However, without identifying or contact information, it will be difficult to follow up with the Complainant. The Corporate Compliance Officer will complete and maintain an investigative summary report.
- Additionally, employees may use other agencies to report suspected healthcare billing-related fraud, waste, abuse or mismanagement:
  - Pines Behavioral Health, William Smith 517-278-2129
  - St. Joe Community Mental Health, Judi Hall 269-467-1000

Element 5: Enforcing Standards through Well-Publicized Disciplinary Guidelines.

Disciplinary action will be applicable to all individuals within the organization who fail to comply with their obligations. When there is information of potential violations or misconduct, the Compliance Officer has the responsibility of conducting an investigation. An internal investigation would include interviews and a review of medical records, billing, and other relevant documents. To assure protections from coerced disclosure of information gained through investigative interviews, the investigation maybe referred to qualified legal counsel. The attorney/client privilege will afford a level of protection in the event that the OIG or other agency requests information developed in the course of an internal investigation.

A. New Employee Policy. New employees and other individuals new to the organization or position will be trained to ensure that their work is consistent with standards to prevent fraud, waste, abuse, or mismanagement. The organization is responsible for providing the same training to individuals who may provide services for ADAPT (such as an independent contractor) even though these individuals are not employees of the organization.

B. ADAPT's management will institute appropriate disciplinary actions against staff members and contract employees who do not follow the policies and procedures. This Corporate Compliance Plan can be found at ADAPT's website.

Element 6: Responding to Detected Offenses and Developing Corrective Action Initiatives.

A. Common compliance violations that can result in disciplinary action:

- Involvement in non-compliant conduct and/or activity;
- Failure to report known non-compliant conduct and/or activity.
- Supervisors who were aware or should have been aware of non-compliant conduct or activity and failed to correct deficiencies.

B. Investigations and Reporting Procedures: All violations will be assessed by the Compliance Officer to determine whether a violation of the compliance plan actually exists. If so and the persons involved are covered individuals within the organization, then a determination that the conduct was negligence and/or inadvertent or willful and/or knowingly conducted should be made. If the individuals involved are not covered individuals within the organization, then the Compliance Officer will forward their findings to the appropriate agency.

- Negligence and/or Inadvertent Conduct: If it is determined, after investigation that non-compliant conduct occurred because of negligence or inadvertence, the matter shall be handled by the appropriate supervisor, who shall inform the ADAPT Compliance Officer of the offense and corrective action taken to address the problem. Any individual dissatisfied with the corrective action imposed by his/her supervisor may appeal the decision to the ADAPT Compliance Officer within ten (10) business days from the date of imposition of the corrective action. Such appeal shall be by written letter to the ADAPT Compliance Officer stating the reasons why the corrective action is not appropriate. The ADAPT Compliance Officer shall schedule a meeting within seven (7) business days to review the request and either affirm or modify the corrective action.
- Willful, Knowing Conduct and/or Gross Negligence: If it is determined, after investigation, that non-compliant conduct occurred as a result of willful and knowing action or gross negligence, then the matter shall be referred to the ADAPT Compliance Officer for corrective action. The ADAPT Compliance Officer shall determine the response and appropriate corrective action, in light of all available information. An individual dissatisfied with the corrective action imposed by the ADAPT Compliance Officer may utilize standard appeal procedures.

C. **Corrective Actions: Appropriate corrective action measures shall be determined on a case-by-case basis. Disciplinary action, if required, and in the support of the ADAPT Compliance Program will be managed in accordance with the disciplinary policies.**

III. ADAPT COMPLIANCE PROGRAM EFFECTIVENESS.

- **Code of Conduct is located in Section II, *Compliance Program Elements* (Element 1. A.) of this plan. All employees are expected to read the Code of Conduct. Upon hire, all Adapt personnel will be provided a written copy of the plan. Staff signature acknowledges the receipt of the Compliance Plan and the Code of Conduct, which will be maintained in the personnel file.**
- **Regular Review of Compliance Program Effectiveness. The organization's Compliance Plan is intended to be flexible and readily adaptable to changes in regulatory requirements and in the healthcare system as a whole. This plan shall be reviewed annually and modified, as necessary.**

IV. SELF-REPORTING.

If credible evidence of misconduct is discovered and, after reasonable inquiry, it is determined that this misconduct may have violated criminal, civil, or administrative law, then ADAPT's legal office/counsel should be contacted promptly to determine self-reporting requirements.

V. CONCLUSION.

The compliance program, as presented in this document, establishes a framework for effective billing and legal compliance by ADAPT. It does not set forth all of the organization's substantive programs and policies that are designed to achieve compliance. The organization has already established various compliance policies. Those and future policies will be a part of the organization's overall compliance enforcement program.

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