

ANNUAL COMPLIANCE & HIPAA REFRESHER TRAINING

Overview of Medicaid Program Administration for Behavioral Health Services

The Medicaid Program is funded by both the federal & state governments & is directly administered by the states with approval & oversight by the Centers for Medicare & Medicaid Services (CMS)

2. STATE

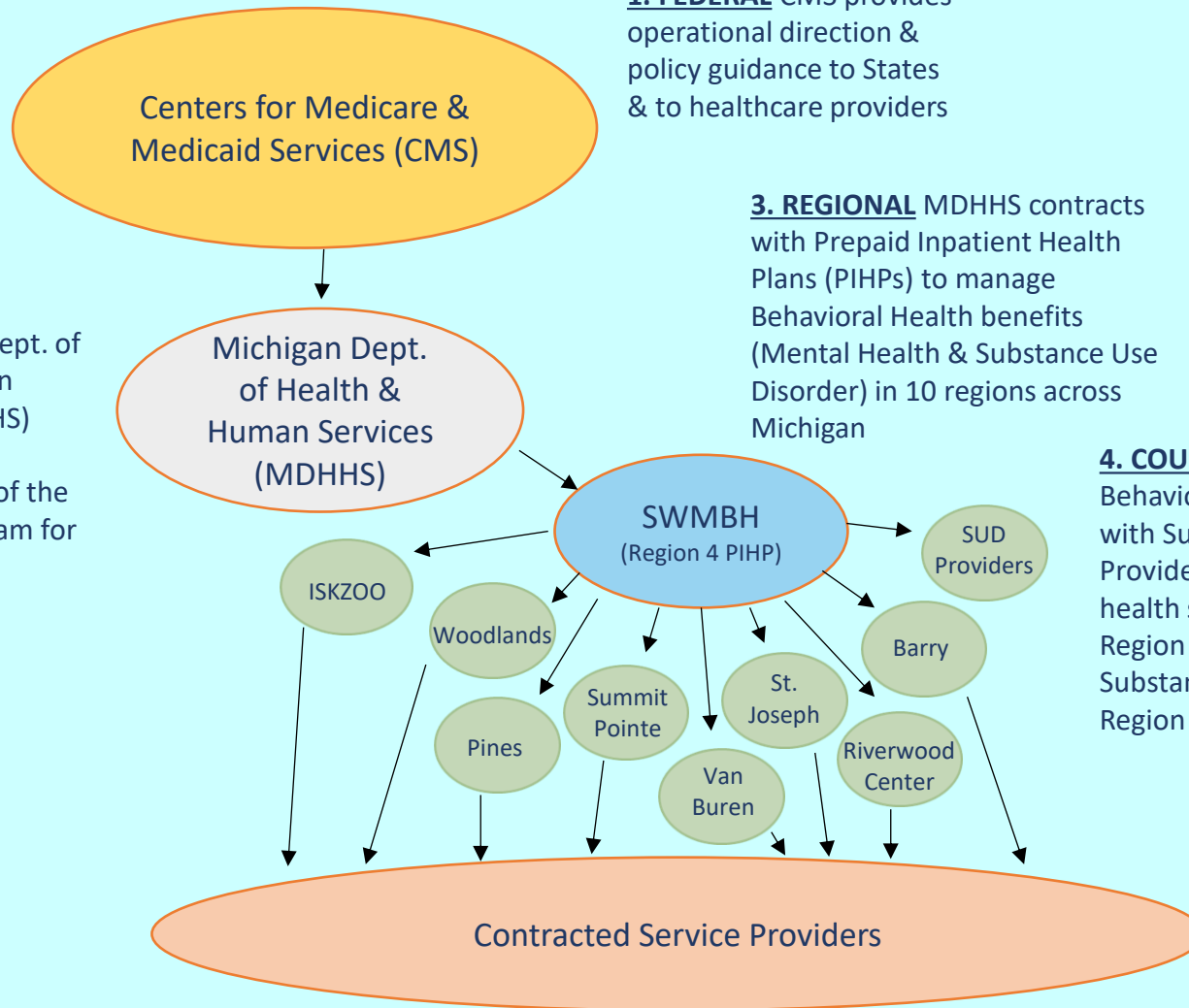
The Michigan Dept. of Health & Human Services (MDHHS) oversees the administration of the Medicaid Program for Michigan

1. FEDERAL CMS provides operational direction & policy guidance to States & to healthcare providers

3. REGIONAL MDHHS contracts with Prepaid Inpatient Health Plans (PIHPs) to manage Behavioral Health benefits (Mental Health & Substance Use Disorder) in 10 regions across Michigan

4. COUNTY Southwest Michigan Behavioral Health (SWMBH) contracts with Substance Use Disorder (SUD) Providers & with each community mental health service provider (CMHSP) in Region 4 to provide Mental Health & Substance Use Disorder services to Region 4 consumers

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



What is Healthcare Compliance?

