Region 9 AAA	Local Policy #	V-2
Policy Name:	**Provider Compliance and Disenrollment Procedures**	
Original Policy Date:	March 2023	
Review Date:		
Revise Date:	August 2023, March 2024, July 2024	

Policy:

Purchase of Service Providers must comply with Michigan Department of Health and Human Services (MDHHS), Bureau of Aging, Community Living, and Supports (ACLS Bureau), and applicable AAA local policies, procedures, practices, operating standards, and uphold certifications and/or licensure requirements to remain eligible to serve Area Agency on Aging (AAA) participants. Providers must maintain written policies and procedures pertaining to cooperation with any duly authorized government agency, including processes relating to the delegation of an inquiry.

The NEMCSA - Region 9 AAA oversees and is held accountable for any functions and responsibilities delegated to Purchase of Service Providers (POS). It is the policy of the AAA to ensure that contracted POS Providers are compliant with program operating standards and are eligible to serve MI Choice and ACLS-funded participants. The AAA conducts periodic monitoring of contracted providers to ensure compliance with established policies/procedures, billing requirements, staffing requirements, and operating standards.

The following procedure is applicable to all Purchase of Service Providers that have had a Purchase of Service Contract terminated for-cause by the AAA. A for-cause termination includes any termination action taken by the AAA for reasons other than provider request, failure to return renewal documents or inactivity of contract. Any provider whose contract was previously terminated for-cause is subject to an exclusionary period of one (1) calendar year. After the exclusionary period has concluded, the provider may resubmit an application during the next open enrollment period; however, reenrollment as a POS provider is not guaranteed after the exclusionary period has been served. Exemptions to the exclusionary period may be granted at the sole discretion of the AAA.

Suspected fraud, waste and abuse committed or condoned by a Purchase of Service Contract provider will be reported to the Michigan Office of Inspector General (OIG) upon completion of an internal investigation.

This policy pertains to NEMCSA and their contracted providers.

Purpose:

To ensure Purchase of Service Providers meet all compliance requirements and assists in maintaining the health, safety and welfare of participants receiving services administered and funded by the AAA, and to outline procedures for provider monitoring visits, overpayments and

recoupments, termination of provider contracts for cause, and referrals to the Michigan Office of Inspector General (OIG).

Procedure:

1. All POS Providers must fulfill the requirements of 42 CFR §438.230 that are appropriate to the service or activity delegated under the subcontract. The AAA includes this information in the subcontractor packet for contracted providers.
    a. POS Provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions as well as ACLS service standards;
    b. POS Provider agrees that MDHHS, CMS, DHHS – Office of Inspector General (OIG), the Comptroller General, Attorney General, Department of Justice (DOJ) or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems that pertain to any aspect of services and activities performed, or determination of amounts payable under the MI Choice agent's contract with the State. For purposes of this policy, NEMCSA-Region 9 AAA is the Pre-paid Ambulatory Health Plan (PAHP) for MI Choice in twelve counties of northeast Michigan.
    c. POS-Provider will make available, for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to Medicaid enrollees served under the MI Choice agreement.
    d. POS-Provider agrees the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    e. POS Provider agrees if MDHHS, CMS, Inspector General, or Attorney General determines that there is a reasonable possibility of fraud or similar risk, MDHHS, CMS, Inspector General, or Attorney General may inspect, evaluate, and audit them at any time.

2. The AAA must evaluate the prospective POS provider's ability to perform the activities to be delegated. Refer to procedures outlined in the A-6a Provider Enrollment and Qualifications Policy.

3. The AAA must have a written agreement between the AAA and the POS Provider that specifies the activities and reporting responsibilities delegated to the POS Provider; and if necessary can impose probation and termination if the POS Provider performance is inadequate. The AAA includes this information in the subcontractor packet.

Provider Monitoring Visits and Audits

1. The AAA must monitor the POS Provider's performance on an ongoing basis and conducts ongoing monitoring of all POS Providers and periodic formal provider monitoring visits. Additionally, all POS Providers are subject to formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations.

2. The AAA formally monitors at least 20% of the MI Choice provider network annually. The sample includes providers selected at random each year and the following applicable special inclusionary criteria:
    a. Fiscal intermediaries
    b. High service utilization
    c. New to the provider network
    d. New ownership or management

3. Providers will be notified of the provider monitoring visit in writing at least two weeks before the review date. The notice will include information about the monitoring process and tools used. A list of participants served over the preceding fiscal year will be sent securely to the provider.

