MI CHOICE WAIVER PROGRAM

PROVIDER MANUAL

EASTERSEALS MORC HOME CARE | 15600 19 MILE RD CLINTON TWP MI

Table of Contents

What is MI Choice Waiver 5

Who is Eligible 5

Medical Necessity 5

What Services Are Offered 6

Service Need Level & Emergency Plan 6

Grid of Service Need Level (See Medicaid Provider Manual MI Choice Section 4.5.A) 7

Grievance/Appeals 8

Policy: 8

Grievance: 9

Definition: 9

Procedure: 9

Standard Internal Appeal Process and Timeframes 9

Extension of timeframe for processing an internal appeal 10

The Internal Appeals Log 11

Expedited internal appeal process and timeframes 11

Extension of timeframe for processing an expedited internal appeal 12

Adverse benefit determination (ABD) 12

Recordkeeping of grievances & internal appeals 13

Grievances & Appeals of Adverse Benefit Determination – Decision Makers 13

Provider Application Policy & Re-Credentialing 14

Policy: 14

Definition: None 14

Procedure: A provider interested in conducting business with the MORC Home Care MI Choice program contacts the office to inquire. The program and contract requirements are explained to the potential provider. Potential providers are sent a sample contract with licensing requirements, MDHHS standards and a bid sheet to be completed and returned. 14

Reference: None 16

Exhibit: None 16

Procedure Manual 16

A dedicated policy and procedure manual is required for the MI Choice Waiver Program. It must be developed and approved prior to signing the contract. See list below, which are the minimal requirements at this time in addition to policy related to the Managed Care Requirements. Each Policy should be tabbed to identify their location within the manual. Each document should have a revision dating. It is the provider's responsibility to update their provider manual annually or upon any contract, associated attachments or federal regulation changes. Any question or assistance regarding the Procedure Manual content should be directed to Kim Buckley at kbuckley@eastersealsmorc.org. 16

Coverage and Limits for All Covered Services 17

Covered Waiver Services (Definition/Requirements/Limits) 18

Billing and Reimbursement for All Covered Services 18

Easterseals MORC Billing Accounting Standards 18

Definitions: 18

Policy Standards: 19

Procedure: 19

Billing Accounting Standards Procedure as it relates to MI Choice Waiver Program: 20

Billing Procedures 20

Provider Payments 20

Claims Auditing 21

Reconciliation Accounting Standards 21

Record Retention Policy 22

Policy: 22

Definition: 22

Procedure: 22

Reference: 22

Exhibit: 22

Fraud, Waste and Abuse Provider Policy 23

Policy: It is the policy of EM to comply with all laws and regulations of the Federal, State and Local government. 23

Definitions: None 23

Procedure: 23

Auditing 23

Monitoring 23
References: 26
Exhibits: 26
Beneficiary Eligibility Verification 26
FINANCIAL ELIGIBILITY 26
Medical Eligibility 27
FREEDOM OF CHOICE (FOC) 27
Primary Care Physician Responsibilities 28
Provider Background Checks 28
Policy: 28
Definitions: 28
Procedure: 29
Responsibility / Action: 30
References: 31
Exhibits: 31
Other Provider/Subcontractors' Responsibilities 31
Prior Authorization and Referral Procedures 32
Claim Submission Protocols and Standards (including clean claim) 33
Encounter Data Reporting 33
Administrative Expense and Other Financial Reporting 33
Financial Audit Requirements 34
Record Retention 34
Policy: 35
Definition 35
Procedure: 35
Reference: 35
Exhibit 35
Medical Record Standards 35
Payment Policies 37

Participant Rights & Responsibilities 37
Self-Reporting Mechanisms and Policies 39
Policy Purpose: 39
Policy Standards 39
Definitions: 39
Procedure 39
Detailed Elements 40
References: 50
Exhibit: 50
MANUAL RESOURCES 51

What is MI Choice Waiver

The MI Choice Waiver Program is a Medicaid-funded initiative in Michigan designed to help older adults and individuals with a disability determination live independently in their communities rather than in institutional settings like nursing homes. The program offers a range of services to support individuals in managing their daily needs and maintaining a higher quality of life at home. The program aims to provide a more personalized and community-based approach to long-term care, giving individuals greater choice and control over their care.

Who is Eligible

Interested individuals must meet specific criteria related to income, disability, and care needs. To be eligible, you generally need to:

To be eligible for the MI Choice Waiver Program, persons must:

- Be medically appropriate for a nursing home meeting the Michigan Medicaid Level fo Care Determination (LOCD) Criteria.
- Be Medicaid eligible
- Be 18 years of age or older with a disability who would otherwise require nursing home care **OR** be over age 65 and in need of nursing home care.
- Meet annual income and asset criteria.
- Reside in Macomb, Oakland, Livingston, Monroe, St. Clair or Washtenaw counties
- Requires Support Coordination and at least one MI Choice service

NOTE: MI Choice Waiver program is a Mutually Exclusive program and cannot occur simultaneously with other Medicaid service programs.

