Mid-State Health Network
Compliance Training

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Compliance Staff for The Right Door

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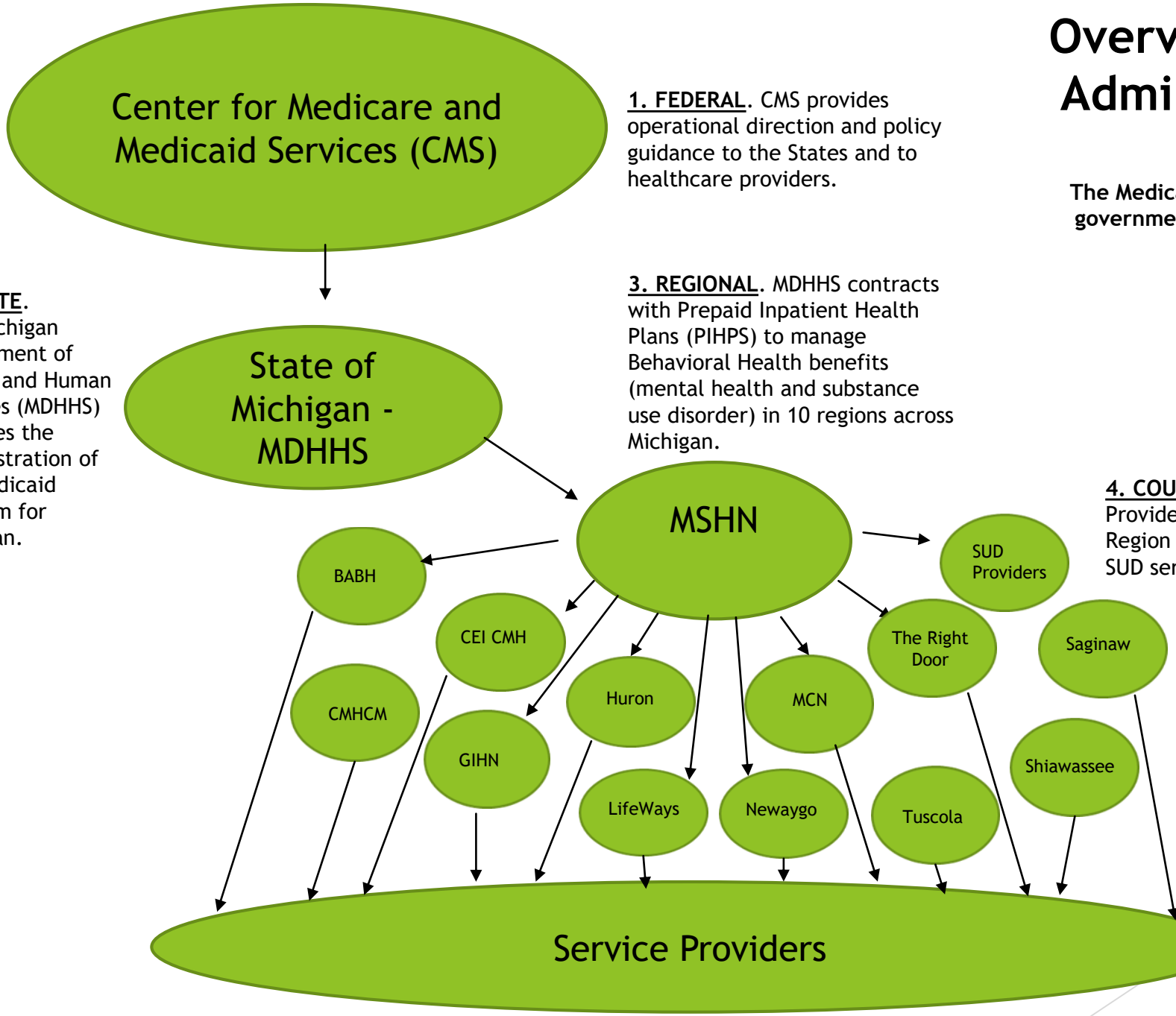
- Security Officer:

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.

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

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. MSHN contracts with SUD Providers and with each of the CMHSPs in Region 5 to provide Mental Health and SUD services to Region 5 customers.

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

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.
  - BUT, Compliance is MORE than a program within an organization, it is an organization-wide philosophy that guides decision-making processes.

- 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.

The Seven Elements of an Effective Compliance Program

1. Implementing written policies, procedures, and standards of conduct

   Code of Ethics; Corporate Compliance Plan; Policies & Procedures

2. Designating a compliance officer and compliance committee

   Compliance Officer Susan Richards; Compliance Committee

3. Conducting effective training and education

   Orientation within 90 days of hire. Annual compliance training requirement. Training provided as needed throughout the year on compliance concerns or changes that emerge or come into affect.

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 Review and Monitoring; Provider Network Reviews; Audits; Clinical Record Reviews; Medicaid Event Verification

6. Enforcing standards through well-publicized disciplinary guidelines

   Contained in Code of Ethics, 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.).

