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

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Proposed by: Traci Smith 07/02/2024
Chief Executive Officer Date

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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 MCCMH 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, all other MCCMH Workforce Members (collectively, "MCCMH Staff"), as well as to MCCMH contract network providers 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 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 be promptly addressed.

In furtherance of these objectives, MCCMH shall 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 costs to the Medicaid program.

B. Enrollees: A Medicaid beneficiary who is currently enrolled in the MCCMH Prepaid Inpatient Health Plan (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/herself 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 Medicaid mental health, developmental disabilities, and substance use services in its geographic area under contract with the State.

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. MCCMH shall maintain a mandatory Compliance Plan, detailed in Exhibit A to MCCMH MCO Policy 1-001, "Compliance Program / Code of Ethics," which contains at least the following 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 15 business days 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 shall 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 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 shall screen, enroll, and periodically revalidate all MCCMH network providers.

2. At the time of enrollment or re-enrollment in MCCMH's provider network, MCCMH shall complete appropriate searches to ensure the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of 5% or more or a managing employee), have not been excluded from participating in federal health care programs.

3. MCCMH shall ensure that all network providers are enrolled with the State as Medicaid providers.

4. MCCMH may execute network provider agreements for 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 persons served of such action.

D. MCCMH shall verify through a system of regular periodic sampling that any services that have been represented have been delivered by network providers to persons served.

E. MCCMH may suspend referrals to any network provider upon receipt of notice from the State that there is an allegation of fraud against that provider. Suspension of referrals may occur following investigation that reveals credible circumstances of fraud or concerns related to health and safety of persons served.

1. Suspension of referrals may occur following concurrence from the MCCMH CEO of a recommendation from the compliance office, network operations, clinical services, recipient rights or other department with substantiated knowledge of provider activity that places persons served at risk or misrepresents services delivered.

2. MCCMH shall have provisions to suspend payments to a network provider for which the State determines there is a credible allegation of fraud. (Refer to 42 CFR 438.608)

F. MCCMH shall 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 shall 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 shall 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 shall 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 shall promptly report the occurrence of any of the following events to the State:

   a. Identification of an overpayment related to fraud, waste, or abuse prior to identification by MDHHS-OIG.

i. For overpayments involving potential fraud, MCCMH refers the findings to MDHHS-OIG and waits for further instruction from MDHHS-OIG prior to recovering the overpayment.

ii. For overpayments involving waste or abuse, MCCMH shall void or correct applicable encounter, recover the overpayment, and report the overpayment on its quarterly submission.

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 shall 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 shall be incorporated into the most recent year's 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.F, below.

I. Contract Network Providers:

1. MCCMH shall provide guidance to subcontracted entities' Program Integrity activities for any subcontracted entity that is delegated PIHP responsibility by MCCMH.

a. MCCMH shall 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, including for a credible allegation of fraud under 42 CFR Section 455.23, MCCMH shall, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG, and may pursue additional measures/remedies independent of the State. If MDHHS-OIG lifts a sanction, MCCMH may elect to do the same.

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, individuals, and entities with ownership

or control interests where the individual or entities could benefit directly or indirectly from receiving Medicaid funds. Screening shall be performed prior to entering a contractual or other relationship, and monthly thereafter.

1. On a monthly basis, MCCMH's Chief of Staff provides MCCMH's Network Operations Division with a complete list of county employee staff, internal contract agency staff, board members, and independent contractors.

2. Network Operations staff forwards spreadsheets containing staff (as detailed above) to contractors to evaluate against the following databases:

    a. Office of Inspector General (OIG) List of Excluded Individuals/Entities
    b. OIG_Most_Wanted, Office of Inspector General - Most Wanted Fugitives
    c. System for Award Management (SAM): Excluded Parties
    d. SDN, Office of Foreign Assets Control - Specially Designated Nationals
    e. Michigan Medicaid List of Sanctioned Providers
    f. Center for Medicare & Medicaid Services Preclusion List
    g. National Medicare Opt-Out Database

3. Upon receipt of the reporting from a contractor, Network Operations staff forward reports to the MCCMH Compliance Department for review and verification of identity and recommendation to MCCMH Chief of Staff for further action.

4. MCCMH's Chief of Staff, upon receipt of the verified report from Compliance and as applicable, informs Macomb County Human Resources and takes action consistent with healthcare funding sources, up to and including termination from MCCMH. All action(s) shall be in accordance with MCCMH Policy 10-005, "Background Checks of Employees/Independent Contractors/Interns/ Volunteers," MCCMH Policy 1-001, "Compliance Plan," and Macomb County Human Resource Policies.

5. MCCMH immediately notifies MDHHS-OIG using the approved OIG reporting form and process if search results indicate that any network provider entities or individuals with ownership or control interests in a provider entity are on the OIG exclusions database. MCCMH shall also provide notification to MDHHS OIG if it has taken any administrative action that limits a provider's participation in the Medicaid program.

C. Reporting Fraud, Waste, or Abuse:

1. MCCMH reports all suspicions of fraud, waste, or abuse on the Quarterly OIG Submission described in Section VI.F 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.