Medical Necessity

MI Choice applicants must demonstrate the need for a minimum of two covered services, one of which must be supports coordination, as determined through an in-person assessment and the person-centered planning process. Applicants must also agree to receive MI Choice services on a regular basis, at least every 30 days. An applicant cannot be enrolled in MI Choice if their service and support needs can be fully met through the intervention of State Plan or other available Medicaid services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications. (MPM 2.3 pg1301)

What Services Are Offered

Waiver Services focus on participants needs to live successfully in the community that are indicated by a current assessment, detailed in the individualized person-centered service plan (PCSP) and are authorized in accordance with the provisions of the approved waiver. Each participant can receive the basic services Michigan Medicaid covers, supports coordination, and one or more of the following services:

- Adult Day Health (Adult Day Care)
- Chore services
- Community health worker
- Community living supports
- Community transportation
- Counseling
- Environmental accessibility adaptations
- Fiscal intermediary
- Goods and services
- Home delivered meals
- Nursing services
- Personal emergency response systems (PERS)
- Private duty nursing/respiratory care
- Respite services
- Specialized medical equipment and supplies
- Supports Brokerage
- Training in a variety of independent living skills

(SEE – Michigan Medicaid Manual – MI Choice Waiver Section 4 for additional information

Service Need Level & Emergency Plan

Waiver agencies classify each MI Choice participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal supports.

Waiver agencies establish and utilize written procedures consistent with the service need levels specified below to ensure each participant's needs are met in the event of an emergency. Waiver agencies make direct service providers aware of the service need levels and the classification of each participant served by that provider so that the service provider can target services to the highest priority participants in emergencies.

Service Need Level classification.

Immediacy of need for the provision of services

1. Immediate – the participant cannot be left alone
2. Urgent – the participant can be left alone for a short time (less than 12 hours)
3. Routine – the participant can be left alone for a day or two

Availability of Informal Supports

1. No informal supports are available for the participant
2. Informal supports are available for the participant
3. The participant resides in a supervised residential setting (SRS)

Grid of Service Need Level (See Medicaid Provider Manual MI Choice Section 4.5.A)

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means the participant cannot be left alone. If services are not delivered as planned, the backup plan needs to start immediately.
Immediate	Available	1B	This means the participant cannot be left alone. If services are not delivered as planned, family or friends need to be contacted immediately.
Immediate	SRS	1C	This means the participant cannot be left alone. Staff at the place of residence must be available as planned or follow established emergency procedures.
Urgent	None	2A	This means the participant can be left alone for a short time. If services are not delivered as planned, the backup plan needs to start within 12 hours.
Urgent	Available	2B	This means the participant can be left alone for a short time. If services are not delivered as planned, family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means the participant can be left alone for a short time. Staff at the place of residence must check on the participant periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means the participant can be left alone for a day or two. If services are not delivered as planned, the backup plan needs to start within a couple of days.
Routine	Available	3B	This means the participant can be left alone for a day or two. If services are not delivered as planned, family or friends need to be contacted within a couple of days.
Routine	SRS	N/A	There is not a 3C service need level because participants in supervised residential settings typically require 24-hour supervision and cannot be left alone for long periods.

Grievance/Appeals

To establish a process to assure that the grievance and appeals rights of individuals receiving MI Choice services are protected.

Policy:

It is the policy of Easterseals MORC Home Care, Inc. to follow all federal and state rules and regulations for a grievance and appeals system which include:

- Internal Grievance Process
- One Level Appeal Process
- A State Fair Hearing from the Michigan Department of Health and Human Services (MDHHS) Administrative Hearing System will occur if requested by the participant/representative/ guardian when the internal MORC Home Care, Inc. appeal process is exhausted. MORC Home Care MI Choice Waiver Office of Grievance & Appeals represents MDHHS at the hearing and follows decisions as ordered by the Administrative Law Judge.

  The individual or legal representative, as appropriate, will be provided with written information on rights guaranteed by Federal and State regulations of all grievance and appeal options at the time of Intake, annually and in the event of an Adverse Benefit Determination (ABD). This information must be accessible to individuals who are limited English proficient and to individuals with disabilities and may be provided in electronic format consistent with federal law.

The Complaint - Grievance - Appeal - State Fair Hearing Definitions Document is provided to all participants upon enrollment & annually. It is also provided to providers upon new contract signing and re-credentialing.

Who can file an appeal, grievance or request a state hearing.

The enrollee OR with enrollee’s written consent a representative or provider.

“Enrollee” will be used to represent enrollee, authorized representative or provider throughout this document unless otherwise specified.

Grievance: An expression of dissatisfaction/complaint about any matter that is NOT an Adverse Benefit Determination (ABD).