MSHN STANDARDS OF CONDUCT

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 Fraud, Waste and Abuse
- 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)

The Right Door for Hope Recovery and Wellness Code of Ethics

- Review – in Guide to Services or Procedure HR 511.1
  - For Guide to Services Handbook
  - For Procedure HR 511.1 CLICK HERE

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 the 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.

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.

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Deficit Reduction Act 2005

- 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

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FEDERAL FALSE CLAIMS ACT

- 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 is required!!**

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FEDERAL FALSE CLAIMS ACT

- 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
  - Substantiated violations of other health care laws
- Penalties:
  - Civil monetary penalties ranging from $5,500 to $11,000 for EACH false claim;
  - 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.
  - Penalties provided for under other health care laws that were violated.

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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??

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FEDERAL FALSE CLAIMS ACT

PROBLEMS??

- 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.

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MICHIGAN FALSE CLAIMS ACT

- 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.

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OTHER APPLICABLE LAWS

Anti-Kickback Statute [42 USC § 1320a-7b(b)]

- Health care providers and suppliers MAY NOT offer, pay, solicit or receive anything of value in exchange for the referral of patients or services covered by Medicaid or Medicare.
- Fines can include up to $25,000 per violation and up to 5 years in prison per violation

Exclusion Authorities (Federal and State)

- 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.
- Federal:
  - Federal exclusions are imposed under the Social Security Act, 42 USC § 1320a-7. They are mandatory and permissive. Examples of mandatory exclusions are: conviction of a crime relating to patient neglect or abuse, felony conviction of health care fraud, etc. Examples of permissive exclusions are: misdemeanor conviction relating to health care fraud, conviction relating to fraud in a non-health care program, etc.
  - Examples of Mandatory Exclusions:
    - Conviction of program related crimes
    - Conviction relating to patient abuse
    - Felony conviction related to health care fraud
    - Felony conviction related to controlled substance

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OTHER APPLICABLE LAWS

- Examples of Permissive Exclusions: (this is not an exhaustive list)
  - Conviction relating to fraud
  - Conviction relating to obstruction of an investigation or audit
  - Misdemeanor conviction relating ot controlled substance
  - License revocation or suspension
  - Exclusion or suspension under Federal or State health care program
  - Claimss for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services
- https://exclusions.oig.hhs.gov/ is the link to the federal exclusions database. The federal list is commonly referred to as the LEIE – 'List of Excluded Individuals and Entities'. Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties.
- https://oig.hhs.gov/exclusions/ - this link explains all the information on the federal Exclusions website.
- State:
  - Social Welfare Act, MCL 400.111a-f

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OTHER APPLICABLE LAWS

Civil Monetary Penalties Law (42 USC § 1320a – Federal)

- 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 (18 USC 1347 - Federal)

- 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.
- With respect to violations of this statute, a person does not need to have actual knowledge of this section or specific intent to commit a violation of this section

Stark Law

- U.S. federal laws that prohibit physician "self-referral", specifically, a physician may not refer a Medicare or Medicaid patient to an entity providing designated health services ("DHS") if the physician or an immediate family member of the physician has a financial relationship with that entity.

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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.

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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

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

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

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 15: Record Keeping)

- The clinical record must be **sufficiently detailed** to allow reconstruction of what transpired for each service billed.
- All documentation must be **signed and dated** by the rendering health care professional
  - Documentation, including signatures, must be **legible**
  - If a signature is not legible, the clinician's name and credentials should be printed below
- 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 the following:
  - Goal(s) and/or Objective(s) of the Plan of Service addressed
  - Progress/lack thereof toward desired outcome

PRIVACY & CONFIDENTIALITY
Behavioral Health Records

Major 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…"
- Prohibits even acknowledging an individual as a recipient of services
- Requires a very specific, detailed Release of Information (ROI)
- Requires information that is disclosed include a Prohibition on Redisclosure
- No information regarding a client should be released without a valid, 42 CFR Part 2-compliant ROI

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 *(insert PIHP name)*, for the purpose of auditing a single date of service. External Provider should provide only the information necessary for (insert PIHP name) 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. Coordination of Care is a more limited disclosure purpose than HIPAA's "Operations".

HIPAA Privacy and Security Scenarios*

- Review Scenarios at this time
  - *for internal direct providers of The Right Door

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.**

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 for investigation.
- Examples:
  - Sending a letter containing PHI to the wrong address
  - Medical records/laptop being lost or stolen
  - Posting about a consumer on social media

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.

Enforcement Efforts

- 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 MSHN 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.

MSHN Compliance Reporting

Compliance Hotline: 844.793.1288

In-person, by telephone, or via email to:
Kim Zimmerman, 517.657.3018 ,
kim.zimmerman@midstatehealthnetwork.org

CMH Compliance Reporting

Compliance Hotline: 616.775.1031
In-person, by telephone, or via email to:
Susan Richards, 616-775-1031,
srichards@rightdoor.org