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REGION 10 PIHP

SUBJECT		CHAPTER	SECTION	SUBJECT
Program Integrity		01	02	07
CHAPTER	**SECTION**			
Administrative	Compliance			
WRITTEN BY	**REVIEWED BY**	**AUTHORIZED BY**		
Kaitlin Bombyk	Ally Wagner	PIHP Board of Directors		

I. APPLICATION:

☐ PIHP Board ☒ CMHSP Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMHSP Subcontractors

II. POLICY STATEMENT:

Region 10 PIHP and the PIHP Network are responsible for complying with all federal, state, and contractual requirements for Program Integrity. The State, MDHHS-Office of Inspector General (OIG), is responsible for overseeing the program integrity activities of the PIHP and all subcontracted entities.

III. DEFINITIONS:

Abuse: Means 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).

Controlling Interest: The Operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Excluded Individuals or Entities: Individuals or entities that have been excluded from participating in Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions

for program-related fraud, patient abuse, licensing board actions, and/or default on Health Education Assistance loans.

Fraud: (Federal False Claims Act): means 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."

Network Provider: any provider, group of providers, or entity that has a network provider agreement with the PIHP, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services because of the state's contract with a PIHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Protected Health Information (PHI): Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information: (i) In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) In records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (iii) In employment records held by a covered entity in its role as employer; and (iv) Regarding a person who has been deceased for more than 50 years. (45 CFR§160.103).

Provider: any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. The PIHP providers include Community Mental Health Service Providers (CMHSPs), Substance Use Disorder (SUD) Providers, individual or corporation; any CMHSP subcontracted provider/practitioner, individual or corporation.

Subcontractor: An individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or an individual, agency, or organization with which a fiscal agent has entered into

contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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.

IV. **STANDARDS:**

A. GENERAL

1. To the extent consistent with applicable Federal and State law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP will disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.
2. The PIHP has administrative and management arrangements or procedures for compliance with 42 CFR §438.608. Such arrangements or procedures must identify program integrity compliance activities that will be delegated and how the PIHP will monitor those activities.
3. The PIHP provides prompt notification to the State, MDHHS BPHASA when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including, changes in the beneficiary's residence and the death of a beneficiary.
4. The PIHP, who makes or receives annual payments of at least $5,000,000, has provisions for written policies for all employees of the PIHP, and of any PIHP or network provider, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
5. The PIHP requires all contracted Providers who make or receive annual payments of at least $5,000,000 to agree to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.
6. The PIHP has a program integrity compliance program as defined in 42 CFR §438.608. The program integrity compliance program includes the following:
    a) Written policies, procedures, and standards of conduct that describe the PIHP's commitment to comply with Federal and State fraud, waste and abuse requirements and standards enforced through well publicized disciplinary guidelines.
    b) Have written standards of conduct in an easy-to-read format and distributed to all employees. All employees must be required to certify that they have read, understand, and agree to comply with the standards.
    c) The designation of a Compliance Officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior

management or Board of Directors, with effective lines of communication to the PIHP's employees.

d) A system for training and education for the Compliance Officer, the PIHP's senior management, and the PIHP's employees regarding fraud, waste and abuse, and the federal and State standards and requirements. While the compliance officer may provide training to the PIHP's employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer to himself/herself.
    i. The PIHP will determine under what circumstances it may be appropriate to train nonemployee agents and subcontractors.

e) A system for training conducted by the Special Investigations Unit to improve information sharing between departments and enhance referrals regarding fraud, waste and abuse.
    i. The yearly training will include a component specific to Michigan Medicaid and the PIHP's approach to address current fraud, waste, and abuse.

f) Provisions for internal monitoring and auditing of compliance risks. Audits may include pre or post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities). Acceptable audit methodology examples include:
    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.
    iii. Provider self-audit protocols.
    iv. The frequency and quantity of audits performed should 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.

g) Provisions for the PIHP's prompt response to detected offenses and for the development of corrective action plans. "Prompt Response" is defined as action taken within 15 business days of receipt and identification by the PIHP of the information regarding a potential compliance problem.

7. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste, or abuse by network provider/subcontractors of the PIHP to both the PIHP and the MDHHS-OIG. Dissemination of this information must be made to all PIHP's network providers/subcontractors and members annually. The PIHP allows reporting of fraud, waste or abuse to be made anonymously.

B. Biannual meetings will be held between MDHHS-OIG and all the PIHP's Compliance Officers to train and discuss fraud, waste, and abuse.

C. SUBCONTRACTED ENTITIES/NETWORK PROVIDERS

1. The PIHP includes program integrity compliance provisions and guidelines in all contracts with subcontracted entities/network providers.
2. If program integrity compliance activities are delegated to subcontractors as outlined in 42 CFR 438.230, the subcontract must contain the following:
   a) Designation of a compliance officer.
   b) Submission to the PIHP of quarterly reports detailing program integrity compliance activities.
   c) Assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity.
   d) Provisions for routine internal monitoring of program integrity compliance activities.
   e) Prompt Response to potential offenses and implementation of corrective action plans.
   f) Prompt reporting of fraud, waste, and abuse to the PIHP.
   g) Implementation of training procedures regarding fraud, waste, and abuse for the subcontracted entities' employees at all levels.
3. Annually, the PIHP submits a list of subcontracted entities and network providers using the template created by MDHHS-OIG.
   a) The PIHP maintains a list that contains all facility locations where services are provided, or business is conducted. This list contains Billing Provider NPI numbers assigned to the entity, what services the entity is contracted to provide, and Provider email address(es).
4. Subcontractors are required to enroll in the Michigan Medicaid Program via the State's Medicaid Management Information System.

D. INVESTIGATIONS

1. The PIHP investigates program integrity compliance complaints to determine whether a potential credible allegation of fraud exists. If a potential credible allegation of fraud exists, the PIHP will refer the matter to MDHHS-OIG and pause any recoupment/recovery in connection with the potential credible allegation of fraud until receiving further instruction from MDHHS-OIG.
   a) To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP will cooperate fully in any investigation or prosecution by any duly authorized government agency, including but not limited to: MDHHS-OIG or the Department of Attorney General, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to schedule interviews with designated PIHP 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 the

investigation or prosecution. The PIHP shall follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.

i. The PIHP has written policies and procedures pertaining to cooperation in investigations and/or prosecutions.

E. REPORTING FRAUD, WASTE, OR ABUSE

1. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e., the PIHP, employee, subcontracted entity, network provider, or member), the PIHP will perform a preliminary investigation. The PIHP must refer all potential Enrollee fraud, waste or abuse that is identified, to MDHHS through http://www.michigan.gov/fraud (File a Complaint - Medicaid Complaint Form) or via the local MDHHS office. Pursuant to 42 CFR 438.60(a)(7), the PIHP shall promptly refer any potential Fraud that is identified. Upon completion of the preliminary investigation, if the PIHP determines 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), the PIHP will promptly refer the matter to MDHHS-OIG and the Attorney General's Health Care Fraud Division (AG-HCFD). These referrals will be made using the MDHHS-OIG Fraud Referral Form and be shared with MDHHS-OIG via secure File Transfer Process (sFTP) using the PIHP's applicable MDHHS-OIG and AG/HCFS sFTP areas. The form must be completed in its entirety, as well as follow the procedures and examples contained within the MDHHS-OIG guidance document. The PIHP must cooperate in presenting the fraud referral to the OIG and AG-HCFD at an agreed upon time and location. The PIHP must defend their potential credible allegation of fraud in any appeal should the referral result in suspension issued by MDHHS-OIG. After reporting a potential credible allegation of fraud, the PIHP shall not take any of the following actions unless otherwise instructed by OIG:
   a) Contact the subject of the referral about any matters related to the referral.
   b) Enter into or attempt to negotiate any settlement or agreement regarding the referral with the subject of the referral; or
   c) Accept any monetary or other valuable consideration offered by the subject of the referral in connection with the findings/overpayment.
   d) If the State makes a recovery from an investigation and/or corresponding legal action where the PIHP has sustained a documented loss, the State shall not be obligated to repay any monies recovered to the PIHP. Unless otherwise directed by the state, the correction of associated encounter claims is not required.
   e) Upon making a referral, the PIHP must immediately cease all efforts to adverse action against or collect overpayments from the referred provider until authorized by MDHHS-OIG.
   f) If a draft or potential referral is declined prior to the PIHP sending the final potential credible allegation of fraud, the PIHP must follow MDHHS-OIG reporting procedures.
2. The PIHP reports all suspicion of fraud, waste or abuse on the Quarterly Submission.