Doing the Right Thing!

- Conducting yourself in an honest & responsible manner
- Adhering to ethical standards & your agency's Code of Conduct
- Following the laws & rules that govern healthcare
- Preventing, detecting & reporting Fraud, Waste & Abuse (FWA) of federal & state funds
- Preventing, detecting & reporting unethical & illegal conduct
- Ensuring funds are used appropriately
- **Everyone** has a responsibility to report suspected non-compliance

Why is Healthcare Compliance Important?

- Each year, billions of dollars are lost due to Fraud, Waste & Abuse (FWA) in the healthcare system
- FWA increases the financial strain on Medicaid & Medicare programs & could result in harm to consumers & less money for everyone
- FWA divert dollars that could otherwise be spent to safeguard the health & welfare of beneficiaries.
- Prosecuting healthcare fraud remains a top priority for the Dept. of Justice (DOJ) & Dept. of Health & Human Services (HHS), Office of Inspector General (OIG)
- The OIG's mission is to protect the integrity of HHS programs & the health & welfare of the people they serve

Why is Healthcare Compliance Important?

- Ensures compliance with federal & state laws, policies & procedures & ethical standards
- Promotes an organizational culture that encourages ethical conduct & commitment to compliance with the law
- Helps prevent & detect Fraud, Waste & Abuse of federal & state funds
- Ensures funds are used appropriately
- Identifies potential areas of vulnerability to help minimize risk
- Demonstrates agency commitment to honest & responsible conduct

Office of Inspector General (OIG) Enforcement

Spring 2026 Semiannual Report to Congress for 10/01/25 – 3/31/26

At a Glance:

OIG Accomplishments

October 1, 2025–March 31, 2026



MONETARY IMPACT*†



OIG's work returns \$12.70 in expected recoveries and receivables for every \$1 invested.



OVERSIGHT ACTIVITIES



78

Reports
Issued



173

Recommendations
Issued



881

Investigations
Completed



182

Recommendations
Implemented

*Totals in appendices may differ and numbers in figures may not sum due to rounding.

†See Appendix E for an explanation of terms.

ENFORCEMENT ACTIONS



1,212

Excluded Individuals
and Entities



245

Criminal Informations
and Indictments



1,168

Criminal Referrals



317

Criminal Actions



287

Civil Actions

Recent Examples of Enforcement Action

7/02/26 – Attorney General, State of Connecticut - Announced a \$710,815.34 settlement with Trading Spaces ABA, LLC, a defunct former autism provider & its owner, resolving allegations under the Connecticut False Claims Act that Trading Spaces & its owner knowingly submitted or caused the submission of false or fraudulent claims for payment to the Connecticut Medical Assistance Program, which includes the Medicaid Program, for autism treatment services that were not provided

7/06/26 – Tennessee Bureau of Investigation – Four Memphis women face charges of TennCare fraud following an investigation by special agents with the Medicaid Fraud Control Division (MFCD) of the Tennessee Bureau of Investigation. MFCD agents received a fraud referral from the TennCare Office of Program Integrity alleging that four paid caregivers had submitted fraudulent time records

Seven Core Elements of Compliance

Required by the Office of Inspector General (OIG)

1. Written Code of Conduct as well as policies & procedures that promote a commitment to compliance
2. Compliance Officer, Compliance Committee & high-level oversight
3. On-going education & training
4. Open lines of communication available for reporting issues
5. Enforcement of standards
6. On-going auditing & monitoring to identify risk areas
7. Prompt response to compliance issues & corrective action



