**ATTACHMENT E**
**FY 2025**

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CONTRACT REQUIREMENTS FOR**

# Reporting for Office of Inspector General

**MI CHOICE PROGRAM**

**HOME AND COMMUNITY BASED SERVICES WAIVER**
**FOR ELDERLY AND YOUNGER ADULTS WITH DISABILITIES**

**October 1, 2024**

## Program Integrity Section

The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Michigan Medicaid MI Choice Waiver Agencies (Grantees) consistent with this Contract and the requirements under 42 CFR 438.608.

If the Grantee should defer any contractual requirement (or any process that lends to a contractual requirement) relating to the detection and prevention of Fraud, Waste, and Abuse to a contractor or agent, it is the Grantee's responsibility to maintain a contract agreement and/or maintain written policies and procedures that reiterate the conditions of this Contract.

A. **Fraud, Waste and Abuse –** Grantee must implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste, and Abuse, including a mandatory compliance plan. The arrangements or procedures must include the following:

1. Grantee's Fraud, Waste and Abuse compliance program and plan must include, at a minimum, all the following elements:

    a. Written policies and procedures and standards of conduct that articulate the Grantee's commitment to comply with all applicable Fraud, Waste, and Abuse requirements and standards under the Contract and all applicable Federal and State requirements.

        i. Standards of Conduct – Grantee must have written standards of conduct that clearly state the Grantee's commitment to comply with all applicable statutory, regulatory and Medicaid program requirements. The standards of conduct must be written 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.

        ii. Written Compliance Policies and Procedures – Grantee must have comprehensive written compliance policies and procedures, developed under the direction of the compliance officer and Compliance Committee, which direct the operation of the compliance program.

            The written compliance policies and procedures must include, at a minimum, the following elements:

            i. Duties and responsibilities of the compliance officer and Compliance Committee.

            ii. How and when employees will be trained.

iii. Procedures for the monitoring of compliance in Grantee and subcontractor systems and processes.

iv. Procedures for how employee reports of noncompliance will be handled.

v. Guidelines on how the compliance department will interact with the internal audit department.

vi. Guidelines on how the compliance department will interact with the legal department.

vii. Guidelines on how the compliance department will interact with the Human Resources department.

viii. Duties and responsibilities of management in promoting compliance among employees and responding to reports of non-compliance.

ix. Ensuring that prospective employees receive appropriate background screening and agree to abide by the Grantee's code of conduct.

x. Conducting periodic reviews, at least annually, of the code of conduct and the compliance policies and procedures.

xi. Procedures for the monitoring of potential Fraud, Waste and Abuse in provider billings and beneficiary utilization.

xii. Procedures for performing an investigation of targets selected for audit, including triage and review processes.

xiii. The prohibition of any managed care entity (MCE) employee also being employed or contracted with one of their subcontractors, network providers, or providers.

b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with Contract requirements and who reports directly to the Chief Executive Officer and the Board of Directors. The Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, or any other individual operating in these provider roles, may not operate in the capacity of the compliance officer.

   i. Grantee must designate a compliance officer whose primary responsibility is to oversee the implementation and maintenance of the compliance program.
   ii. The compliance officer must have adequate authority and independence

within the Grantee's organizational structure in order to make reports directly to the board of directors and/or to senior management concerning actual or potential cases of non-compliance.

iii. The compliance officer must also report directly to corporate governance on the effectiveness and other operational aspects of the compliance program.

iv. The compliance officer's responsibilities must encompass a broad range of duties including, but not limited to, the investigation of alleged misconduct, the development of policies and rules, training officers, directors and staff, maintaining the compliance reporting mechanism and closely coordinating with the internal audit function of the Grantee.

c. Maintenance of a Regulatory Compliance Committee comprised of individuals of the Board of Directors and senior management charged with overseeing the Grantee's compliance program and its compliance with requirements under the Contract.

i. Regulatory Compliance Committee will advise the compliance officer and assist in the maintenance of the compliance program.

ii. The Compliance Officer will remain duty-bound to report on and correct alleged fraud and other misconduct.

iii. The compliance officer must chair the Regulatory Compliance Committee.

iv. The Regulatory Compliance Committee must meet no less than quarterly.

d. A system for annual training and education for the compliance officer, the Grantee's senior management, and the Grantee's employees on Federal and State standards and requirements under the Contract. The Compliance Officer must not perform their own training and education.

i. Formal Training Programs – Grantee must provide general compliance training to all employees, officers, managers, supervisors, board members and long-term temporary employees that effectively communicates the requirements of the compliance program, including the company's code of conduct and applicable Medicaid statutory, regulatory and contractual requirements.

i. Grantee must also determine under what circumstances it may be appropriate to train nonemployee agents and Grantees.