- Can be filed at any time when concern is not resolved with the MORC Home Care MI Choice Complaint Process.
- Can be either written or oral
- Does NOT give rights to a State Fair Hearing
- Examples: SC unkind to enrollee; Failure to respect enrollee's rights, enrollee unhappy with provider
- MI Choice must acknowledge receipt of each grievance and provide resolution with Notice within 90 calendar days of receipt of the

Definition: None

Procedure:

Standard Internal Appeal Process and Timeframes

INTERNAL APPEAL: A review by the MORC Home Care MI Choice Waiver Office of Grievance & Appeals of an adverse benefit determination.

- Gives right to a State Fair Hearing
- To appeal an Adverse Benefit Determination (ABD is the reduction, suspension or termination of a previously authorized service).
- MORC Home Care MI Choice Waiver Office of Grievance & Appeals must acknowledge receipt of each appeal of adverse benefit determination.
- An internal appeal must be filed by the enrollee within 60 calendar days from the date on the ABD Notice.
- Enrollee may request appeal either in writing or orally.
    - If enrollee requests a representative to act on enrollee's behalf, both the enrollee and named representative must sign and date a statement indicating this is the enrollee's preference.
    - MORC Home Care MI Choice Waiver Office of Grievance & Appeals is required to ensure that oral internal appeal requests of an adverse benefit determination are treated as state appeals & confirmed in writing.

  Exception: If enrollee requests an expedited resolution.

- MORC Home Care MI Choice Waiver Office of Grievance & Appeals will mail Receipt of Internal Appeal Request letter and Notice of Receipt of Internal Appeal/Grievance to enrollee within 2 business days.

  - MORC Home Care must receive a response from the enrollee within 10 calendar days from the date of the Internal Appeal Request letter.
  - Documents are required if there is a Guardian or activate Durable Power of Attorney for Healthcare.
  - MORC Home Care MI Choice Waiver Office of Grievance & Appeals to provide the enrollee copies of all documents, case records, etc. in connection with the internal appeal upon receiving written request by enrollee.
  - MORC Home Care MI Choice Waiver Office of Grievance & Appeals must provide written Decision Notice of resolution within 30 calendar days from the date MORC Home Care received the appeal.
    - Written Decision Notice of Resolution must be provided to enrollee by MORC Home Care and include:
      - The date of the appeal resolution
      - The result of the appeal resolution
      - Language that meets applicable notification standards

When Appeal decisions are not wholly in enrollee's favor MORC Home Care must include the following in the written notice:

- The Right to Request a State Hearing
- How to Request a State Hearing
- The right to request & receive benefits pending a State Hearing
- How to request the continuation of benefits pending a State Hearing.

See ****ENROLLEE REQUEST FOR CONTINUED WAIVER BENEFITS. grievance.

Internal Appeals are deemed exhausted & enrollee may initiate a State Fair Hearing when:

- MORC Home Care FAILS to adhere to the Notice & timing requirements
- Enrollee is deemed to have exhausted the level one internal appeals process
- Enrollee must request a state fair hearing within 120 calendar days from the date of the MORC Home Care's Internal Appeal Resolution Notice.

Extension of timeframe for processing an internal appeal

- Make reasonable effort to provide prompt oral notice to enrollee of delay.
- Give written notice within 2 calendar days which includes the reason for the decision to extend the timeframe.
- Resolve the appeal expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

- A 14-day extension – may be granted when enrollee requests or waiver agency show there is a need for additional information and that the delay is in the enrollee's interest.

The Internal Appeals Log: MORC Home Care MI Choice Office of Grievance and Appeals completes the Internal Appeals Log.

Expedited internal appeal process and timeframes

Expedited Internal Appeal: Enrollee may request or when enrollee's provider indicates that a standard resolution could seriously jeopardize the enrollee's life, physical or mental health or ability to maintain or regain max function.

Expedited Internal Appeal Resolution Time Frame: MORC Home Care must provide resolution & notice within 72 hours after the MORC Home Care receives the appeal.

Office of Grievance & Appeals for the MI Choice Waiver will review the electronic and paper chart.

Office of Grievance & Appeals for the MI Choice Waiver will call enrollee to address the expedited appeal and verify Guardianship/ DPOA paperwork is being mailed/ faxed/ emailed to MORC Home Care if not in record.

Compass documentation is required to justify & process expedited internal appeal.

Documentation must include:

- Date of Call
- Name of enrollee or contact person
- Justification for expedited appeal and discussion
- Status of Guardianship or active DPOA paperwork
- Resolution of expedited appeal.

Oral Notices - a reasonable effort must be made to provide an oral notice of the Notice of Resolution to the enrollee in an expedited appeal in addition to written notice.