**Now, for a quick review of some of the
important laws that impact Healthcare**

LAWS
you need to
KNOW

Deficit Reduction Act (DRA) of 2005

- In 2006, President Bush signed into law provisions designed to reduce federal spending & improve oversight across a variety of government programs including Medicare & Medicaid. It includes provisions to eliminate Fraud, Waste & Abuse (FWA)
- Section 6032 requires healthcare providers who receive over \$5M in annual Medicaid payments to provide detailed information to employees including written policies on state & federal False Claims Acts, whistleblower provisions & other applicable laws
- Requires education & training for employees & contractors that contains detailed information on these laws as well as information about how to prevent & detect FWA in federal healthcare programs
- Failure to comply with these requirements may cause ineligibility to receive Medicaid payments

Anti-Kickback Statute

- Healthcare providers may not offer, pay, solicit or receive anything of value in exchange for the referral of consumers or services covered by Medicaid or Medicare
- Ensures healthcare decisions are based on medical necessity & not profit motives
- Punishable by prison time up to 10 years or fines up to \$100,000 or both

Exclusion Authorities

- Healthcare providers must ensure no federal funds are used to pay for items or services furnished by an individual who is disbarred, suspended or excluded from participation in federal healthcare programs.
- The Office of Inspector General (OIG) has the authority to exclude certain individuals or entities from participation in federal healthcare programs. Fraud, abuse, neglect or unlawful distribution of controlled substances are examples of actions that could result in exclusions

Civil Monetary Penalties Law (CMPL)

- Allows the Office of Inspector General (OIG) to impose civil monetary penalties (fines) up to \$100K or more for violations of the Anti-Kickback Statute & other violations including submitting false claims & making false statements on applications or contracts to participate in a federal healthcare program

Criminal Healthcare Fraud Statute

- Makes it a criminal offense to knowingly & willfully execute a scheme to defraud a healthcare benefit program or obtain money or property from a healthcare benefit program by false or fraudulent means
- Healthcare fraud is punishable by prison time up to 10 years & fines up to \$250K (per individual) & fines up to \$500K (per organization). Specific intent is not required for conviction

Federal False Claims Act (FCA)

- Federal law that imposes liability on individuals & organizations that knowingly submit false or fraudulent claims for payment to the government
- 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

Federal False Claims Act (FCA)

- The federal government has implemented measures to identify fraudulent practices among healthcare organizations
- The Federal False Claims Act was originally enacted in 1863 during the Civil War, largely in response to fraud involving defense contractors/suppliers
- Penalties for Violations:
 - Civil monetary penalties ranging from \$14K - \$28K (as of recent inflation adjustments) for each false claim
 - Treble damages – Three times the amount of the government's actual losses related to the fraudulent or abusive conduct
 - Exclusions from participating in state & federal programs
 - Federal criminal enforcement for intentional participation in the submission of a false claim

What are some examples of things that would violate the False Claims Act (FCA)?

- Billing for services that were never provided to the consumer
- Billing for more time than what you spent (face-to-face) with the consumer (e.g., upcoding, padding times, rounding times)
- Billing for unnecessary services. Services must be medically necessary
- Billing for services performed by an excluded individual
- Falsifying or manipulating documentation, such as:
 - Creating documentation for services that weren't performed
 - Altering records to support a higher level of billing
 - Submit false or fabricated documentation

Michigan False Claims Act (FCA)

- State law that prohibits knowingly making or presenting false claims, false records, or false statement involving Medicaid
- Applies specifically to claims & conduct involving Michigan's Medicaid program
- “Knowingly” includes:
 - Actual knowledge
 - Deliberate ignorance of the truth
 - Reckless disregard of the truth
- Violations can result in civil penalties including fines of \$5K - \$10K per false claim + 3x damages incurred by the State. Criminal penalties could bring felony conviction, prison time up to 4 years & fines up to \$50K

Whistleblower Protection Act

- Designed to protect against the fraudulent use of public funds by encouraging people with knowledge of fraud to “blow the whistle” on wrongdoers
- Provides legal protection to employees who report violations or suspected violations of federal, state or local law or participate in related investigations or actions
- Promotes transparency, accountability & non-retaliation
- Employers may not discharge, threaten or discriminate against an employee regarding the employee’s compensation, terms, conditions, location, or privileges of employment
- Under the Michigan Whistleblower's Act, employers in violation could face civil fines up to \$500

