POLICY AND PROCEDURE MANUAL

SUBJECT Compliance Reporting and Investigation	ACCOUNTABILITY NMRE and NMRE Network Providers	Effective Date: January 17, 2024	Pages: 4
REQUIRED BY Office of the Inspector General	BBA Section: 42 CFR 455.17 (Reporting Requirements); 42 CFR 438.608 (Program Integrity Requirement); 42 CFR, Part 2 (Confidentiality of Substance Use Disorder Patient Records) PIHP Contract Section: Schedule A, Section R, Program Integrity Other: Michigan Mental Health Code	Last Review Date: April 11, 2024	Past Review Date: January 17, 2024
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: Customer Services and Compliance Specialist	Responsible Department: Compliance	Reviewers: NMRE CEO

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical 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 of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Fraud: (Federal False Claims Act): An 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. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2) (per Michigan statute and case law interpreting same): Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person "should have been aware that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge." But errors or mistakes do not constitute "knowing" conduct necessary to establish Medicaid fraud, unless the person's "course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present."

Michigan Department of Health and Human Services (MDHHS): The principal department of the state of Michigan, headquartered in Lansing, that provides public assistance, child and family welfare services, and oversees health policy and management.

Northern Michigan Regional Entity (NMRE): The PIHP for Region 2, the 21- counties located in Michigan's northern lower peninsula.

Network Provider: A provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its Member CMHSPs, and the Substance Use Disorder Provider Panel.

Office of the Inspector General (OIG): An agency in the Michigan Department of Health. and Human Services (MDHHS) that investigates cases of fraud within the Department [MCL 400.43b].

Prepaid Inpatient Health Plan (PIHP): A term contained in federal regulations from the Centers for Medicare & Medicaid Services. Michigan has ten (10) PIHPs, responsible for managing the Medicaid resources for behavioral health and intellectual/developmental disabilities services for Medicaid and Healthy Michigan enrollees.

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.

Purpose

The purpose of this policy/procedure is to establish methods for identification, investigation, and referral of suspected Medicaid fraud, waste, and/or abuse cases.

Policy

The NMRE will report any activity that is in violation of the law, ethical standards, or NMRE policies to the NMRE Compliance Officer. Network Providers are expected to report any activity that is believed to be in violation of the law, ethical standards, or NMRE policies as it relates to fraud, waste or abuse to the NMRE Compliance Officer. Neither the NMRE nor its Network Providers need to be certain that the violation has occurred to report. Reporting enables the Compliance Officer to ensure potential problems are investigated quickly and to take prompt action to resolve them.

Approval Signature

NMRE Chief Executive Officer

4/18/24

Date

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Suspected Medicaid Fraud and/or Abuse:

NMRE staff and Network Providers will report all suspected Medicaid fraud and abuse to the NMRE Compliance Officer in accordance with the standards established in the NMRE's current Compliance Plan. Investigations will be conducted in accordance with the NMRE's current Compliance Plan.

- Allegations involving suspected fraud will be reported to the NMRE Compliance Officer.
- The NMRE's Compliance Officer will initiate a preliminary investigation to determine if suspicion of fraud exists.
- If suspicion of fraud exists, a report will be made in writing by the NMRE Compliance Officer utilizing the Office of Inspector General Fraud Referral Form
- If there is suspicion of fraud, and involves an overpayment of $5,000 or more, the NMRE's Compliance Officer will report the suspected fraud and abuse to the MDHHS Office of Inspector General via secure File Transfer Process (FTP) using the NMRE's Fraud Referral template. After reporting a credible allegation of fraud, the NMRE will not take any of the following actions unless otherwise instructed by OIG:
  - Contact the subject of the referral about any matters related to the referral.
  - Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral;
  - Accept any monetary or other thing of valuable consideration offered by the subject of the referral in connection with the findings/overpayment.
  - If the State makes a recovery from an investigation and/or corresponding legal action where Contractor has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Contractor.
- If a credible allegation of fraud exists, the NMRE will refer the matter to MDHHS-OIG and pause any recoupment/recovery in connection with the allegation until further instructions are received from the MDHHS Office of Inspector General.
- The NMRE will report overpayments due to fraud, waste, or abuse to MDHHS-OIG.