Written Notice of Resolution must be provided by MORC Home Care Office of Grievance & Appeals to enrollee

- Include the date of the internal appeal resolution
- Include the result of the appeal resolution
- Contain language that meets applicable notification standards

When internal appeal decisions are not wholly in enrollee's favor, MORC Home Care Office of Grievance & Appeals must include the following in the written notice:

- The Right to Request a State Hearing
- How to Request a State Hearing
- The right to request & receive benefits pending a State Hearing
- How to request the continuation of benefits pending a State Hearing.

See ****ENROLLEE REQUEST FOR CONTINUED WAIVER BENEFITS.

Internal Appeals Deemed exhausted & enrollee may initiate a State Fair Hearing when:

- MORC Home Care FAILS to adhere to the Notice & timing requirements
- Enrollee is deemed to have exhausted the level one internal appeals process
- Enrollee must request a state fair hearing within 120 calendar days from the date of the MORC Home Care's Internal Appeal Resolution Notice.

When MORC Home Care Office of Grievance & Appeals denies a request for an Expedited Resolution of an Appeal

- MORC Home Care Office of Grievance & Appeals must transfer the appeal to the
- standard timeframe of within 30 calendar days from the day waiver receives the appeal (with possible 14-day extension – when enrollee requests extension or waiver agency shows there is a need for additional information and that the delay is in the enrollee's interest ~per and upon state approval).

Extension of timeframe for processing an expedited internal appeal

MORC Home Care Office of Grievance & Appeals may extend the timeframe for processing an expedited internal appeal by 14 calendar days.

If MORC Home Care Office of Grievance & Appeals extends the timeline for appeal & not at request of enrollee, MORC Home Care must:

- Make reasonable effort to provide prompt oral notice to enrollee of delay.
- Give written notice within 2 calendar days which includes the reason for the decision to extend the timeframe.
- Resolve the appeal expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

Adverse benefit determination (ABD)

ABD NOTICE TIMING: Must be mailed at least 10 days before the date of action (termination, suspension or reduction of a previously authorized service.

See Decision Guide for Notices attached to the bottom of this document (provided by MDHHS 9/20/17).

- Explain the reasons for the determination

- Explain Enrollee's right to request (free of charge) reasonable access to & copies of all documents, records, etc. – medical necessity criteria, processes, strategies or evidentiary standards used in setting coverage limits relevant to the enrollee's benefit determination.
- Explanation of the procedures on how the enrollee can exercise their right to an appeal.
- Explanation of circumstances under which an appeal can be expedited and how to request it.
- Explanation of the enrollee's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued.

The waiver Agency must explain the enrollee's right to request an appeal of the agency's adverse benefit determination which includes information on exhausting the agency's one level of appeal and the right to request a state hearing after receiving notice the ABD was upheld.

******ENROLLEE REQUEST FOR CONTINUED WAIVER BENEFITS –**

The request to continue or reinstate waiver benefits while the internal appeal or state hearing is pending.

If requested – MORC Home Care must continue or reinstate the benefits while the internal appeal or state hearing is pending, until 1 of the following occurs:

- Enrollee withdraws at either level.
- Enrollee does NOT request a state hearing & continuation of benefits within 12 calendar days from the date of the Adverse Appeal Notice.
- A state hearing decision is issued against (adverse) to the enrollee.

Recordkeeping of grievances & internal appeals

MI Choice waiver is required to have a grievance and appeal system in place for enrollees

MI Choice waiver agents are required to maintain records of grievances & appeals

MDHHS will review grievance & appeal information collected by waiver agencies for ongoing program monitoring, updates, revisions to the State Quality strategy & be accessible to the State and CMS.

Records must include:

- Date received
- General description of grievance or appeal resolution
- Date of review or review meeting
- Names of covered person
- Date and outcome of resolution at each level

Grievances & Appeals of Adverse Benefit Determination – Decision Makers

- Can NOT be involved in any previous level of review or decision making

- Be a subordinate of any individual previously involved in the review or decision making
- Must have appropriate clinical expertise in treating enrollee's condition or disease when:
    - The decision involves a denial based on lack of medical necessity.
    - The decision involves a grievance or appeal involving clinical issues.
    - The decision involves a grievance regarding a denial of an expedited resolution of an appeal.

REFERENCE: None

EXHIBIT: None

Provider Application Policy & Re-Credentialing

To outline the steps taken in the credentialing of vendors seeking a contract to provide services to MORC Home Care Waiver participants.

Policy:

It is the policy of the MORC Home Care, to maintain an adequate number of credentialed vendors to meet the needs of Mi Choice Program participants within the designated service area. The MORC Home Care Provider Network is evaluated and updated as program needs dictate.

Definition: None

Procedure:

A provider interested in conducting business with the MORC Home Care MI Choice program contacts the office to inquire. The program and contract requirements are explained to the potential provider. Potential providers are sent a sample contract with licensing requirements, MDHHS standards and a bid sheet to be completed and returned.