3. Questions regarding whether suspicions should be classified as fraud, waste or abuse should be presented to MDHHS-OIG for clarification prior to making the referral.
4. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable Federal and State privacy rules and regulations, including but not limited to HIPAA.

F. OVERPAYMENTS

1. The PIHP will report identified and/or recovered overpayments due to fraud, waste, or abuse to MDHHS-OIG.
   a) If the PIHP identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the PIHP refers the findings to MDHHS-OIG and waits for further instruction from MDHHS-OIG prior to recovering the overpayment.
   b) If the PIHP identifies an overpayment involving waste or abuse prior to identification by MDHHS- OIG, the PIHP will;
      i. Void or correct applicable encounters,
      ii. Should recover the overpayment,
      iii. Will report the overpayment on its quarterly submission.
   c) If a Network Provider identifies an overpayment, they must agree to:
      i. Notify the PIHP, in writing, of the reason for the overpayment and the date the overpayment was identified.
      ii. Return the overpayment to the PIHP within 60 calendar days of the date the overpayment was identified.
2. The PIHP shall include a provision in all contracts with subcontractors and/or network providers giving the PIHP the right to recover overpayments directly from the providers for the post payment evaluations initiated and performed by the PIHP. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

G. QUARTERLY SUBMISSIONS

1. The PIHP will provide information on program integrity compliance activities performed quarterly using the template provided by the MDHHS-OIG. Program integrity compliance activities include, but are not limited to:
   a) Tips/grievances 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 dis-enrollments.
h) Contact terminations.

2. All program integrity activities performed each quarter will be reported to OIG according to Schedule E- Reporting Requirements of the PIHP's contract with the State.
   a) PIHP's Program Integrity Activity Reporting Requirements for CMHSP
   b) Providers: Schedule C of provider's contract with the PIHP.
   c) PIHP's Program Integrity Activity Reporting Requirements for SUD Providers: Attachment D of provider's contract with the PIHP.
3. The PIHP will provide MDHHS-OIG with documentation to support that these program integrity compliance activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.
4. The PIHP will include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the PIHP during the course of its program integrity activities. It is understood that identified overpayment recoveries may span multiple reporting periods. This report also includes a list of the individual encounters corrected. To ensure accuracy of reported adjustments, the PIHP will:
   a) Purchase at minimum one (1) license for MDHHS-OIG's case management software. This license will be utilized to upload report submissions to the case management system and to check the completeness and accuracy of report submissions.
   b) For medical equipment, supplies, or prescription provided, adjust any encounter for an enrollee to zero dollars paid. If the encounter with a dollar amount cannot be adjusted to zero dollars paid, then the encounters with dollars paid shall be voided and resubmitted with zero dollars paid.
   c) Specify if overpayment amounts were determined via sample and extrapolation or claim-based review. In instances where extrapolation occurs, the PIHP may elect to correct claims, and thus encounters, as they see fit.
   d) Specify encounters unavailable for adjustment in CHAMPS due to the encounter aging out or any other issue.
      i. These encounters will be identified by the PIHP and reported to MDHHS-OIG. MDHHS-OIG will record a gross adjustment to be taken out of the PIHP's next capitation payment.
   e) Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.
   f) Once all applicable appeal periods have been exhausted, the PIHP will adjust all associated encounter claims within 45 days.
      i. The PIHP must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

ii. All adjustments must be performed regardless of recovery from the subcontractor and / or Network Provider.

H. MDHHS-OIG SANCTIONS

1. 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 PIHP will, at minimum, apply the same sanction to the provider upon receipt of written notification of the sanction from MDHHS-OIG. The PIHP may pursue additional measures/remedies independent of the State. If MDHHS OIG lifts a sanction, the PIHP may elect to do the same.