Review of Definitions - Fraud

- Intentional deception or misrepresentation made by a person with knowledge the deception or misrepresentation could result in benefit to said person or another person. Includes any act that constitutes fraud under applicable federal or state laws
- Examples include billing for services not provided, performing medically unnecessary services solely to obtain payment, altering documentation to obtain higher payment (upcoding), falsifying or altering medical records to justify tests, treatments or services & deliberate duplicate billing for the same service

Review of Definitions - Waste

- Overutilization of services, or other practices that result in unnecessary cost to the payer. Waste generally involves the inefficient or unnecessary use of healthcare resources rather than intentional deception or misrepresentation
- Examples include healthcare spending that can be eliminated without reducing the quality of care, unnecessary costs resulting from inefficient or ineffective practices, systems or controls, unnecessary or excessive tests & procedures, unnecessary or excessive prescriptions or unnecessary or excessive consumer visits



Review of Definitions - Abuse

- Practices that are inconsistent with sound fiscal, business or medical practices & result in unnecessary costs to the payer, reimbursement for services that are not medically necessary or services that fail to meet professionally recognized standards of care
- Examples include misuse of billing codes or failure to follow applicable billing requirements, inappropriate or excessive charges for services, billing Medicare as the primary payer when another insurer is responsible for payment or other practices that result in unnecessary costs or improper reimbursement
- Abusive practices may rise to the level of fraud when there is evidence of intentional deception or misrepresentation to obtain an unauthorized benefit



Service Documentation Requirements

- Michigan Medicaid Provider Manual, Section 14: Record Keeping states:
 - Providers must maintain, in English & in a legible manner, written or electronic records necessary to fully disclose & document the extent of services provided to beneficiaries
 - The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed & dated by the rendering health care professional
- You have a responsibility to ensure that you bill accurately for the services you provide. All claims must be supported by complete & accurate documentation. **If you bill it, the documentation needs to support it**
- Supporting documentation should accurately reflect the services provided on each date of service & should not contain copied or duplicative entries that do not accurately reflect what took place during the contact

Service Documentation Requirements

SWMBH Operating Policy 12.11, Section D (Progress Note Documentation) states:

- Progress note documentation must correspond to the member's IPOS/plan of care, including current status, progress toward specific goals & objectives addressed during the encounter & interventions offered by the clinician/staff during the encounter & shall include these mandatory elements (non-exhaustive list):
 - Customer's legal name
 - Service provided
 - Clinician/staff member providing the service/credentials (if applicable)
 - Other persons present during the service
 - Location or method of delivery (office, home, community, telephone)
 - Date of service
 - Start & stop time of the encounter (duration)
- Service documentation or progress notes must be completed & be part of the consumer record within a reasonable time period **after the deliver of the service & prior to the submission of the claim or encounter**

Error Protocol for Handwritten Documentation

- Proper error correction procedures should be used when an error is made on handwritten documentation
 1. Draw a line through the entry
 2. Make sure the original information is still legible
 3. Write “error” by the incorrect entry & state the reason for the error in the margin or above the note
 4. Sign/initial & date the entry
 5. Document the correct information
 6. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line, documenting the current date & time & referring to the original entry
 7. Do not obliterate, alter or permanently erase the original entry – do not use white-out, black marker or write over the original information
- Documentation must clearly show what was originally recorded & what was corrected. Inadequately supported documentation may be subject to audit review & potential recoupment

Additional Reminders

- For general rules for reporting & other helpful information regarding billing codes, code descriptions, provider qualifications, place of service (POS) codes & modifiers, please see the SFY 2026 Behavioral Health Code Sets, Charts & Provider Qualifications Document on the MDHHS website at <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting>
- Providers are responsible for familiarizing themselves with applicable billing & documentation requirements & ensuring claims are accurate
- Before submitting a claim, ask:
 - Was the service actually provided?
 - Was it medically necessary & within the scope of the provider's qualifications?
 - Does the documentation support the service, date, time & level of service billed?
 - Is the correct code, modifier & place of service being reported?
 - Is the claim being submitted to the correct payer?

