Upper Peninsula Health Plan
Policy & Procedure

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Authorized By: _____ **Date:** _____ **Title:** CEO

Product Type(s): ☒ **All Products** ☐ Medicaid ☐ Healthy Michigan Plan ☐ Medicare ☐ MIChild ☐ MI Health Link

Purpose

The Center for Medicare and Medicaid (CMS) and the Michigan Department of Health and Human Services (MDHHS) require Health Plans to identify ways to detect and report fraudulent activities. This policy outlines the detection and reporting of member, provider and health plan fraud and abuse.

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare and/or 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 recipient practices that result in unnecessary cost to the Medicare and/or Medicaid program. 42 CFR 455.2 Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

Downstream Entity: Any party that enters into a written agreement below the level of arrangement between a sponsor and a first tier entity for the provision of administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.

First Tier Entity: Any party that enters into a written agreement with a plan sponsor to provide administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.

Fraud: 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 the applicable Federal or State law. 42 CFR 455.2

Related Entity: Any entity that is related to the sponsor by common ownership or control and 1) performs some of the sponsor's management of functions under contract of delegation; 2) furnishes services to Medicare enrollees under an oral or written agreement; or 3) leases real property or sells materials to the sponsor at a cost of more than $2500 during a contract period.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare and/or Medicaid Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy

The Upper Peninsula Health Plan, Inc. (UPHP) is committed to conducting its affairs in accordance with applicable laws and to maintaining a policy on fraud and abuse that abides by accrediting agency guidelines and local, state and federal regulations. To this end, the UPHP strives to assure its business practices are held to exceptional standards and policies and procedures are in place to prevent, detect, correct and report fraud, waste and abuse. These procedures are further elaborated upon in UPHP's Auditing and Monitoring Plan. UPHP's Auditing and Monitoring Plan is reviewed and updated quarterly by the Compliance Committee.

Procedure

<u>Education Regarding Fraud and Abuse</u>
UPHP employees, UPHP Management Committee and First Tier, Downstream or Related Entity (FDR) employees who have involvement in the administration or delivery of Medicare benefits to UPHP Medicare enrollees receive FWA training within 90 days of initial hiring or contracting and annually thereafter. UPHP will maintain proof of training for a period of 10 years and require FDRs to maintain records of training of the FDR employees.

The UPHP will educate employees, providers and members on its detection and prevention of fraud and abuse in the following manner:

1. Employees must attend annual Fraud, Waste and Abuse and Compliance training which includes information about UPHP internal controls for detecting fraud and abuse with members, providers and UPHP staff and the procedures to follow to report suspected fraud and abuse. Employees are also required to complete online lessons and tests annually and attest that they have completed the training requirements.
2. FDRs will be receive a First Tier, Downstream and Related Entity Attestation upon contracting and annually thereafter.

3. The UPHP will have a section on fraud and abuse in its Provider Manual and UPHP's Fraud, Waste and Abuse policies will be available at www.uphp.com.
4. UPHP's Compliance Guide which includes information about the elements of an effective compliance plan, Fraud, Waste and Abuse, available reporting channels, and compliance with federal and state law including: HIPAA, the False Claims Act, Anti-Kickback Statute, Stark Statute, Exclusion and Deficit Reduction Act will be available at www.uphp.com.
5. UPHP will publish at least one article a year in its Provider Newsletter relating to detection of Medicaid and Medicare fraud and abuse. UPHP will publish at least one article a year in its Member Newsletter about Medicaid and Medicare fraud and abuse.
6. The UPHP will have a section on fraud and abuse in its Medicaid Member Handbook with contact information for the health plan and the Michigan Department of Health and Human Services if they suspect fraud and abuse with members, other providers or UPHP personnel.

Data Analysis

UPHP will perform effective monitoring in order to prevent and detect Fraud, Waste and Abuse through data analysis. UPHP has a Data Analysis Team that analyzes medical and pharmacy claims data to identify any unusual patterns suggesting potential errors or fraud, waste and abuse. Any potential errors or suspected fraud and abuse are investigated to determine whether potential FWA has occurred. The Data Analysis Team meets at least quarterly.

Reporting and Investigation of Alleged Fraud and Abuse

UPHP will maintain a system to receive, record, respond to and track reports of suspected or detected fraud and abuse. UPHP will also support reporting mechanisms; one of which will allow for anonymous reporting if desired.

Any employee, enrollee/family member, or provider of the UPHP who suspects an improper or illegal activity associated with the UPHP is required to report such suspicion to the Compliance Officer. Any employee, enrollee/family member or provider who reports such matters shall not be subjected to retaliation or harassment in any manner and any employee of the UPHP engaging in such conduct will be subject to discipline up to and including termination.

UPHP will investigate potential FWA activity to make a determination whether potential FWA has occurred. UPHP will conclude investigations of potential FWA within a reasonable time period after the activity is discovered. For all incidents of fraud and abuse within any of the federal or state programs, the Compliance Officer will report this directly to MDHHS OHSIG (Medicaid) and to CMS for federal programs (Medicare). The UPHP will inform MDHHS-OHSIG or NBI MEDIC of actions taken to investigate or resolve the reported suspicion, knowledge or action as appropriate.

Compliance Committee

The UPHP will appoint a Compliance Officer for the health plan and will establish a Compliance Committee that is composed of senior staff from the following departments: Information Systems; Customer Service; Clinical Services; Pharmacy; Claims and Finance. The Compliance Officer will act as the liaison between the health plan and the MDHHS Office of State health Inspector General (OHSIG) (for Medicaid) and the Center for Medicare and Medicaid (CMS) (for Medicare).
The Committee and Compliance Officer shall meet at least quarterly to review Management Reports from the departments to identify potential fraud and abuse by Providers and Members. The Compliance Officer will report directly to the Chief Executive Officer and will provide a yearly report on compliance activity to the UPHP Management Committee.

Prohibited Affiliation with Individuals Debarred by a Federal Agency
UPHP will not pay or affiliate itself with any individual that has been debarred by a Federal Agency. See UPHP policy 200-005.

Corrective Action Plan
When an issue is discovered for which corrective action is indicated, the Compliance Officer and applicable UPHP management shall develop a formal plan to address the issue. Such a plan can include, without limitation, additional education and/or training, seeking clarification from appropriate personnel and/or obtaining the advice of legal counsel and/or outside consultations. Corrective actions will be designed to correct the underlying problem that results in program violations and to prevent future noncompliance. A root cause analysis determines what caused or allowed the FWA, problem or deficiency to occur. UPHP's corrective action will be tailored to address the particular FWA, problem or deficiency identified, and must include timeframes for specific achievements. See Corrective Action Policy.

The Compliance Officer shall be responsible for determining whether certain individuals or groups of individuals are responsible for particular compliance problems and shall determine the degree of monitoring required for such individuals or groups of individuals.

Administrative Remedies
To correct abusive practices, administrative remedies may be initiated. These may include provider education, recovery of overpayments, withholding payments, or referrals to state licensing boards of medical and professional societies or to peer review organizations.

Penalties for Fraud and Abuse
Depending on the situation, abusive or questionable practices can be dealt with in a wide variety of ways ranging from educational contacts to conviction and jail time. If the incident warrants, UPHP will refer to the appropriate regulatory agency. If convicted, penalties can include civil monetary penalties, criminal conviction/fines, civil prosecution, imprisonment, loss of provider license and exclusion from federal and state health care programs.

Exception to this policy may be made with the approval of the Chief Executive Officer or an authorized designee.

END OF POLICY & PROCEDURE