ii. Employees, officers, managers, supervisors and Board members must be required to complete compliance training and to sign certifications that they have completed the appropriate trainings.

iii. The initial compliance training for new employees must occur at or near (within 90 days of) the date of hire.

iv. Grantee must provide annual refresher compliance training that highlights compliance program changes or other new developments. The refresher training should re-emphasize Medicaid statutory, regulatory and contractual requirements and the Grantee's code of conduct.

ii. Informal On-going Compliance Training – Grantee must employ additional, less formal means for communicating its compliance message such as posters, newsletters and Intranet communications. The compliance officer must be responsible for the content of the compliance messages and materials distributed to employees and managers.

e. Effective lines of communication between the Compliance Officer and the Grantee's employees.

i. Hotline or Other System for Reporting Suspected Noncompliance – Grantee must have mechanisms in place for employees and others to report suspected or actual acts of non-compliance.

i In order to encourage communications, confidentiality and non-retaliation policies must be developed and distributed to all employees.
ii Grantee must use e-mails, newsletters, suggestion boxes, and other forms of information exchange to maintain open lines of communication.
iii A separate mechanism, such as a toll-free hotline, must be employed to permit anonymous reporting of non-compliance.
iv Matters reported through the hotline or other communication sources that suggest substantial violations of compliance policies or health care program statutes and regulations must be documented and investigated promptly to determine their veracity.
v Grantee must create an environment in which employees feel free to report concerns or incidents of wrongdoing without fear of retaliation or retribution, when making a good faith report of non-compliance.

ii. Routine Communication and Access to the Compliance Officer – Grantee must have a general "open door" policy for employee access to the compliance officer and the Compliance Department staff. Staff must be advised that the compliance officer's duties include answering routine questions regarding compliance or ethics issues.

iii. The Compliance Officer must establish, implement and maintain processes to inform the Grantee's employees of procedure changes, regulatory changes, and contractual changes.

f. Enforcement of standards through well-publicized disciplinary guidelines.

i. Consistent Enforcement of Disciplinary Policies – Grantee must maintain written policies that apply appropriate disciplinary sanctions on those officers, managers, supervisors, and employees who fail to comply with the applicable statutory and Medicaid program requirements, and with the Grantee's written standards of conduct. These policies must include not only sanctions for actual noncompliance, but also for failure to detect non-compliance when routine observation or due diligence should have provided adequate clues or put one on notice. In addition, sanctions should be imposed for failure to report actual or suspected non-compliance.

i. The policies must specify that certain violations, such as intentional misconduct or retaliating against an employee who reports a violation, carry more stringent disciplinary sanctions.
ii. In all cases, disciplinary action must be applied on a case-by-case basis and in a consistent manner.
iii. Grantee may identify a list of factors that will be considered before disciplinary action will be imposed. Such factors may include degree of intent, amount of financial harm to the company or the government or whether the wrongdoing was a single incident or lasted over a long period of time.

ii. Employment of, and Contracting with, Ineligible Persons – Grantee must have written policies and procedures requiring a reasonable and prudent background investigation to determine whether prospective employees and prospective non-employee subcontractors or agents were ever criminally convicted, suspended, debarred or excluded from participation in a federal program. Grantee must also conduct periodic reviews of current employees and/or subcontractors and agents to determine whether any have been suspended or debarred or are under criminal investigation or indictment.

iii. If an employee or non-employee agent or subcontractor is found to be ineligible, Grantee must have a written policy requiring the removal of the employee from direct responsibility for, or involvement with, the Medicaid program, or for the termination of the subcontract, as appropriate.

g. Maintenance of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with requirements under the Contract.

i. Auditing – Grantee must have a comprehensive internal audit system to ensure that the Grantee is in compliance with the range of contractual and other MDHHS requirements in critical operations areas. The internal audit system staff must be independent from the section/department under audit. The auditors must be competent to identify potential issues within the critical review areas and must have access to existing audit resources, relevant personnel and all relevant operational areas. Written reports must be provided to the compliance officer, the Compliance Committee and appropriate senior management. The reports must contain findings, recommendations and proposed corrective actions that are discussed with the compliance officer and senior management.

Grantee must ensure that regular, periodic evaluations of its compliance program occur to determine the program's overall effectiveness. This periodic evaluation of program effectiveness may be performed internally, either by the compliance officer or other internal source - or by an external organization. These periodic evaluations must be performed at least annually, or more frequently, as appropriate.

ii. Monitoring – Grantee must maintain a system to actively monitor compliance in operational areas. Grantee must have a means of following up on recommendations and corrective action plans resulting from either internal compliance audit or MDHHS review to ensure implementation and evaluation.

Grantee must have an Exit Interview Questionnaire that includes questions regarding whether any exiting employee observed any violations of the compliance program, including the code of conduct, as well as any violations of applicable statutes, regulations and Medicaid program requirements during the employee's tenure with the Grantee. The Compliance Department must review any positive responses to questions regarding compliance violations.

2. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to MDHHS OIG. See Section B of this Contract for the method and timing of such reporting.

a. Grantee must have the right to recover overpayments directly from Providers for the post payment evaluations initiated and performed by the Grantee.

i. Contractor must specify:
(i)i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically

the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

(i)ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.

(i)iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.

b. ii. Pursuant to 42 CFR § 438.608(d)(1)(iv), this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations. Grantee questions regarding whether suspicions should be classified as Fraud, Waste and Abuse should be presented to MDHHS OIG for clarification prior to making a referral.

c. Pursuant to 42 CFR § 438.608(a)(7), the Grantee must promptly refer any potential Fraud that the Grantee identifies.

i. Upon completion of the preliminary investigation, if the Grantee 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 or AG-HCFD), the Grantee must:

1. Promptly refer the matter to MDHHS-OIG and the Attorney General's Health Care Fraud Division (AG-HCFD). These referrals must be made using the MDHHS-OIG Fraud Referral form. The template must be completed in its entirety, as well as follow the procedures and examples contained within the MDHHS-OIG guidance document.
2. Share referral via secure File Transfer Process (sFTP) using the Grantee's applicable MDHHS-OIG/AG-HCFD sFTP areas.
3. Cooperate in presenting the fraud referral to the OIG and AG-HCFD at an agreed upon time and location.
4. Defend their potential credible allegation of fraud in any appeal should the referral result in a suspension issued by MDHHS-OIG. After reporting a potential credible allegation of fraud, the Grantee shall not take any of the following actions unless otherwise instructed by OIG:

i. Contact the subject of the investigation about any matters related to the investigation;
ii. Enter into or attempt to negotiate any settlement or agreement regarding the findings/overpayment; or
iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the

findings/overpayment.

ii. Upon making a referral, the Grantee must immediately cease all efforts to take adverse action against or collect overpayments from the referred provider until authorized by MDHHS-OIG.

iii. If a draft/potential referral is declined prior to Grantee sending a final potential credible allegation of fraud, Grantee must follow reporting procedures in Section B of this Contract.

iv. If the State successfully prosecutes and makes a recovery based on a Grantee referral where the Grantee has sustained a documented loss, the State shall not be obligated to repay any monies recovered to Grantee. Unless otherwise directed by the State, the correction of associated encounter claims is not required.

v. Grantee must refer all potential Enrollee fraud, waste or abuse that the Grantee identifies to MDHHS via the local MDHHS office or through https://www.michigan.gov/fraud (File a Compliant - Medicaid Complaint Form). In addition, the Grantee must report all fraud, waste and abuse referrals made to MDHHS on their quarterly submission described in Section B of this Contract.

d. Grantee must have a mechanism for Providers to report to the Grantee when it has received an overpayment, to return the overpayment to the Grantee within 60 days of overpayment identification (in accordance with 42 CFR § 401.305 and MCL 400.111b(16)), and to notify the Grantee in writing for the reason for the overpayment.

e. Once all applicable appeal periods have been exhausted, Grantee must adjust all associated encounter claims identified as part of their Program Integrity activities within 45 days. Failure to comply may result in a gross adjustment for the determined overpayment amount to be taken from the Grantee.
   i. Grantee must also resolve outstanding encounter corrections in the timeframe designation in any authorization granted by MDHHS-OIG.
   ii. All adjustments must be performed regardless of recovery from the Subcontractor and/or provider.

f. MDHHS-OIG will perform post payment evaluations of the Grantee's Network Providers for any potential Fraud, Waste and Abuse and to recover overpayments made by the Grantee to their Network Providers when the post payment evaluation was initiated and performed by MDHHS-OIG.
   i. Grantee's Network Providers must adhere to the Medicaid Provider Manual.

ii. Grantee's Network Providers must agree that MDHHS-OIG has the authority to conduct post payment evaluations of their claims paid by the Grantee.

iii. Grantee's Network Providers must agree to follow the appeal process as outlined in Chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post payment evaluations conducted by MDHHSOIG.

iv. Section A.2.d(i-iii) requirements must be included in the Grantee's:

1. Provider enrollment agreements that must be in effect by January 1, 2023, and/or:

2. Provider manual – if the Provider enrollment agreements in effect by January 1, 2023, require Providers to adhere to the Grantee's provider manual.

v. Prior to initiating a post payment evaluation of a Grantee's Network Provider, MDHHS-OIG will:

1. Review the Grantee's quarterly submission information to determine whether the Grantee:

i. Performed a post payment evaluation of the Provider in the previous 12-month period or:

ii. Is currently performing post payment evaluation of the Provider.