I. MDHHS-OIG ONSITE REVIEWS

1. MDHHS-OIG may conduct onsite reviews of the PIHP and/or its subcontracted entities.
2. To the extent consistent with applicable law, including, but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

J. PIHP OWNERSHIP AND CONTROL INTEREST

1. Prohibited Relationships: In order to comply with 42 CFR §438.610, the PIHP will not knowingly have a relationship of the type described in section (2) of this Section with 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 under guidelines implementing Executive Order No. 12549.
   b) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101, of a person described in section (1.a) of this Section.
   c) An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Act.
2. The relationships described in paragraph (1) of this Section, are as follows:
   a) A director, officer, or partner of the PIHP.
   b) A subcontractor of the PIHP, as governed by 42 CFR §438.230.
   c) A person with beneficial ownership of five percent (5%) or more of the PIHP's equity.
   d) A network provider or person with an employment, consulting, or other arrangement with the PIHP for the provision of items and/or services that are significant and material to the PIHP's obligations under its Contract with the State.

K. OWNERSHIP & CONTROL DISCLOSURES

1. The PIHP complies with the Federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal

convictions as specified in 42 CFR §455.104- 106. The PIHP requires provider entity disclosure of ownership and control information at the following intervals:

a) Provider enrollment.
b) Provider re-enrollment.
c) Whenever there is a change in ownership or control of the provider entity.

2. Pursuant to 42 CFR §455.104: the State will review ownership and control disclosures submitted by the PIHP and any of the PIHP's Subcontractors and/or Network Providers. The PIHP is required to identify and report whether an individual or entity with an ownership or control interest in the disclosing entity is related to another individual with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling and/or whether the individual or entity with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest is related to another individual with ownership or control interest as a spouse, parent, child, or sibling. The PIHP is also required to identify the name of any other disclosing entity in which the owner of the disclosing entity has an ownership or control interest.

L. EXCLUSIONS MONITORING

1. At the time of provider enrollment or re-enrollment in the PIHP's provider network, and whenever there is a change in ownership or control of the provider entity, the PIHP searches the following databases to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent (5%) or more or a managing employee), have not been excluded from participating in federal health care programs.
   a) Office of Inspector General's (OIG) exclusions database. This list includes parties excluded from federal programs and may also be referenced as the "excluded parties lists" (EPLS).
   b) The State of Michigan Sanctioned Provider list.
   c) System for Award Management (SAM) exclusions.
2. The PIHP searches the OIG exclusions database and the State of Michigan Sanctioned Provider list monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time providers submit new disclosure information.
   a) The PIHP will notify the MDHHS OIG immediately using the approved OIG reporting form and process if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database. The PIHP will also provide notification to MDHHS OIG if it has taken any administrative action that limits a provider's participation in the Medicaid program.

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Program Integrity	01	02	07

CHAPTER	SECTION
Administrative	Compliance

V. **PROCEDURES:**

None.

VI. **EXHIBITS:**

None.

VII. **REFERENCES:**

A. MDHHS – PIHP Contract
B. Region 10 Policy: Regulatory Compliance Committee 01.01.04
C. Region 10 Policy: Corporate Compliance Program 01.02.01
D. Region 10 Policy: Conflict of Interest 01.02.03
E. Region 10 Policy: Corporate Compliance Complaint, Investigation, & Reporting Process 01.02.05
F. Region 10: Disclosure of Information 01.02.06
G. Region 10: Credentialing and Privileging 01.06.05
H. Region 10: HIPAA Privacy & Security Measures 03.03.01
I. Region 10: HIPAA Privacy Measures - Protected Health Information 03.03.02
J. Region 10: Behavioral Health Consent Form 03.03.03
K. Region 10: HIPAA Breach Notification 03.03.04
L. Region 10: Claims Verification 04.03.02
M. Region 10 Corporate Compliance Program Plan
N. Region 10 Code of Conduct
O. 42 CFR Part 2
P. 42 CFR 438.2
Q. 42 CFR §438.60(a)(7), 438.230, §438.608, §438.610
R. 42 CFR §455.104- 106, §455.2, §455.23
S. 45 CFR §160.103
T. 48 CFR §2.101