The completed and signed bid sheet is submitted to the Program Director/ Designee for review and approval. Upon approval potential provider will be notified.

A formal contract between MORC Home Care and the provider is drawn up and submitted to MORC CFO for review and signature.

Upon approval of formal contract, the provider is notified, and a meeting or call is scheduled or email correspondence initiated to review formal contract, MDHHS standards and requirements, insurance and to sign required documents.

The potential contracted provider meets/ calls/ emails MORC staff to receive/provide the following documents.

- Introductory Letter
- Provider Application or
- Existing Provider Re-Credentialing Application
- MORC Home Care Brochure
- Compliance Attestation
- Declaration of Provider Ownership or Controlled Interest 5% or Greater Form
- Subcontractor Enrollment Agreement with contract
- MDHHS minimum Service Standards
- MI Choice Minimum Operating Standards
- Automatic Deposit Form
- Vendor View Information
- Provider Manual Requirements
- Managed Care Requirements (attachment C)
- Provider Audits (attachment J)
- Person Centered Planning Process (attachment M)
- MORC Home Care Documents/ Information Documents
- Internal/ External Grievance Summaries
- Information on use of Seclusion & Restraints
- Critical Incident Reporting
- Quality Assurance & Documentation
- Electronic Visit Verification (EVV)

MORC Home Care submits to MDHHS a list of its provider network with at least the required 125% capacity within 60 days of the effective date of the contracts and within 30 days as changes occur.

Orientation for new providers and during re-credentialing for existing providers on vendor view; provider monitoring frequency (using Attachment J); required supervisor visits (twice annually); in home logs/electronic visit verification (EVV); training regarding health and wealth issues including critical incidents and individualized emergency response procedures; documentation retention for a minimum of ten years; as well as, all other required MDHHS applicable terms and conditions of contract.

Documentation is required to be retained for ten years and includes:

- Participant name
- Date of service
- Type of service
- Unit cost
- Time
- Number of units provided per participant

Provider training is completed through Vendor View Notifications, Provider Audits & Recredentialing of providers every two years.

- Health and welfare
- Critical Incidents
- Contingency plan procedures

Reference: None

Exhibit: None

Procedure Manual

A dedicated policy and procedure manual is required for the MI Choice Waiver Program. It must be developed and approved prior to signing the contract. See list below, which are the minimal requirements at this time in addition to policy related to the Managed Care Requirements. Each Policy should be tabbed to identify their location within the manual. Each document should have a revision dating. It is the provider's responsibility to update their provider manual annually or upon any contract, associated attachments or federal regulation changes. Any question or assistance regarding the Procedure Manual content should be directed to Kim Buckley at kbuckley@eastersealsmorc.org.

- Participant Confidentiality
- Participant Grievances and Appeals
- Participant Satisfaction and Evaluation
- Honoring & Addressing Participant Preferences
- Participant Rights and Responsibilities
- Participant Emergencies in their Home
- Agency Emergency Plan
- Priority Classification System & Contingency Plan **(Information located in Operating Standards Section II)**
- Participant Status Changes - Notification to MORC Home Care **(must address Provider missed visits, ER visits, Hospitalizations, Nursing facility admissions, Significant change in a medical or health status, noted medication changes and communication when noting other providers in the home via the use of vendor view to notify MORC Home Care and indicate the timeline which states a notification will be sent to MORC Home Care on the day of occurrence or when first made aware)**
- Critical Incident Reporting for Participant & Provider Reference **(information document attached)**
- Information on the use of Seclusions and Restraints

- Identify, Report and Prevent incidents of neglect, abuse, and or exploitation **(include provider reporting to APS and MORC Home Care)**
- Utilization or Non-Utilization of Volunteers
- Person Center Planning
- New Employee Recruitment & Orientation
- Training (**which includes MI Choice training)**
- Supervision & Supervisory visits of Direct Care Staff **(see Attach. H - Section II General Info & Section III under each specific service in which you are interested in providing).**
- Medication policy **(procedure should include vendor view notification to MORC Home Care when a participant's medication has changed).**
- Vendor View Information **(Information is attached with Introductory Letter)**
- Managed Care Requirements Adherence **(Attach. C)**

Coverage and Limits for All Covered Services

Services provided by Easterseals MORC Home Care MI Choice Program are subject to the prior approval of CMS. Services must.

- Be indicated by the current assessment
- Be detailed in the person-centered service plan (PCSP)
- Be authorized in accordance with the provisions of Easterseals MORC Home Care

Services must not be authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

MDHHS, waiver agencies, and direct service providers must not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of the last resort. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The waiver agency must deem the chosen provider capable of performing the required tasks.

For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.

Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.

Covered Waiver Services (Definition/Requirements/Limits)

In addition to regular State Plan coverage, MI Choice participants may receive services as outlined in the Medicaid Provider Manual Section 4.1 which includes Covered Services and Limits.