2. Contact the Grantee to determine whether the Grantee and any vendors/subcontractors have identified concerns with the Provider. The Grantee must respond to MDHHS-OIG within 10 Business Days of being contacted by MDHHS-OIG.

i. After MDHHS-OIG contacts, and during pendency of MDHHS-OIG's review. Grantee must not:

a. Initiate a new investigation on the subject of MDHHS-OIG's investigation.

b. Contact the subject of MDHHS-OIG's investigation about any matters related to the post payment evaluation.

ii. The Grantee or it's vendor/subcontractor may only initiate an investigation once they have requested and received written approval from MDHHS-OIG. Such requests will only be approved once MDHHS-OIG's investigation is closed.

vi. If MDHHS-OIG proceeds with a post payment evaluation, MDHHS-OIG will:

1. Limit the scope to dates of service that are at least one year old, and:

2. Notify the Grantee in writing and request applicable information from the Grantee. (Applicable information may include, but is not limited to; detailed Grantee post payment evaluation history with the Provider, Grantee communication history with the Provider, signed provider enrollment agreement for the Provider, relevant Grantee policy, etc.) Grantee must provide MDHHS-OIG with the name of an individual that will act as the main Grantee contact for each post payment evaluation. Grantee must provide the requested information within 10 Business Days of MDHHS-OIG requests.

3. Determine if a claim-based audit or a sample/extrapolation post payment evaluation will be performed.

vii. If an overpayment is identified:

1. MDHHS-OIG will provide written preliminary results to both the Provider and Grantee. The Provider will be permitted opportunity to submit additional information by the due date indicated on the preliminary results letter (normally 30 Days) to substantiate their claims.

2. MDHHS will review any additional information submitted by the Provider received by the due date indicated in the preliminary results letter. MDHHS-OIG will issue the final written results (including appeal rights as outlined in Chapters four and six of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306) to the Provider.

i. The Grantee must not:

a. Contact the subject of MDHHS-OIG's investigation about any matters related to the investigation.

b. Enter into or attempt to negotiate any settlement or agreement regarding MDHHS-OIG's findings/overpayment; or
c. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with MDHHS-OIG's findings/overpayment.

ii. If the Provider does not appeal the final findings, MDHHS-OIG will proceed with recovering overpayments from the Grantee

iii. If the Provider appeals the final findings, MDHHS-OIG will not initiate recoupment from the Grantee until the appeal is resolved.

iv. If the Provider appeals the final findings and the appeal is resolved in the State's favor, MDHHS-OIG will proceed with recovering the overpayment from the Grantee.

viii. Pursuant to 42 U.S.C. § 1396b, the State has one year from the date of discovering an overpayment before it must refund the federal portion of the overpayment to the federal government, regardless of recovery from the Provider. Overpayments identified by MDHHS-OIG will be recovered from the Grantee via an MDHHS withhold or offset from the next capitation payment or primary push pay to the Grantee.

1. Grantee is responsible for the recovery of overpayments from their Providers.

ix. Grantee must make all necessary adjustments (i.e., for claim-based findings) to encounter data resulting from MDHHS-OIG post payment evaluations within 45 days of notice from MDHHS-OIG. Grantee must notify MDHHS-OIG when the adjustments are complete.

g. Grantee must resolve outstanding encounter corrections in the timeframe designated in any authorization granted by MDHHS-OIG.

3. Provision for prompt notification to MDHHS when it receives information about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility, including but not limited to:

a. Changes in the Enrollee's residence;

b. The death of an Enrollee.

4. Provision for notification to MDHHS OIG when it receives information about a change in a provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Grantee. See B **Reporting** of this Section for method and timing of such reporting.

5. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by providers were received by Enrollees and the application of such verification processes on a regular basis.

a. Grantee must have methods for identification, investigation and referral of suspected Fraud cases (42 CFR § 455.13, 455.14, 455.21).

i. Grantee must respond to all MDHHS-OIG audit referrals with Grantee's initial findings report within the timeframe designated in the MDHHS-OIG referral. Initial findings means prior to the provider receiving a final notice with appeal rights.

i. Grantee may request a one-time extension in writing (email) to MDHHS-OIG no less than two business days prior to the due date, if the Grantee is unable to provide the requested information within the designated timeframe. The request must include a status update and estimated date of completion.

b. Grantee must have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Grantee in preventing and detecting potential Fraud, Waste and Abuse activities.

i. Special Investigations Unit – The Grantee must operate a Fraud, Waste and Abuse Unit, Special Investigations Unit (SIU).

i. The investigators in the unit must detect and investigate Fraud, Waste and Abuse by its Michigan Medicaid Enrollees and Providers. The unit can either be a part of the Grantee's corporate structure or operate under contract with the Grantee.

ii. The Grantee must have at minimum one full-time equivalent (FTE) dedicated to Michigan Medicaid for every 100,000 Michigan Medicaid Enrollees or fraction thereof. If staff operating as part of the SIU perform additional functions within the organization, the Grantee must be able to demonstrate the allocated time each employee dedicates to Michigan Medicaid to reach the FTE requirements.