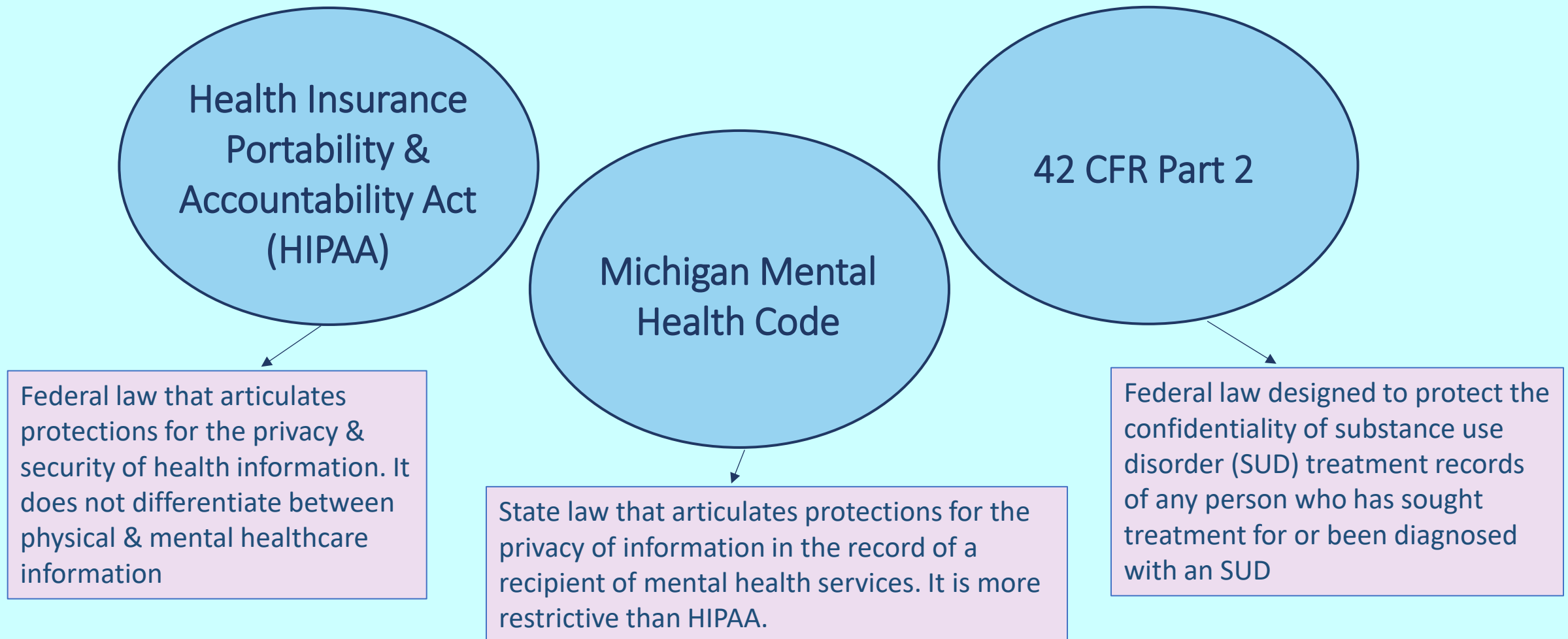
Enforcement Agencies

- Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Dept. of Health & Human Services (HHS) that administers Medicare & works with states to administer Medicaid
- Office of Inspector General (OIG) is a federal HHS office responsible for oversight, audits, evaluations & investigations involving fraud, waste & abuse & other misconduct
- MI Office of Inspector General (OIG) investigates fraud, waste & abuse involving Michigan health & human services programs
- Dept. of Justice (DOJ) is a federal agency responsible for enforcing federal criminal laws & prosecuting federal offenses
- Michigan Attorney General (AG) investigates & prosecutes certain fraud & other violations of Michigan law, including Medicaid fraud
- Audits, reviews & investigations may occur at the federal & state levels

Consequences of Compliance Violations

- Civil & criminal enforcement actions
- Exclusion from federal & state healthcare programs
- Civil Monetary Penalties Law (CMPs) under applicable laws
- Corporate Integrity Agreements (CIAs) could be imposed
- Recoupment of funds & Corrective Action Plans (CAPs)
- Disciplinary action or termination of contract
- Audits, reviews & investigations at local, state & federal level
- Increased scrutiny & oversight
- Reputational harm to the service provider
- Legal expenses & litigation costs

Privacy & Confidentiality – Three Governing Laws



Health Insurance Portability & Accountability Act (HIPAA)

- HIPAA is a federal law enacted in 1996 that establishes standards to protect Protected Health Information (PHI)
- It gives individuals rights regarding their health information & limits how PHI may be used & disclosed
- Includes the Privacy Rule, Security Rule & Breach Notification Rule
- Applies to covered entities such as healthcare providers & their business associates
- **If you have access to PHI, you are responsible for protecting it & following HIPAA requirements**

What is Protected Health Information (PHI)?