4. Providers agree to have the following items prepped and ready for review:
    a. Participant files – those communicated via the participant list
    b. Employee files – all employees who served participants on the list; all employees who signed the participant journal during the selected billing review quarter. The billing review quarter will be communicated with the participant list
    c. Billing documentation – service authorizations, journals, timesheets, case record documentation, payroll records, DCW (Direct Care Worker) payroll records
    d. Policies and Procedures outlined in the checklist
    e. Employee training records
    f. Accident and Incident records (if applicable to the participants being reviewed)

5. The AAA will follow procedures outlined in MDHHS MI Choice policy to identify deficiencies or areas for improvement in the POS Provider's performance. In addition to internal tools, AAA reviewers utilize the following State tools to conduct formal provider monitoring visits based on the provider type:
    a. MI Choice Waiver Provider Monitoring Tool (Attachment J)
    b. MI Choice In-Home Participant Visit
    c. Participant Survey for Provider-Owned Setting
    d. Home and Community-Based Services (HCBS) Residential Setting Survey Template
    e. HCBS Non-Residential Setting Survey Template
    f. Self-Determination in Long-Term Care – Fiscal Intermediary Annual Performance Review (Attachment N)

6. Providers must implement corrective action when deficiencies are noted. When a formal provider monitoring visit is conducted, the AAA reviewer will inform providers of the review results and corrective action deficiencies as part of an exit interview then in writing, as warranted, by issuing a "Findings Letter" or "Findings Report."
    a. A Findings Letter is sent to a provider within 14 business days following completion of the initial review, if compliance items are identified during the visit that require immediate action. Items requiring immediate action include noncompliance with criminal history background checks and OIG exclusionary screenings as outlined in 42 CFR 455 and the Public Act 28 of 2021. The provider

will have 5 business days from the receipt of the findings letter to submit their response and corrective action(s) taken. The reviewer will communicate the deficiencies requiring immediate action, expectation for correction, time periods, and process during the exit interview.

b. A Findings Report is sent to a provider within 30 days after the initial review to outline the review results. The Findings Report includes the compliance items outlined in the findings letter even if action has already been taken on those findings. If a provider is required to submit a response or correction action plan (CAP) back to Region 9 AAA, it will be outlined in the letter with a date the response or CAP is due. CAPs are due 30 days from receipt of the findings report.

7. If the AAA requests a corrective action or CAP in a findings letter or findings report, the POS Provider is required to take one or more of the following actions:
    a. Accept the deficiencies as they are and submit a corrective action plan outlining the actions the provider plans to initiate or implement to correct the deficiencies identified. Providers must include the date they expect to be fully compliant by meeting all deficiencies outlined in the findings report will be compliant from that date forward. For example, policies found deficient should be updated prior to that date. Date should not be more than six months away.
    b. Respond by submitting a rebuttal with evidence to support each claim being disputed.
    c. A combination of the above actions.

8. The AAA has the sole discretion to accept or deny submissions of rebuttal or corrective action, including CAPs. POS Providers are expected to meet CAP requirements on first submission, though the AAA reserves the right to grant the provider additional CAP resubmissions.

9. The AAA will schedule an onsite follow-up review with the provider, three to six months following the date of an accepted correction action plan (CAP) to ensure that the provider initiated and implemented the corrective action. For continued program participation, providers are expected to be in full compliance with the standards and conditions at the time of the follow-up review.

10. NEMCSA monitors and conducts additional audits for the following:
    a. Claim payments including retrospective medical and coding review on relevant claims and provider transactions
    b. Vendor contracts
    c. Credentialing activities
    d. Quality of Care / Quality of Service concerns
    e. Data mining flags
    f. Tips/grievances
    g. Referrals received from the OIG or other source

11. Any audit that indicates potential fraud, waste, or abuse is subject to an internal special investigation. The investigation determines whether the suspicion or allegation is substantiated or not.

Overpayments and Recoupment:

1. MI Choice Waiver Providers must promptly report overpayments made with Medicaid funding to the AAA. NEMCSA – Region 9 AAA reports any overpayments to the OIG.