1. While investigators may split time between multiple lines of business (or multiple states/regions), the Grantee must demonstrate that an individual dedicates a minimum of 25% of their time specifically to Michigan Medicaid in order for said individual to count towards the FTE requirement. Any individual under 25% dedication to Michigan Medicaid cannot have their work/percentage counted towards the requirement.

iii. On a yearly basis, the Grantee's SIU must conduct program integrity training to improve information sharing between departments within the Grantee, such as Provider Credentialing, Payment Integrity, Customer Service, Human Resources, and the General Counsel, and to enhance referrals to the SIU regarding Fraud, Waste and Abuse within the Grantee's Medicaid program.

1. The yearly training must include a component specific to Michigan Medicaid and the Grantee's approach to address current fraud, waste, and abuse within the program.

c. Grantee, at a minimum, must perform the following verification processes:

   i. In compliance with the MI Choice chapter of the Medicaid Provider Manual, perform 30-day phone calls to Enrollees, 90-day and annual assessments of Enrollees.

   ii. Grantee must track any complaints received from Enrollees and resolve the complaints according to its established policies and procedures based on the 30-day and 90-day conversations with Michigan Medicaid Enrollees. The resolution may be Enrollee education, Provider education or referral to MDHHS OIG.

   iii. Grantee must report all complaints identified from the 30-day and 90-day conversations with Enrollees within the previous quarter to MDHHS OIG. See B **Reporting** of this section for the method and timing of such reporting.

d. Data Mining Activities – Grantee must have surveillance and utilization control programs and procedures (42 CFR § 456.3, 456.4, 456.23) to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. Data Mining must be performed at least annually.

   Grantee must utilize statistical models, complex algorithms and pattern recognition programs to detect possible fraudulent or abusive practices. The Grantee must report all data mining activities performed (including all program integrity cases opened as a result) within the previous quarter to MDHHS OIG. See B **Reporting** of this section for the method and timing of such reporting.

e. Preliminary Investigations – Grantee must promptly perform a preliminary investigation of all incidents of suspected Fraud, Waste and Abuse. The Grantee must report all program integrity cases opened within the reporting period to MDHHS OIG. See B **Reporting** of this section for the method and timing of such reporting. All confirmed or suspected provider Fraud must immediately be reported to MDHHS OIG.

   Unless prior written approval is obtained from MDHHS OIG, Grantee must not take any of the following actions as they specifically relate to Michigan Medicaid claims:

   i. Contact the subject of the investigation about any matters related to the investigation;

ii. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

iii. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation connected with the incident.

f. Audit Requirements – Grantee must conduct risk-based auditing and monitoring activities of provider transactions, including, but not limited to, claim payments, vendor contracts, credentialing activities and Quality of Care/Quality of Service concerns that indicate potential Fraud, Waste or Abuse. These audits should include a retrospective medical and coding review on the relevant claims.

In accordance with the Affordable Care Act, Grantee must promptly report overpayments made by Michigan Medicaid to the Grantee as well as overpayments made by the Grantee to a provider and/or Subcontractor. See B **Reporting** of this section for the method and timing of such reporting.

6. Provision for written policies for all employees of the Grantee, and of any Grantee or agent, 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.

i. Grantee must include in any employee handbook a description of the laws and the rights of employees to be protected as whistleblowers.

7. The Grantee must have written documentation of internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected Fraud, Waste and Abuse activities.

a. Grantee must adjust all associated encounter claims identified when authorized by MDHHS-OIG for overpayment recoupment within 45 days of notification from MDHHS-OIG. Grantee failure to comply with the encounter correction timeliness standards may result in a gross adjustment for the determined overpayment amount to be taken from Grantee. In addition to the determined overpayment amount being withheld via gross adjustment, the Grantee may be subject to other contract remedies.

8 Provision for the Grantee’s suspension of payments to a provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR§ 455.23.A credible allegation of Fraud may be an allegation, which has been verified by the State, from any source, including, but not limited to the following:

a. Fraud hotline complaints;

b. Claims data mining; or

c. Patterns identified through provider audits, civil false claims cases and law enforcement investigations.

Allegations are considered credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

Provision for the Grantee to include available methods (e.g., toll-free telephone numbers, websites, etc.) for reporting Fraud, Waste, and Abuse to the Grantee and MDHHS OIG in employee, member, and provider communications annually. Grantee must indicate that reporting of Fraud, Waste, and Abuse may be made anonymously.