Billing and Reimbursement for All Covered Services

Easterseals MORC Billing Accounting Standards

To ensure Easterseals MORC materially adheres to all applicable professional governmental accounting standards.

Definitions: The following is offered for clarification and understanding.

- Audited Financial Statement: Financial statements that have been audited, according to auditing standards, by a Certified Public Accountant with an opinion given regarding the accuracy of the information presented.
- Financial Statements: A formal record of the financial activities of a business in which all relevant financial information is presented in a structured manner and in an easy-to-understand form. The statements are typically a standard set of documents presenting the information in a predetermined format.
- Internal Controls: The Method and procedures a company uses to ensure the accuracy and validity of their financial statements.
- Workforce member: Employees, volunteers, trainees, and other persons whose conduct in the performance of work for a covered entity, is under control of the covered entity, whether or not they are paid by that entity.

Policy Standards:

- It is the policy of Easterseals MOR that all accounting practices conform to Generally Accepted Accounting Principles (GAAP) accepted in the United States of America.
- Audited and unaudited financial statements are prepared by management in accordance with GAAP and with the applicable Financial Accounting Standards Board (FASB) pronouncements.
- Internal controls are consistent with good business practice and with requirements of law, regulations, contracts and grants applicable to federal awards, including OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations.
- Annual financial statements are audited by a licensed CPA firm approved by Easterseals MORC Board of Directors (Board) in accordance with Generally Accepted Auditing Standards (GAAS) as established by the Auditing Standards Board of American Institute of Certified Public Accountants and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller of the United States.
- All Financial Statements, Form 1099, and related documents will be retained in accordance with industry standards, applicable policy and laws.

Procedure:

- Finance and Accounting Department staff will perform all accounting and accounting functions in accordance with GAAP. This is inclusive of journal entries and ledger postings.
- The Controller will review the general work product from the Accounting Department staff to assure GAAP is followed
  - The Controller will provide direct guidance to Accounting Department staff with matters such as asset valuation and life expectancy, depreciation methods, significant estimates and materiality decisions.
  - The Controller will maintain responsibility for the final assembly of the financial statements based upon the work of the accounting staff.
- The Chief Financial Officer (CFO) will remain current of changes in GAAP and any other accounting stand which directly affects the accounting practices of Easterseals MORC.
- As Appropriate the CFO will discuss the applicability of any proposed accounting changes with Easterseals MORC's Board approved certified public accountants. Assurance will be gained that any significant changes will be accepted during the yearly audit.
- The CFO will determine the effects of all significant accounting changes on the future financial performance of Easterseals MORC and communicate the impact to senior management and the Board of Directors.

Billing Accounting Standards Procedure as it relates to MI Choice Waiver Program:

To establish the procedures for supporting claims submission to MDHHS for contracted providers and further and reported authorized services are in accordance with Person Centered Service Plan (PCSP).

- Providers obtain login credentials for Vendor Billing website along with authorizations of services for open individuals in the MI Choice Waiver.
- Claims are submitted to Easterseals MORC through the Vendor Billing system by the 10th day of the month following the month in which services are provided.
- Accounts Payable staff (AP staff) have login credentials for the Vendor Billing system as Agent for the purposes of reviewing and approving claims submitted by Contracted Providers.
- Claims are reviewed and compared to authorized units and rates in Vendor Billing. If Contracted Providers overbill units, MI Choice Waiver are notified of any discrepancies for investigation. Once rectified, the AP staff notify the Contract Provider and adjust the claims to match the authorized units/rates as applicable. Flow sheets are maintained at the provider's location and reviewed periodically for audit.
- New providers are audited for the first 3 months of their contract.
- Authorized services are entered into Vendor Billing according to the participants PCSP. Once the PCSP is approved, the authorized units are entered with an applicable service code. The authorizations are used as a guide to approve submitted claims.
- Approved claims are entered into AP system, and checks issued to Contracted Providers.
- Encounters are submitted monthly to MDHHS to submit units and dollars spent by individuals.
- Reports are downloaded to the MORC Home Care directory for OIG reporting purposes upon completion.

Billing Procedures

- Providers of MI Choice services submit bills to the waiver agency detailing the date of service, the type of service, the unit cost, and the total number of units provided for each MI Choice participant served.
- Waiver agencies specify in provider contracts the acceptable amount of time from date of service that providers may send bills to the waiver agency in order to receive payment for services rendered.
- Waiver agencies match and verify provider bills against the participant's approved PCSP using MICIS, COMPASS, or a compatible data system.
- Waiver agencies have written procedures regarding the billing process.

Provider Payments

- Waiver agencies process payment for all verified bills submitted by providers.

