NMRE Regulatory Compliance Plan

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).

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."

Waste: Overutilization of services or other practices that, directly or indirectly, results in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources or inefficient practices.

Purpose

It is NMRE policy to provide quality, cost-effective services in a positive and productive work environment. The Northern Michigan Regional Entity (NMRE) is dedicated to adhering to the highest ethical standards and recognizes the importance of full compliance. The NMRE is committed to detect and prevent fraud, waste, and abuse. The Regulatory Compliance Plan is intended to address matters related to the Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statue, the Health Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act (1996)/Managed Care Rules, the Deficit Reduction Act/Medicaid Integrity Program (2006), as well as any other circumstances in which potential or actual Medicaid fraud, waste, and abuse is involved.

Compliance Elements

The Regulatory Compliance Plan is intended to establish administrative and management arrangements to detect and prevent fraud, waste, and abuse.

Element 1 – Standards, Policies and Procedures

The NMRE is obligated to conduct itself in accordance with the Standards of Conduct. The NMRE will comply with all applicable requirements under the MDHHS-PIHP Contract5, Federal, and State Requirements.

Element 2 – Compliance Program Administration

The NMRE has a designated Compliance Officer (CO) charged with the responsibility of developing and implementing policies, procedures, and practices designed to ensure compliance with the MDHHS-PIHP Contract. The Compliance Officer reports directly to the NMRE Chief Executive Officer.

The NMRE has a committee of senior management staff to assist with risk assessments, develop policies and procedures, and review the Regulatory Compliance Plan.

The NMRE will conduct an annual evaluation of the Regulatory Compliance Plan to determine that required elements have been met.

Methods used to assess and evaluate the Regulatory Compliance Plan include:

- Working with NMRE provider network to coordinate Regulatory Compliance activities;
- Analyzing reports generated as part of the Medicaid Encounter Verification reviews and other processes to identify trends;
- Analyzing all allegations of abuse and/or fraud and reporting requirements/process and providing notifications to MDHHS-Office of Inspector General (OIG);
- Reviewing and analyzing compliance activities and provider agencies via ongoing and annual contract monitoring processes.

The NMRE Regional Compliance Committee membership includes Provider Network Compliance Officers and representatives, SUD representatives, and Contract Managers. Activities include:

- Meeting a minimum of once each quarter every year
- Assessing region-wide trainings and staff training requirements (see training grid)
- Determining overall strategies or approaches to promoting compliance and/or detecting violations of regulations
- Reviewing Compliance Plans annually
- Reviewing content/information from state-wide meetings
- Monitoring and auditing; analyzing, monitoring, and reviewing high-risk compliance areas.

Element 3 – Screening and Evaluation

- **Disclosure of Ownership:** The NMRE shall comply with all requirements to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions. The NMRE shall ensure that all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided with Federal and State healthcare funds are compliant with applicable Federal and State regulations.

  The NMRE will require disclosure statements from all Medicaid providers, fiscal agents and any subcontractor that receives 25,000 or more Medicaid dollars per year. NMRE requires each provider, fiscal agent, and applicable contractor to identify all owners and others with an ownership or controlling interest, and the identity of managers and others in positions of influence or authority. NMRE defines its managing employees as: CEO and CFO. NMRE Board Members are required to submit disclosure statements to the NMRE Compliance Officer.

- **Excluded Provider:** The NMRE ensures compliance with 42 USC 1320a-7(b), which imposes penalties for "arranging (by employment or otherwise) with an individual or entity that the person knows, or should know, is excluded from participation in a Federal health care program for the provision of items or services for which payment may be made under such a program. Providers are expected to comply with the elements contained herein," as well as applicable NMRE policies and procedures.

  Prior to employing or contracting with any individual or provider, the NMRE will take appropriate steps to confirm that the individual or provider has not been excluded.

Element 4 – Compliance Communication, Education, and Training

The NMRE and its Provider Network is committed to open communication as an essential component of proper implementation of the its Compliance Program. The NMRE Compliance Officer shall be available to communicate compliance topics/complaints/issues received from NMRE employees and/or its Provider Network and will protect the anonymity of complainants and protect callers from retaliation.

- TELEPHONE: 866.789.5774
- WEBSITE: NMRE.org → Compliance → Report Compliance Issues
- EMAIL: Compliancesupport@nmre.org
- MAIL or in PERSON: 1999 Walden Drive, Gaylord, MI 49735 (after January 1. 2019)

All staff is expected and required to report any conduct that he/she, in good faith, reasonably believes may be fraudulent or erroneous. It is the NMRE's expectation that all suspected violations are reported. NMRE will maintain the anonymity of, and seek no retribution from, the complainant. Staff who makes good faith reports of violations of federal or state law is protected by state and federal Whistleblower laws under the False Claims Act.

