Chapter: **CORPORATE COMPLIANCE**
Title: **PROGRAM INTEGRITY**

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Proposed by: Dave Pankotai 02/14/2022
Chief Executive Officer — Date

Approved by: Albert L. Lorenzo 02/15/2022
Albert L. Lorenzo (Feb 15, 2022 17:00 EST)
County Executive Office — Date

I. ABSTRACT

This policy establishes the standards and procedures maintained by Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to prevent and detect Fraud, Waste, and Abuse, and to otherwise ensure that the MCCMH Prepaid Inpatient Health Plan (PIHP) is compliant with the various Program Integrity standards defined by applicable law, including but not limited to the Medicaid Managed Care Rules.

II. APPLICATION

This policy shall apply to the MCCMH Board, all MCCMH administrative/management staff, Access staff, all other MCCMH Workforce Members (collectively, "MCCMH Staff"), as well as to contract network providers of the MCCMH Board and their workforce members, including but not limited to their employees, independent contractors and volunteers (collectively, "Contract Network Providers").

III. POLICY

It is the policy of MCCMH that MCCMH and its network providers will comply with the Federal False Claims Act, the Michigan Medicaid False Claims Act, the Anti-Kickback Statute, the Health Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act, and the Deficit Reduction Act, and that any circumstance that could result in the occurrence of Medicaid Fraud, Waste or Abuse will be promptly addressed.

In furtherance of these objectives, MCCMH will implement and maintain procedures that are designed to detect fraud, waste, and abuse, consistent with the requirements of 42 CFR 438.600 – 438.610.

IV. DEFINITIONS

A. Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

B. Enrollees: A Medicaid beneficiary who is currently enrolled in the MCCMH PIHP.

C. Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable Federal or State law.

D. PIHP Contract: The current contract between MCCMH and the Michigan Department of Health and Human Services (MDHHS), wherein MDHHS contracts to obtain the services of MCCMH to manage the Concurrent 1915(b)/(c) Programs, the Healthy Michigan Plan and SUD Community Grant Programs, and relevant Waivers in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports.

E. Program Integrity: Standards promulgated by the Centers for Medicare & Medicaid Services (CMS) under the Medicaid Integrity Program (MIP), intended to combat Medicaid provider fraud, waste and abuse.

F. Waste: The overutilization or inappropriate utilization of services and misuse of resources.

G. Workforce Member: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for MCCMH, is under the direct control of MCCMH, including but not limited to, administrative and directly-operated network provider employees, independent contractors, and volunteers.

V. STANDARDS

A. Compliance Program: MCCMH will maintain a mandatory Compliance Plan, detailed in Exhibit A to MCCMH MCO Policy 1-001, "Compliance Program / Code of Ethics," which will contain at least the following minimum required elements:

1. Written policies, procedures, and standards of conduct that articulate a commitment to comply with the requirements and standards of the PIHP Contract and all applicable Federal and State laws and regulations;

2. A Chief Privacy and Compliance Officer that is responsible for implementing policies, procedures, and practices designed to ensure compliance with the PIHP Contract, and who reports directly to the Chief Executive Officer and the Board with respect to such compliance activities;

3. A Regulatory Compliance Committee charged with overseeing the Compliance Program and compliance with the PIHP Contract;

4. Effective lines of communication between the Chief Privacy and Compliance Officer and MCCMH Staff and Contract Network Providers;

5. Well-publicized disciplinary guidelines;

6. Procedures and a system with dedicated staff for implementing the following:

    a. Routine internal monitoring/auditing of compliance risks related to Fraud, Waste, Abuse and Privacy including but not limited to the following methods;

        i. Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers;

        ii. Beneficiary interviews to confirm services rendered; and/or

        iii. Provider self-audit protocols.

    b. Prompt response to compliance issues (i.e., action taken within 2 weeks of receipt of information regarding a potential compliance problem) and recommendations for risk mitigation.

    c. For suspected criminal acts, reporting to appropriate law enforcement agencies.

    d. Ongoing compliance with the requirements of the PIHP Contract.