- Waiver agencies make payments only for services authorized within the PCSP and delivered to the participant.
- Waiver agencies submit MI Choice encounter data to CHAMPS electronically. Encounter data for MI Choice services meets CHAMPS requirements (including CHAMPS edits) for processing.
- The CHAMPS system records encounter data detail.
- Waiver agencies use MICIS, COMPASS, or compatible software to maintain an audit trail for funds expended.
- MICIS, COMPASS, or compatible software produces claims detailing provider and participant identification, date of service, specific procedure, and payment data.
- Waiver agencies have written procedures ensuring full payment to providers who furnish MI Choice services according to the authorized PCSP.

Claims Auditing

The guidelines for auditing contracted provider claims submitted to MDHHS through MORC Home Care, Inc.

– Easterseals MORC reserves the right to review and reconsider all services rendered and invoices submitted by Contracted Providers to confirm that monies paid by MORC to Contracted Provider are reasonable, verifiable and appropriate. To the extent that MORC determines that Contracted Providers have been paid for services that it should not have been for, Contracted Provider shall return all such amounts to MORC immediately upon request.
– The Contracted Providers must establish accessible record systems to verify all programmatic and fiscal information reported and make such records available to review by MORC staff and/or Michigan Department of Health and Human Services.
– The Contract Providers must maintain auditable records for a period of not less than 10 years after the date of service and give MORC access to such records upon reasonable notice for the purpose of inspection of such records and for the purpose of conducting audits.
– All services provided by Contracted Providers to MORC Home Care Inc. must comply with MDHHS and MORC Home Care Inc. service definitions, unit definitions, minimum standards of operation, and HIPAA policies located at the following link: https://www.morcinc.org/i-need-support-for/senior-services/

Reconciliation Accounting Standards

To establish the procedures for reconciliation of monthly reports, and invoices submitted by Providers to its Accounting records.

– Invoices are processed monthly.
– Once completed, reports are generated from Compass and compared against the General Ledger (GL) account in the Accounts Payable (AP) system.
– A report is based only on Home Care claims and this report is compared against the reports from Compass to check for variances.
– Service code totals are compared for all codes authorized and processed through vendor billing.

– Files are saved in the Elder Care directory for the OIG monthly reporting purposes.

Record Retention Policy

To specify the proper handling and maintenance of MORC Home Care & Provider Agency participant records.

Policy: MORC Home Care records are maintained in accordance with the agency and Michigan Department of Health Human Services Program Guidelines.

Definition: None

Procedure:

Reporting forms and formats are utilized as required by MDHHS Guidelines.

All participant records will be maintained in a locked file room, which are only accessible to authorized staff members.

MORC Home Care/ Providers will follow strict confidentiality standards outlined in the MORC HIPAA Policy.

MORC obtains a signed copy of the Release of Information. Providers are required to obtain a signed Release of Information when discussing participant protected health information. This Release contains the participant's name and signature, the date, signature of support coordinator or provider representative completing form and one-year time limit for release.

Program and fiscal records and files including source documentation to support program activities, and all expenditures are maintained for at least 10 years from date of contract termination.

Program and fiscal records will be maintained for longer periods of time based on the following circumstances: until the final expenditure report is submitted or until litigation and audit findings have been resolved.

Any appeals which occur as a result of MI Choice Waiver Program administration will be maintained for a minimum of 10 years from the date of occurrence.

All participant records must be maintained for ten years.

Reference: None

Exhibit: None

Fraud, Waste and Abuse Provider Policy

Implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste and Abuse.

Policy: It is the policy of EM to comply with all laws and regulations of the Federal, State and Local government.

Definitions: None

Procedure:

The following Procedure apply to Easterseals MORC Employees.

Auditing –EM has a comprehensive internal audit system to ensure that the EM follows the range of contractual and other MDHHS requirements in critical operations areas. The internal audit system staff are independent from the section/department under audit. The auditors are competent to identify potential issues within the critical review areas and have access to existing audit resources, relevant personnel, and all relevant operational areas. Written reports will be provided to the compliance officer, the Compliance Committee and appropriate senior management. The reports will contain findings, recommendations and proposed corrective actions that are discussed with the compliance officer and senior management. EM will ensure that regular, periodic evaluations of its compliance program occur to determine the program's overall effectiveness. This periodic evaluation of program effectiveness will be performed internally, either by the compliance officer or other internal source. These periodic evaluations will be performed at least annually, or more frequently, as appropriate.

Monitoring – Easterseals MORC will maintain a system to actively monitor compliance in operational areas. Easterseals MORC has a means of following up on recommendations and corrective action plans resulting from either an internal compliance audit or MDHHS review to ensure implementation and evaluation. Easterseals MORC has 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 Easterseals MORC, the Compliance Department must review any positive responses to questions regarding compliance violations.

Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to MDHHS OIG.

> Easterseals MORC will send all program integrity notifications and reports to the MDHHS OIG sFTP. Easterseals MORC will follow the procedures and examples contained within the MDHHS OIG submission forms and accompanying guidance document.