9 Provision for the Grantee to submit to MDHHS-OIG a list of all entities with whom it has contracted to perform MI Choice Waiver services, under this contract. This list shall contain all facility locations where services are provided or business is conducted, all NPI numbers assigned to the entity and what services the entity is contracted to provide. The Grantee is responsible for updates to this information 30 days after changes are made (See Section B).

B. **Reporting** – Grantee must send all program integrity notifications and reports to the MDHHS OIG sFTP. The Grantee must follow the procedures and examples contained within the MDHHS OIG submission forms and accompanying guidance document. See Appendix 1 at the end of this Attachment for the listing of compliance reports and their respective due dates:

1. On a quarterly basis, the Grantee must submit to MDHHS OIG, in a format determined by MDHHS OIG, a report detailing the program integrity activities performed by the Grantee, as required by A of this section, during the previous quarter. This report must include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by the Grantee during the course of its program integrity activities. It is understood that identified overpayments may not be recovered during the same reporting time period. This report also includes a list of the individual encounters corrected. To ensure accuracy of reported adjustments, Grantees must:

   a. Purchase at minimum one 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 must be voided and resubmitted with zero dollars paid.

c. Specify overpayment amounts determined via sample and extrapolation, rather than claim-based review. In these instances where extrapolation occurs, there are no encounters to correct.

d. Specify encounters unavailable for adjustment in CHAMPS due to the encounter aging out or any other issue.

    i. These encounters must be identified by the Grantee and reported to MDHHS-OIG. MDHHS-OIG will record a gross adjustment to be taken out of the Grantee's next capitation payment.

e. Report only corrected encounters associated with post payment evaluations that resulted in a determined overpayment amount.

    i. Grantee must adjust all associated encounters identified by MDHHS-OIG for overpayment recoupment within 45 days of notification from MDHHS-OIG.

2. Notwithstanding the obligation to report suspicions of provider and subcontractor Fraud directly to MDHHS OIG as required by this Contract, Grantee must, on a quarterly basis, submit to MDHHS OIG, in a format determined by MDHHS OIG, a report detailing all allegations of provider and subcontractor Fraud received and reviewed by the Grantee during the previous quarter.

3. Pursuant to 42 CFR § 438.608(d)(3), on an annual basis, Grantee must submit to MDHHS OIG, in a format determined by MDHHS OIG, an annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Grantee for the preceding year. The report must also address the Grantee's plan of activities for the current and upcoming fiscal year. The report must include all provider and service-specific program integrity activities. The report must include an attestation confirming compliance with the requirements found in 42 CFR § 438.608 and 42 CFR § 438.610.

   Pursuant to 42 CFR § 438.606, the annual Program Integrity Report must be certified by either the Grantee's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification must attest that, based on best information, knowledge and belief, the information specified is accurate, complete and truthful.

4. Grantee must submit to MDHHS OIG, in a format determined by MDHHS OIG, a complete list of all contracted entities as described in A.10 and is due within 60 days after the start of the contract year.

5. Any excluded individuals and entities discovered in the screening described in G of this section, including the provider applications and credentialing documentation, must be reported to the federal HHS OIG and MDHHS OIG, in a format determined by MDHHS OIG, within 20 Business Days of discovery.

6. Grantee must submit to MDHHS OIG, in a format determined by MDHHS OIG, a Quarterly Provider Disenrollment Log for providers terminated as a result of a program integrity activity.

7. Contract Compliance Review Score – Grantee will be scored based on the quantity and quality of the quarterly reports submitted to MDHHS OIG.

    a. Grantee will receive a score of Met if they initiated program integrity activities as required by A of this section during the reporting period, complied with the MDHHS OIG quarterly submission form content requirements and accompanying guidance document, and complied with deliverable due dates.

    b. Grantee will receive a score of Not Met for any compliance review quarter where it has not initiated any program integrity activities, as required by A of this section, during the previous quarter.

    c. Grantee will receive a score of Not Met for any compliance review quarter where it has not complied with the MDHHS OIG quarterly submission form content requirements and accompanying guidance document.

    d. Grantee will receive a score of Not Met for any compliance review quarter where it has not complied with the deliverable due dates.

C. **Availability of Records** – Grantee must cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal. Such cooperation must include providing, upon request, information, access to records and access to interview Grantee 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. The Grantee must follow the procedures and examples contained within processes and associated guidance provided by MDHHS-OIG.

1. Grantee must maintain written policies and procedures pertaining to cooperation with any duly authorized government agency, including processes relating to the delegation of an inquiry.

2. Grantee and its providers, subcontractors and other entities receiving monies originating by or through Michigan Medicaid must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the

individual Enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in this Contract.