B. Prohibited Affiliations:

1. MCCMH will not knowingly have a "relationship" of the type described in subsection V.B.2 of this policy with any of the following:

    a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;

    b. An individual or entity that is an "affiliate", as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (1)(a) of this section; or

    c. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

2. For purposes of this policy, a "relationship" means someone who MCCMH interacts with in any of the following capacities:

    a. A director, officer, or partner of MCCMH;
    b. A subcontractor of MCCMH;

c. A person with beneficial ownership of five (5) percent or more of MCCMH's equity; or

d. A network provider or person with an employment, consulting or other arrangement for the provision of items and services which are significant and material to the Board's obligations under the PIHP Contract.

C. Screening, Enrollment and Revalidation of Providers:

1. The State will screen and enroll, and periodically revalidate all MCCMH network providers.

2. MCCMH will ensure that all network providers are enrolled with the State as Medicaid providers.

3. MCCMH may execute network provider agreements of a duration of up to one hundred twenty (120) days pending the outcome of the State's screening/enrollment/revalidation process, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, whichever precedes the other, and notify the affected enrollees of such action.

D. MCCMH will verify through a system of regular periodic sampling that any services that have been represented have been delivered by network providers to enrollees. See MCCMH Critical Risk Audit Plan, Exhibit A to MCCMH MCO Policy 3-001, "Audit Content and Timetable."

E. MCCMH will suspend payments to any network provider upon receipt of notice from the State that there is an allegation of Fraud against that provider.

F. MCCMH will maintain written policies that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, and that include information about rights of employees to be protected as whistleblowers. Such policies will be accessible to all MCCMH Workforce Members, including but not limited to all its direct employees and all employees of its contract network providers.

G. Program Data & Information Reporting:

1. As required by the PIHP Contract and applicable law, MCCMH will submit the following information and data to the State:

a. Encounter data in the form and manner described in 42 CFR 438.818;

b. Base data described in 42 CFR 438.5(c), and other data required for the State to certify the actuarial soundness of capitation rates;

c. Information establishing compliance with medical loss ratio requirements described in 42 CFR 438.8;

d. Information establishing that MCCMH has made adequate provision against the risk of insolvency as required under 42 CFR 438.116;

e. Information establishing network adequacy, as set forth in 42 CFR 438.206;

f. Information describing ownership and control of MCCMH and its subcontractors as described in 42 CFR 455.104 and 438.230;

g. An annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3); and

h. Any other data, documentation, or information relating to the performance of MCCMH's Program Integrity obligations required by the State or the Secretary.

2. Certification of Data, Documentation or Information Submitted:

a. Concurrent with its submission, MCCMH will certify and attest that the data described in Subsection V.G.1, above, is accurate, complete and truthful, based on the most accurate information, knowledge, and belief.

b. Certification will be made by the Chief Financial Officer, or a delegate with authority to sign for the Chief Financial Officer.

H. Data & Information Reporting:

1. MCCMH will promptly report the occurrence of any of the following events to the State:

a. Overpayments related to Fraud.

b. Any potential Fraud, Waste, or Abuse identified by MCCMH to the State Medicaid program integrity unit or any potential Fraud directly to the State Medicaid Fraud Control Unit.

c. Receipt of information about changes in an enrollee's circumstances that may affect the enrollee's eligibility, including but not limited to:

i. Changes in the enrollee's residence;
ii. Death of an enrollee.

2. Additional Disclosures. MCCMH will provide the State with a written disclosure of any of the following:

a. Receipt of any information about a change in a network provider's circumstances that may affect eligibility to participate in the managed care program, including the termination of the provider agreement.

b. Any prohibited affiliation under 42 CFR 438.610 (see Section V.B, above).

c. Changes in any information on ownership and control required under 42 CFR 455.104.

d. Capitation payments or other payments in excess of amounts specified in the contract (including recoveries of overpayments due to Fraud, Waste, or Abuse), within sixty (60) calendar days after discovery of such payments.

e. Annually, a report of MCCMH recoveries of overpayments made to providers. Such data will be incorporated into the most recent years cost settlement of the shared risk arrangement between MDHHS and MCCMH in compliance with the cost settlement instructions for the Financial Status Reporting requirements published by MDHHS.

f. Annually, at the commencement of the Fiscal Year, a list of all entities with whom MCCMH has contracted to perform services, regardless of funding type. The list shall contain all facility locations where services are provided or business is conducted, identification of a Compliance Officer, all NPI numbers assigned to the entity and what services the entity is contracted to provide.