- Individually identifiable health information in electronic, paper or oral form that is created, received, maintained or transmitted by a healthcare provider or business associate
- Includes information about an individual's past, present or future health condition, treatment or payment for healthcare
- Includes information that identifies an individual or could reasonably be used to identify the individual
- Examples include name, address, DOB, SSN, medical records, diagnoses & treatment information

HIPAA Privacy Rule

- HIPAA Privacy focuses on the rights of the individual & their ability to control their Protected Health Information (PHI)
- Defines how PHI can be used & disclosed
- Requires healthcare providers to protect PHI
- HIPAA Privacy is the *overarching concept* that applies to **all** PHI.
- HIPAA Security is an aspect of HIPAA privacy, but it refers **specifically to the security of electronic PHI (ePHI)**



HIPAA Security Rule

- Healthcare providers must protect the confidentiality, integrity & availability of **electronic PHI** (ePHI) such as ePHI sent via email or stored in an Electronic Health Record (EHR)
- Requires administrative, physical & technical safeguards to protect ePHI from unauthorized access, use, disclosure & security threats
- Use e-mail encryption
- Avoid using free email platforms when conducting business. Use only approved, secure methods for transmitting ePHI
- Be alert for phishing scams & other security threats
- Ensure workforce compliance

Security Threats in Healthcare

- Healthcare data is a valuable target for cybercriminals
- Common threats include:
 - Malware, ransomware & hacking
 - Lost or stolen devices
 - Phishing emails & attachments
- How you can help:
 - **Think before you click!** Don't open suspicious emails or attachments
 - Report suspicious activity to your IT Dept. immediately
 - Keep electronic devices secure & protected
 - Use strong passwords & two-factor authentication (2FA)
- When in doubt, ask!



Security Threats in Healthcare

- Phishing is a deceptive attempt to trick you into providing confidential information or clicking a malicious link or attachment
- Warning signs include:
 - Poor grammar, spelling or unusual wording
 - Fuzzy, altered or unusual logos
 - Requests for passwords, payment information or other sensitive information
 - Urgent or threatening requests for immediate action
 - Unexpected or unusual emails
 - Ask yourself is the email out of ordinary or unexpected
- Trust your gut! If it looks phishy, stop & ask before you click!



Health Insurance Portability & Accountability Act (HIPAA)

- HIPAA permits the use & disclosure of PHI for Treatment, Payment & Healthcare Operations (TPO) without consumer authorization
- **Treatment** – Activities related to providing & coordinating consumer care
- **Payment** – Activities related to billing & payment for healthcare services
- **Operations** – Day-to-day activities such as quality improvement, training & management

Michigan Mental Health Code

- Information in a consumer's record & information obtained while providing mental health services must be kept confidential
- Michigan law allows certain disclosures for Treatment, Payment & Coordination of Care consistent with HIPAA
- When required, obtain a valid Authorization to Release Information before disclosing
- When in doubt, follow your agency's confidentiality policies & procedures
- If you have questions, contact your agency's Compliance Officer or the CMHSP's Compliance Officer



Michigan Mental Health Code

- **Coordination of Care** involves activities that help ensure consumers receive timely, appropriate & coordinated services
- Examples include:
 - Care planning & communication
 - Coordinating services among providers & care teams
 - Connecting consumers with community resources
 - Follow-up on referrals & lab tests
 - Monitoring & documenting care
 - Supporting transitions & continuity of care



42 CFR Part 2 – Substance Use Disorder (SUD) Confidentiality

- Federal regulations that provide additional confidentiality protections for SUD treatment records
- Applies to SUD treatment programs & providers covered by Part 2
- Generally, information about a person's participation in an SUD treatment program cannot be disclosed without appropriate authorization, unless an exception applies
- Part 2 requirements may apply in addition to HIPAA
- Updated in 2024 to better align with HIPAA while maintaining additional protections

Need to Know & Minimum Necessary

- Access PHI only when necessary to perform your job duties
- If you don't need the information to do your job, don't access it
- PHI should never be accessed out of curiosity or for personal reasons
- Make reasonable efforts to limit the use, disclosure & requests for PHI to the minimum necessary to accomplish the intended purpose
- Request, use or disclose only the PHI needed to perform your job duties

Protect consumer health information as if it were your own!