Education/Training

The NMRE shall have a system for training and educating the NMRE Compliance Officer, senior management, and personnel on Federal and State standards and requirements under the MDHHS-PIHP Contract. NMRE personnel are trained on compliance during orientation and annually thereafter, using a web-based system. Staff compliance training is documented and reported via signed attestation to

the NMRE Compliance Officer. Member CMHSPs can verify compliance by submitting a copy of the Inspector General's "Certification of Compliance" letter to the NMRE Compliance Officer annually. Subcontractors must track and keep all training records on-site to be monitored by the Member CMHSPs and the NMRE Compliance Officer, as applicable.

The NMRE and its Provider Network must demonstrate 100% completeness with compliance training requirements. Results are reported to MDHHS-OIG per Section 6032 of the Deficit Reduction Act (DRA) of 2005, pursuant to Section 1902 (a)(68) of the Social Security Act on training, which includes, but is not limited to:

- Written policies on the False Claims Act including administrative remedies, criminal penalties and Whistle blower protection/non-retaliation.
- Written policies on detecting and preventing fraud, waste, and abuse.
- Written policies on Code/Standards of Conduct and Conflict of Interest

Network Providers are expected to train staff, and all agents working on behalf of the agency, on compliance at orientation and annually thereafter, or as needed. Compliance training is considered a condition of employment and failure to cooperate may result in disciplinary action as deemed appropriate by supervisors or the CEO.

The NMRE Regulatory Compliance Plan and PowerPoint training is kept on the NMRE website at nmre.org, and is maintained by the NMRE Compliance Officer, and the Regional Compliance Committee, as approved by the NMRE Board of Directors.

Element 5 – Monitoring & Auditing

The purpose for monitoring and auditing is to identify compliance risks. Correction of the identified risks reduces the potential for recurrence and promotes ongoing compliance with the MDHHS-PIHP Contract. All NMRE personnel are responsible for monitoring and reporting compliance activities and operations within the NMRE.

The NMRE employs a variety of monitoring and auditing techniques including:

- Periodic questionnaires, surveys, and interviews with personnel within the NMRE, member CMHSPS, and subcontracted providers regarding their perceived levels of compliance and the effectiveness of training/education within their departments or areas of responsibilities.
- Periodic audits that comply with Federal and State law, regulations, rules, and guidelines.
- Input from Provider Compliance Officers
- Internal/external audit results for specific compliance guidelines
- Information from past investigations of noncompliance
- Information from Exit interviews

Reporting/reviewing Compliance Data:

- Quarterly reports of issues (*e-mail/voicemail/ website/-mail)*
- Quarterly results of Medicaid Service Verification
- Annual reviews of the Regulatory Compliance Plan

- Annual summaries of compliance activities, including number of investigations, summaries of results of investigations, and summaries of disciplinary actions
- Annual reports of Medicaid Verification to the NMRE CEO & NMRE Board of Directors
- Annual reports to MDHHS of Medicaid Verification results
- Annual reports to MDHHS of compliance with annual trainings on the Deficit Reduction Act (DRA) from all Network Providers
- Annual reports to the OIG of any non-compliance communication resulting in OIG involvement.

Quarterly Submissions to the OIG:

- Tips/grievances received
- Data mining and analysis of paid claims, including audits performed
- Audits Performed
- Overpayments collected
- Identification and investigations of fraud, waste, and abuse
- Corrective action plans implemented
- Provider Disenrollment
- Contract terminations

Element 6 – Discipline for Non-Compliance

All reports of non-compliance shall be reviewed. If the review indicates a determination of non-compliance, a corrective action plan will be requested. The following disciplinary steps are recommended by the OIG in ascending order:

1. Contact direct Manager/Supervisor
2. Written warning
3. Suspension without pay
4. Termination

Documentation of all occurrences shall be kept with the NMRE Compliance Officer. Disciplinary actions cannot occur without properly informing employees of expectations. An atmosphere that promotes positive feedback, education, and incentives, will be maintained by the NMRE and its Provider Network.

Element 7 – Investigations and Remedial Measures

Detection of non-compliance may occur through already established reviews including audits, claims data, record reviews, and/or complaints made by staff, individuals served, subcontracted providers, or others. Findings of non-compliance could result in disciplinary action, corrective action, a review of additional claims, possible payback of inappropriate payments, and reporting to the MDHHS-OIG. Prompt reporting of misconduct to the appropriate governmental authority within a reasonable period, after determining credible evidence that a violation occurred, is expected.

Investigations into fraud, waste, and abuse are intended to address matters relating to the Federal False Claims Act (1863), the Michigan Medicaid False Claims Act (1977), the Anti-Kickback Statue, the Health

Insurance Portability & Accountability Act (HIPAA), the Balanced Budget Act (1996), the Deficit Reduction Act (Medicaid Integrity Program) (2006), and any other circumstance in which potential or actual violations have occurred.

Record Retention

Records will be maintained in accordance with the "State of MI, Department of History, Arts and Libraries – Record Management – Records Retention and Disposal Schedule". Dated 2007
http://www.michigan.gov/documents/hal/mhc_rm_gs20_195724_7.pdf

Approval Signature

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NMRE Chief Executive Officer Date