    - If the NMRE identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the NMRE will refer the findings to MDHHS-OIG and wait for further instruction from MDHHS-OIG prior to recovering the overpayment.
    - If the NMRE identifies an overpayment involving waste or abuse prior to identification by MDHHS- OIG, the NMRE will void or correct applicable encounters, recover the overpayment, and report the overpayment on its quarterly submission.
    - If a Network Provider identifies an overpayment, they must agree to:
        - Notify the NMRE, in writing, of the reason for the overpayment and the date the overpayment was identified.
        - Return the overpayment to the NMRE within 60 calendar days of the date the overpayment was identified.
- The NMRE's Compliance Officer will inform the appropriate Network Provider when a report is made to the MDHHS Office of Inspector General.
- The NMRE will follow the guidance/direction provided by the MDHHS Office of Inspector General regarding investigation and/or other necessary follow-up.
- All suspicions of fraud and abuse will be reported on the Quarterly OIG Program Integrity Report template.
- Questions regarding whether suspicions should be classified as fraud, waste or abuse will be presented to MDHHS-OIG for clarification prior to making the referral.
- When MDHHS-OIG sanctions (suspends and/or terminates from the Medicaid Program) providers, including for a credible allegation of fraud under 42 CFR § 455.23, the NMRE will, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. The NMRE may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, the NMRE may elect to do the same.

Suspected Violations and/or Misconduct (not involving Medicaid Fraud and/or Abuse):
NMRE staff and Network Providers will report all suspected violations and/or misconduct to the NMRE Compliance Officer and/or the appropriate Network Provider's Compliance Officer. Reporting and Investigations will be conducted in accordance with the NMRE Regulatory Compliance Plan.

- Where internal investigation substantiates a reported violation, corrective action plans will be initiated by NMRE staff or its Network Providers.
- Corrective action plans developed by Network Providers will be submitted to NMRE within thirty (30) days of the approved plan.
- The NMRE will review corrective action plans and ensure, as appropriate, prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, coordinating with the Network Provider's designee for follow-up monitoring and oversight, and implementing system changes to prevent a similar violation from recurring in the future.

Required Reporting:

NMRE's Network Providers will submit compliance activity reports quarterly to the NMRE utilizing the Office of Inspector General's Program Integrity Report template. Minimally, the report will include the following:

- Tips/grievances received.
- Data mining and analysis of paid claims, including audits performed based on the results.

- Audits performed.
- Overpayments collected.
- Identification and investigation of fraud, waste, and abuse.
- Corrective action plans implemented.
- Provider disenrollments.
- Contract terminations.

Reporting Period/due dates to NMRE:

Reporting Period	Due Date
January 1st through March 31st	May 1st
April 1st through June 30th	August 1st
July 1st through September 30th	November 1st
October 1st through December 31st	February 1st

The NMRE Compliance Officer will prepare a quarterly summary report of its Network Providers and direct NMRE Compliance activities and present the findings to the NMRE Quality Oversight and Compliance Committee (QOC). An annual summary report of the regional compliance activities will be presented to the NMRE Board of Directors and the NMRE Regional Operations Committee.

The NMRE will provide MDHHS-OIG with documentation to support that program integrity compliance activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.

To the extent consistent with applicable law, including but not limited to 42 CFR, Part 2, HIPAA, and the Michigan Mental Health Code, the NMRE will comply with the MDHHS-OIG's request for documentation and information related to program integrity and compliance.

The NMRE will cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal. Such cooperation will include providing, upon request, information, access to records and access to interview NMRE 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.

NMRE Chief Executive Officer

4/18/24

Date