Breach Notification

- A breach is an unauthorized acquisition, access, use or disclosure of PHI that compromises its privacy or security
- Depending on the circumstances, a breach may require notification to the consumer & or regulatory agencies & other mitigation efforts
- Examples:
 - Lost or stolen laptop or records containing PHI
 - Posting consumer information on social media
 - Faxing PHI to the wrong person
 - Emailing PHI to the wrong person
 - Discussing PHI with someone who is not authorized to receive it
 - Leaving consumer documents or PHI visible or unattended in a public area

Consequences of a Breach

- Harm to the consumer, including potential fraud or identity theft
- Required notification to consumers & regulatory agencies
- Civil monetary penalties of up to \$68,928 per violation, depending on the circumstances
- Corrective Action Plans (CAPs)
- Loss of consumer & community trust
- Damage to provider's reputation
- Disciplinary action or termination of contract
- Legal expenses & litigation costs
- Increased scrutiny, investigations & oversight



Enforcement Responsibility

- The U.S. Dept. of Health & Human Services (HHS) Office of Civil Rights (OCR) is responsible for enforcing HIPAA
- The OCR may:
 - Investigate complaints filed
 - Conduct compliance reviews to determine if healthcare providers are complying with the law
 - Perform education & outreach to foster compliance with the requirements of the law
 - Work in conjunction with the Department of Justice (DOJ) to refer possible criminal violations of HIPAA
 - OCR may impose civil monetary penalties for HIPAA violations

Recent Example of Enforcement Action

7/29/26 - The Office for Civil Rights (OCR) announced a settlement with OSF Healthcare for an incident involving a Nephilim ransomware attack discovered back in April 2021. PHI of 53,907 individuals was exfiltrated

The OCR investigation found inadequate HIPAA risk analysis, impermissible disclosure of PHI & untimely notifications to affected individuals & OCR

The OCR issued a Corrective Action Plan (CAP) requiring a comprehensive risk analysis & implementation of a risk management plan addressing identified ePHI security risks that will be monitored for 2 years. OSF agreed to pay \$552,250 to OCR

A thorough, current HIPAA Security Rule risk analysis is fundamental to identifying & mitigating ransomware & other ePHI security risks

HIPAA Enforcement Results: Latest Available Data

- Since the Privacy Rule compliance date in April 2003, the Office for Civil Rights (OCR) has received over 374,321 HIPAA complaints & initiated 1,193 compliance reviews. They have resolved 99% of these cases (370,578)
- The most frequently alleged compliance issues, compiled cumulatively, are:
 - Impermissible uses & disclosures of PHI
 - Lack of safeguards of PHI
 - Lack of consumer access to their PHI
 - Lack of administrative safeguards of ePHI (electronic PHI)
 - Use or disclosure of more than the minimum necessary PHI
- As of October 31, 2024, the OCR has settled or imposed civil monetary penalties in 152 cases, totaling \$144,878,972

Note: October 31, 2024 is the latest enforcement data published by OCR as of 8/10/26

Reporting Responsibilities

- If you are aware of a Compliance or HIPAA violation including:
 - Fraud, Waste or Abuse (FWA)
 - Whistleblower violations
 - Violations of HIPAA, 42 CFR Part 2 or Michigan Mental Health Code
 - Unethical or illegal conduct

It is your right & your responsibility to report actual or suspected violations to your agency's Compliance Officer & or the CMHSP's Compliance Officer.

You may not be intimidated, threatened, coerced, discriminated against or retaliated against for making a good faith report

Contact Information

If you have questions or concerns, please contact your agency's Compliance Dept. or Riverwood Center's Director of Regulatory Compliance/Privacy Officer

Cynthia Bingaman
Anonymous Hotline

269.934.1632 or clb@riverwoodcenter.org
800.876.2501

Sources:

<http://www.hhs.gov/ocr/office/index.html>

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