NOTE: MCCMH must provide the State with written disclosure of any updates to the information described in this Subsection, on a quarterly basis.

g. "Quarterly Submissions" are described in Section VI.E, below.

I. Contract Network Providers:

1. To the extent that any subcontracted entity is delegated PIHP responsibility by the Board, MCCMH will provide guidance with respect to the subcontracted entities' Program Integrity activities.

a. MCCMH will include Program Integrity provisions and guidelines in all contracts with such subcontracted entities (i.e., Contract Network Providers), which shall address at least the following:

i. Designation of a Chief Privacy and Compliance Officer;

ii. Submission to MCCMH of quarterly reports detailing Program Integrity activities;

iii. Assistance and guidance by MCCMH with audits and investigations, upon request of the subcontracted entity;

iv. Provisions for routine internal monitoring;

v. Prompt response (two weeks) to potential offenses and implementation of corrective action plans;

vi. Prompt reporting of Fraud, Waste and Abuse to MCCMH; and

vii. Implementation of training procedures regarding Fraud, Waste and Abuse for the subcontracted entities' employees at all levels.

2. Network providers shall report to MCCMH when they have identified any overpayment received, return the overpayment to MCCMH within sixty (60) calendar days after the date on which the overpayment was identified, and notify MCCMH in writing of the reason for the overpayment.

3. In the event MDHHS-OIG sanctions a provider, MCCMH will, at minimum, apply the same sanction, and may pursue additional measures/remedies independent of the State.

VI. PROCEDURES

A. MCCMH shall adopt policies and procedures that are consistent with applicable law and that ensure compliance with its Program Integrity obligations.

B. MCCMH and its Contract Network Providers shall each respectively monitor for excluded individuals and entities by screening employees and individuals and entities with ownership or control interests for excluded individuals and entities where the individual or entity would benefit directly or indirectly from receiving Medicaid funds. Screening shall be performed (i) prior to entering a contractual or other relationship, and (ii) monthly thereafter.

C. Reporting Fraud, Waste or Abuse:

1. MCCMH will report all suspicion of Fraud, Waste or Abuse on the Quarterly OIG Submission described in Section VI.E of this policy.

2. Questions regarding whether suspicions should be classified as Fraud, Waste or Abuse will be presented to MDHHS-OIG for clarification prior to making a referral.

3. Documents containing protected health information (PHI) or protected personal information will be submitted in a manner consistent with applicable State and Federal privacy rules and regulations, including but not limited to HIPAA.

D. Investigations:

1. MCCMH will investigate Program Integrity complaints/issues. If it is determined that a suspicion of Fraud exists, MCCMH will contact MDHHS-OIG with updates on the process and amount of recoupment/recovery.

2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA and the Michigan Mental Health Code, MCCMH will cooperate fully with any investigation by MDHHS-OIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

E. Quarterly Submissions: On a quarterly basis, MCCMH will provide information on Program Integrity activities, including but not limited to those related to subcontractors, using either (i) MDHHS-OIG's case tracking system, or (ii) the template provided by the MDHHS-OIG.

1. Program Integrity activities that must be reported upon include, but are not limited to the following:

   a. Complaints and referrals received;

   b. Data mining and analysis of paid claims, including audits performed based on the results;

   c. Audits performed;

   d. Overpayments collected;

   e. Identification and investigation of Fraud, Waste and Abuse;

   f. Corrective action plans implemented;

   g. Provider disenrollment's;

   h. Contract terminations.

2. Quarterly Submissions must be made to the OIG according to the following schedule:

Reporting Period:	Report Due Date:
January – March	May 15
April – June	August 15
July – September	November 15
October – December	February 15

VII. REFERENCES / LEGAL AUTHORITY

A. 42 CFR Parts 431, 433, 438, 440, 457 and 495

B. 42 CFR 438.600-438.610

C. 42 CFR 455.23 [suspension of payments]

D. 42 CFR 455.2 [definition of credible allegation of fraud]

E. "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," 81 Federal Register 88 (6 May 2016), pp. 27498

F. Medicaid Integrity Program - General Information, *accessed 3/1/2021 at* https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/medicaidintegrityprogram/ (Page last Modified: 07/22/2020)

G. MCCMH MCO Policy 1-001, "Overview: Compliance Code / Code of Ethics"

H. MDHHS-MCCMH Managed Specialty Supports and Services Contract

VIII. EXHIBITS

None