4. MCCMH shall ensure contact information for reporting fraud, waste, or abuse to MCCMH and/or the MDHHS-OIG is disseminated to all MCCMH network providers and workforce members on an annual basis, along with information indicating that such reporting may be done anonymously. MDHHS-OIG may be contacted at:

Phone: 855-MI-FRAUD
Website: www.michigan.gov/fraud

D. Investigations:

1. MCCMH shall perform a preliminary investigation and upon completion of the preliminary investigation if a potential credible allegation of fraud exists and an overpayment of $5,000 or greater is identified (cases under this amount shall not be referred to OIG), promptly refer the matter to MDHHS-OIG and the Attorney General's Health Care Fraud Division.

    a. Referrals must be made using the MDHHS OIG Fraud Referral Form and be shared with MDHHS-OIG via secure File Transfer Process (FTP).

    b. After reporting a potential credible allegation of fraud, MCCMH shall not take any of the following actions unless otherwise instructed by OIG:

        i. Contact the subject of the referral about any matters related to the referral.

        ii. Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or

        iii. Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.

        iv. If the State makes a recovery from an investigation and/or corresponding legal action where MCCMH has sustained a documented loss, the State shall not be obligated to repay any monies recovered to MCCMH.

    c. MCCMH will contact MDHHS-OIG with updates on the process and amount of recoupment/recovery.

    d. Questions regarding whether suspicions should be classified as fraud, waste, or abuse should be presented to MDHHS-OIG for clarification.

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 shall cooperate fully in any investigation or prosecution by any duly authorized government agency, including but not limited to MDHHS-OIG and the Department of Attorney General. Such cooperation must include:

a. Disclosing protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the person served to disclose such information;

b. Access to records and interviews with MCCMH employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation or prosecution.

E. Provider Network Audits

1. Audits shall be completed for MCCMH directly-operated programs and contract providers. The audit process shall minimally ensure that all provider organizations have at least one identified compliance risk area reviewed every 24 months.

2. The frequency and quantity of audits performed shall be dependent on the number of fraud, waste, and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims and investigative results.

3. MCCMH's regular auditing shall be consistent with a risk-based strategy. Audits, frequency, and responsible departments are identified below:

Audit Area	Audit Responsibility	Frequency	Expectation	Sample Size
Documentation of Services	Compliance/ Special Investigations Unit	In response to complaints and reports.	Post payment review of paid claims, progress notes (or other clinical documentation of service provision) procedure codes, modifiers, and quantities of service.	Audit/Investigation specifics are dependent on report/complaint received.
Documentation of Services	Provider sites – Self Audit. Audits may be initiated by provider to assess sufficiency of documentation to support claims or be required by MCCMH Compliance to address suspected deficiencies	At least annually, as indicated based on findings.	Pre or Post payment review of claims and documentation to be conducted by appropriate staff (Compliance and Quality). Self-audit results are reported to MCCMH via Program Integrity Quarterly Reports.	Sample Size is to be determined.
Quality of Care *See MCO Policy 8-005	Quality Department	Annually for directly-operated and applicable	Post payment review of clinical records. Any suspicions of	Review of 5% or a maximum of 20

		contract network providers.	fraud, waste, abuse are forwarded to the Compliance Office.	files from each provider.
Accuracy of Billing/ Medicaid Event Verification (MEV)	Contractor (Jefferson Wells)	Audit done annually on specific service lines. Bi-annually for previous two-year period.	Contractor performs audits of Medicaid service billings and non-Medicaid covered services for directly operated and contract operated programs.	Behavioral Health – Stratified sample for each vendor covering 5% of the total number of claims processed during the audit period. SUD – Sample size determined based on 5% of total cases and minimum of 5% of amounts paid per funding source.
Data Mining	Compliance Office, Clinical Informatics, Finance Department	Ongoing	MCCMH utilizes data technology, including dashboards, pre-adjudication edits, staff data processing, ad hoc and custom reports to identify potential areas of fraud, waste, abuse for further audit/ investigation, financial recovery, and remediation. Reporting is aggregated quarterly for reporting on Program Integrity Quarterly Report.	Expectation that once algorithm for specific data mining target is established, 100% of applicable scenarios will be tested.

4. Audit and Investigative results that identify inappropriately paid claims shall be summarized into a report identifying the compliance issue, findings, timeframe of audit/review, claims found to not meet the minimum standard for payment, and dollar amount of recovery. The Compliance Office shall provide the Provider/Supervisor, Chief Executive Officer, and Finance Director with a copy of all reports with substantiated findings of Fraud, Waste and/or Abuse.

5. The MCCMH Finance Department shall take appropriate action to ensure recovery of dollars inappropriately paid (credit memo, direct payback, etc.). The Finance Department shall confirm to the Compliance Office the date, amount, method of recovery of inappropriately paid monies and associated adjustments of encounters reported.

6. Reports of fraud, waste, and abuse shall be reported to MDHHS-OIG on a quarterly basis.

7. The Chief Privacy and Compliance Officer shall verify the completion of the audits and any corrective action measures that arise from them.

F. Quarterly Submissions: On a quarterly basis, MCCMH shall 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 disenrollments;

   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. Macomb County Human Resource Policies

F. MCCMH MCO Policy 1-001, "Compliance Program"

G. MCCMH MCO Policy 10-005, "Background Checks of Employees/Independent Contractors/Interns/Volunteers"

H. "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

I. 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)

J. MDHHS-MCCMH Managed Specialty Supports and Services Contract

VIII. EXHIBITS

None