3. Grantee must ensure within its own organization and pursuant to any agreement the Grantee may have with any other providers of service, including, but not limited to providers, subcontractors or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid, that MDHHS representatives and authorized federal and State personnel, including, but not limited to MDHHS OIG, the Michigan Department of Attorney General, the US Department of Health and Human Services, US Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized State or federal agency must have immediate and complete access to all records pertaining to services provided to Michigan Medicaid Enrollees, without first obtaining authorization from the Enrollee to disclose such information (42 CFR § 455.21 and 42 CFR § 431.107).

    a. Access will be either through on-site review of records or by any other means at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time.

        i. Upon request, the Grantee, its provider or subcontractor must provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate MDHHS OIG or other state or federal agency.

    b. Grantee must send all requested records to MDHHS OIG within 30 Business Days of request unless otherwise specified by MDHHS or MDHHS rules and regulations.

    c. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records must be maintained in their original form or may be converted to electronic format if the records are readable and/or legible. These records, books, documents, etc., must be available for any authorized federal and State personnel during the Contract period and seven years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records must be kept until all tasks or proceedings are completed.

4. Grantee and its subcontractors and any providers of service, including, but not limited to providers or any person or entity receiving monies directly or indirectly by or through Michigan Medicaid must make all records (including, but not limited to, financial, medical and enrollee grievance and appeal records, base data in 42

CFR 438.5(c), Medical Loss Ratio (MLR) reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610) available at the Grantee's, provider's, and/or the subcontractor's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from the MDHHS OIG, the Michigan Department of Attorney General, DHHS OIG and the DOJ, or any duly authorized State or federal agency for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

D. Provider Manual and Bulletins – Grantee must issue Provider Manual and Bulletins or other means of Provider communication to the providers of medical, behavioral, dental and any other services covered under this Contract. The manual and bulletins must serve as a source of information to providers regarding Medicaid covered services, policies and procedures, statutes, regulations, and special requirements to ensure all Contract requirements are being met. The Grantee may distribute the provider manual electronically (e.g., via its website) as long as providers are notified about how to obtainthe electronic copy and how to request a hard copy at no charge to the provider.

1. The Grantee's provider manual must provide all of its Providers with, at a minimum, thefollowing information:

   a. Description of the Michigan Medicaid managed care program and covered populations;

   b. Scope of Benefits;

   c. Covered Services;

   d. Emergency services responsibilities;

   e. Grievance/appeal procedures for both Enrollee and provider;

   f. Medical necessity standards and clinical practice guidelines;

   g. The Grantee's policies and procedures including, at a minimum, the following information:

      i. Policies regarding provider enrollment and participation;

      ii. Policies detailing coverage and limits for all covered services;

      iii. Policies and instructions for billing and reimbursement for all covered services;

      iv. Policies regarding record retention;

v. Policies regarding Fraud, Waste and Abuse;

vi. Policies and instructions regarding how to verify beneficiary eligibility;

h. Primary Care Physician responsibilities;

i. Requirements regarding background checks;

j. Other provider/subcontractors' responsibilities;

k. Prior authorization and referral procedures;

l. Claims submission protocols and standards, including instructions and all informationnecessary for a clean claim;

m. Medical records standards;

n. Payment policies;

o. Enrollee rights and responsibilities.

p. Self-reporting mechanisms and polices as cited in A.2.c.

2. Grantee must review its Provider Manual, Bulletins and all Provider policies and procedures atleast annually to ensure that Grantee's current practices and Contract requirements are reflected in the written policies and procedures.

3. Grantee must submit Provider Manual, Bulletin and or other means of Provider communications to MDHHS-OIG upon request.

E. **Provider Agreements -** Grantee must submit its Provider Agreements to MDHHS OIG upon request.

F. **Affiliations with Debarred or Suspended Persons** – Pursuant to 42 CFR § 438.610:

1. Grantee must not knowingly have a director, officer, partner, managing employee or person with beneficial ownership of more than 5% of the Grantee's equity who has been or are currently debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non- procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

2. Grantee must not knowingly have a director, officer, partner or person with beneficial ownership of more than 5% of the Grantee's equity who is affiliated (as defined in the Federal Acquisition Regulation at 48 CFR § 2.101) with another

person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

3. Grantee must not have a Provider, subcontractor, or person with an employment, consulting or any other contractual agreement who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing such order.

4. Grantee must provide written disclosure of any director, officer, partner, managing employee, person with beneficial ownership or more than 5% of the Grantee's equity, Network Provider, subcontractor, or person with employment consulting, or any other contractual agreement who is (or affiliated with a person/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 such order; and any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

5. If MDHHS learns that the Grantee has a prohibited relationship as described above and provided by Federal Acquisition Regulation, Executive Order No. 12549, or under section 1128 or 1128A of the Act, MDHHS may continue an existing agreement with the Grantee unless CMS directs otherwise. MDHHS may not renew or otherwise extend the duration of an existing agreement with the Grantee unless CMS provides to MDHHS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite prohibited affiliations.