2. If NEMCSA – Region 9 AAA identifies an overpayment was received from Michigan Medicaid, the Director of Business / Financial Resources must report the overpayment to MDHHS OIG on the required quarterly report via secure transfer file.

3. If a MI Choice provider identifies an overpayment was received, the following actions must be taken:
    a. Report the overpayment to the AAA. This can be done via a form: Region 9 AAA – Provider/Vendor Overpayment Reporting Form or https://forms.office.com/r/YATU4qtFau
    b. Return the overpayment to the AAA within 30 days of the date the overpayment was identified (in accordance with 42 CFR § 401.305 and MCL 400.111b(16))
    c. Notify the AAA in writing regarding the reason for the overpayment, if the overpayment was not reported to the AAA using the form.

4. The AAA will recover provider reported overpayments, less than $5,000, as soon as possible, within 45 days of receiving notification of an overpayment.

5. If NEMCSA identifies overpayments or inappropriate payments have been made to providers during audit or otherwise, every effort is made to recover the full overpayment. Additional monitoring or auditing activities may be pursued as deemed necessary.

6. NEMCSA - Region 9 AAA will pursue applicable recoupment proceedings for improper payments or overpayment by notifying providers of overpayment identification and recoupment procedures in writing. The provider has an opportunity to dispute the findings.

7. Providers have thirty (30) days from receipt of the Notice of Preliminary Findings letter to respond to all discrepancies and to submit additional documentation for review as determined by the SIU. Providers must submit a letter of dispute accompanied by all documentation related to the discrepancy in question, any relevant policies as previously described, and any other supporting information to NEMCSA's Compliance Department. The SIU will review the dispute, research the issue(s) and consult other subject matter experts as necessary. NEMCSA will make a good faith effort to review the dispute and notify the provider in writing of the final determination within thirty (30) days of receipt of the dispute. NEMCSA reserves the right to extend the review period if necessary to complete a full and final review. If the review period is extended, the SIU will notify the provider in writing of the extension.

8. Providers have 30 days from receipt of the Final Notice of Recovery or Reconsideration Response letter to request an internal conference or appeal with NEMCSA. If a provider

requests an appeal or conference, NEMCSA will not institute recoupment action until the appeal is resolved. If a provider does not appeal the action within thirty (30) days from the date of the Final Notice of Recovery or Reconsideration Response letter, those letters will act as a final determination notice (MAC R 400.3405) and recovery will begin on the 31st day.

9. If an overpayment of $5,000 or greater is identified, involving a potential credible allegation of fraud, the case is referred to MDHHS-OIG and the Attorney General's Health Care Fraud Division (AG-HCFD).

Referrals to the MDHHS-OIG and AG-HCFD:

1. Suspected fraud, waste and abuse committed or condoned by a MI Choice Waiver Purchase of Service Contract provider will be subject to an internal investigation. Upon completion of the internal investigation, if the AAA's Special Investigation Unit finds the referral to be a credible allegation of fraud, the case will be referred to the OIG.

2. If findings or investigations of Tips or Grievances result in substantiated fraud, waste, or abuse, the AAA refers the case to the OIG and AG-HCFD.

3. Pursuant to 42 CFR § 438.608(a)(7), if the AAA identifies potential credible allegation of Fraud and refers the case to the OIG/AG-HCFD, the AAA will not:
    a. Contact the subject of the investigation about any matters related to the investigation;
    b. Enter into or attempt to negotiate any settlement or agreement regarding the findings/overpayment; or
    c. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the findings/overpayment.

4. If the potential credible allegation of Fraud referral results in a suspension issued by MDHHS OIG in accordance with 42 CFR § 455. 23, the AAA will suspend payments to the network provider.

Termination of Provider Contract for Cause

1. The AAA has the authority to activate provider termination proceedings. The following provider actions, or inaction, may result in the activation of a 30-day notice of Intent to Terminate the Purchase of Services Agreement:
    a. Failure to respond to written communications to address actual or suspected compliance issues.
    b. Failure to submit a corrective action plan at the request of the AAA.
    c. Failure to correct identified findings.
    d. Failure to comply with applicable policies, procedures, practices, and standards.

2. The AAA will make a good faith effort to give written notice of termination of a contracted provider to each MI Choice participant who received services from the provider. Notice to the participant must be provided by the later of 30 calendar days

prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

3. MI Choice POS Providers have the right to appeal review findings or audits when actions of probation, suspension or termination are taken.