6. Grantee must agree and certify it does not employ or contract, directly or indirectly, with:

    a. Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

    b. Any individual or entity discharged or suspended from doing business with Michigan Medicaid; or

    c. Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the

Social Security Act.

d. The Federal and State sanction database will be checked at least monthly to ensure compliance with this contract. Federal exclusions database: http://exclusions.oig.hhs.gov; State exclusion database URL: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-16459--,00.html

7. MDHHS may refuse to enter into or renew a contract with the Grantee if any person who has an ownership or control interest in the Grantee, or who is an Agent or managing employee of the Grantee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. Additionally, MDHHS may refuse to enter into or may terminate the Contract if it determines that the Grantee did not fully and accurately make any disclosure required under F of this section.

G. **Disclosure by Managed Care Entities: Information on Ownership and Control** – Pursuant to 42 CFR § 455.104: MDHHS may review ownership and control disclosures submitted by the Grantee and any of the Grantee's Subcontractors.

1. Grantee must provide to MDHHS the following disclosures:

a. The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of 5% or more of the Grantee's equity (or, in the case of a Subcontractor's disclosure, 5% or more of the Subcontractor's equity);

b. The identification of any person or corporation with an ownership interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by the Grantee if that interest equals at least 5% of the value of the Grantee's assets (or, in the case of a subcontractor's disclosure, a corresponding obligation secured by the Subcontractor equal to 5% of the Subcontractor's assets);

c. The name, address, date of birth and Social Security Number of any managing employee of the MI Choice Waiver Agency. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, corporate officer, director (i.e., member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

2. The disclosures must include the following:

a. The name, address and financial statement(s) of any person (individual or corporation) that has 5% or more ownership or control interest in the Grantee.

b. The name and address of any person (individual or corporation) that has 5% or

more ownership or control interest in any of the Grantee's Subcontractors.

c. Indicate whether the individual/entity with an ownership or control interest is related to any other Grantee's employee such as a spouse, parent, child or siblings; or is related to one of the Grantee's officers, directors or other owners.

d. Indicate whether the individual/entity with an ownership or control interest owns 5% or greater in any other organizations.

e. The address for corporate entities must include as applicable primary business address, every business location and P.O. Box address.

f. Date of birth and Social Security Number (in the case of an individual).

g. Other tax identification number (in the case of a corporation) with an ownership or control interest in the MI Choice Waiver Agency or its Subcontractor.

3. The Grantee must terminate or deny participation if a provider, or any person with 5% or greater direct or indirect ownership interest fails to submit sets of fingerprints in a form and manner to be determined by MDHHS, within 30 Days when requested by MDHHS or any authorized federal agency.

4. Disclosures from the Grantee are due to MDHHS at any of the following times:

   a. When the Grantee submits a proposal in accordance with an MDHHS procurement process.

   b. When the Grantee executes the Contract with MDHHS.

   c. Upon renewal or extension of the Contract.

   d. Within 35 Days after any change in ownership of the Grantee.

   e. Upon request by MDHHS.

5. All required disclosures under this subsection must be made to MDHHS, the Secretary of the US Department of Health and Human Services and the Inspector General of the US Department of Health and Human Services in the format developed by the requestor. Failure to provide required information may lead to sanctions including withholding of capitation payment. Federal financial participation is not available for entities that do not comply with disclosures, therefore, MDHHS may withhold capitation from the Grantee for services provided during the period beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied.

H. **Excluded Individuals and Entities** – Grantee is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded

person, at the medical direction or on the prescription of an excluded person. (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR § 455.104, 42 CFR § 455.106, and 42 CFR § 1001.1901(b)). Grantee must monitor for excluded individuals and entities by requiring:

1. Grantee must not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Grantee must immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.
2. Grantee is prohibited from entering into any employment, contractual and control relationships with any excluded individual or entity.
3. Civil monetary penalties may be imposed against the Grantee if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees (SSA section 1128A(a)(6)).
4. An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5% or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR § 455.104(a), and 42 CFR § 1001.1001(a)(1)).
5. Grantee must immediately terminate all beneficial, employment, and contractual and control relationships with any individual or entity excluded from participation by MDHHS.

## Appendix 1 - COMPLIANCE REVIEW

November 15
Quarterly Program Integrity Report (Jul-Sep)

December 1
Contracted Entities List (updates due 30 days after changes are made)

January 15
Annual Program Integrity Report for Michigan Medicaid for previous fiscal year (includes Annual Program Integrity Plan and Attestation form)

February 15
Quarterly Program Integrity Report (Oct-Dec)

March 15
Compliance Program (Grantee policies and procedures in place and or revised in previous fiscal year/current fiscal year.

May 15
Quarterly Program Integrity Report (Jan-Mar)

August 15
Quarterly Program Integrity Report (Apr-Jun)