On a quarterly basis, Easterseals MORC will submit to MDHHS OIG, in a format determined by MDHHS OIG, a report detailing the program integrity activities performed by Easterseals MORC, during the previous quarter. This report will include any improper payments identified and amounts adjusted in encounter data and/or overpayments recovered by Easterseals MORC 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 will also include a list of the individual encounters corrected.

Notwithstanding the obligation to report suspicions of provider and subcontractor Fraud directly to MDHHS OIG as required by MDHHS Contract, Easterseals MORC 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 Easterseals MORC during the previous quarter.

Pursuant to 42 CFR § 438.608(d)(3), on an annual basis, Easterseals MORC will 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 EM for the preceding year. The report will also address Easterseals MORC plan of activities for the current and upcoming fiscal year. The report will include all provider and service-specific program integrity activities. Pursuant to 42 CFR § 438.606, the annual Program Integrity Report will be certified by either Easterseals MORC 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 will attest that, based on best information, knowledge and belief, the information specified is accurate, complete and truthful.

IF Easterseals MORC has questions regarding whether suspicions should be classified as Fraud, Waste and Abuse they should be presented to MDHHS OIG for clarification prior to making a referral.

Pursuant to 42 CFR § 438.608(a)(7), EM will promptly refer any potential Fraud that Easterseals MORC identifies.

Upon completion of the preliminary investigation, if Easterseals MORC 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), EM must:

- 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.
- Share referral via secure File Transfer Process (sFTP) using the Grantee’s applicable MDHHS-OIG/AG-HCFD sFTP areas.

- Cooperate in presenting the fraud referral to the OIG and AGHCFD at an agreed upon time and location.

Easterseals MORC shall not take any of the following actions unless otherwise instructed by OIG:

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

Enter into or attempt to negotiate any settlement or agreement regarding the findings/ overpayment; or

Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the findings/overpayment.

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

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

Easterseals MORC has a mechanism for Providers to report to Easterseals MORC when it has received an overpayment, to return the overpayment to EM within 60 days of overpayment identification (in accordance with42 CFR § 401.305 and MCL 400.111b(16)), and to notify Easterseals MORC in writing for the reason for the overpayment.

Data Mining Activities – Easterseals MORC has a surveillance and utilization control program and procedure (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. Easterseals MORC utilize statistical models, complex algorithms, and pattern recognition programs to detect possible fraudulent or abusive practices. EM will report all data mining activities performed (including all program integrity cases opened as a result) within the previous quarter to MDHHS OIG.

Preliminary Investigations – Easterseals MORC will promptly perform a preliminary investigation of all incidents of suspected Fraud, Waste and Abuse. EM will report all program integrity cases opened within the reporting period to MDHHS OIG. All confirmed or suspected provider Fraud will immediately be reported to MDHHS OIG. Unless prior written approval is obtained from MDHHS OIG, EM must not take any of the following actions as they specifically relate to Michigan Medicaid claims:

- Contact the subject of the investigation about any matters related to the investigation.
- Enter into or attempt to negotiate any settlement or agreement regarding the incident. or

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

Audit Requirements – Easterseals MORC will 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 will include a retrospective medical and coding review on the relevant claims. In accordance with the Affordable Care Act, Easterseals MORC must promptly report overpayments made by Michigan Medicaid to EM as well as overpayments made by EM to a provider and/or Subcontractor.

References: MDHHS MI Choice Contract Attachment E

Exhibits: None

Beneficiary Eligibility Verification

The MI Choice program is available to persons who are either elderly (age 65 or older) or adults with disabilities age 18 or older and meet the following eligibility criteria:

- An applicant must establish their financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.
- Must be categorically eligible for Medicaid as aged or disabled.
- The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- It must be established that the applicant requires at least two waiver services, one of which must be supports coordination, and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program.

FINANCIAL ELIGIBILITY

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by MDHHS. MI Choice Support Coordinator works with applicant and local field office to complete Medicaid Application.

As a provision of the waiver, MI Choice applicants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is available to participants in the special home and community-based group under 42 CFR §435.217 with a special income level up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. Medicaid eligibility rules stipulate that

participants are not allowed to spend-down to the income limit to become financially eligible for MI Choice.

To initiate a financial eligibility determination, MI Choice waiver agencies must enter enrollment notifications electronically in the Community Health Automated Medicaid Processing System (CHAMPS). Once the electronic enrollment is completed in CHAMPS, the participant will be assigned an associated MI Choice Program Enrollment Type (PET) code. MI Choice waiver agencies must enter disenrollment notifications electronically in CHAMPS to notify MDHHS of participants who are no longer enrolled in MI Choice. Once an electronic disenrollment is completed in CHAMPS, the participant's PET code will end

The following participant program classifications are used in Michigan's Data Warehouse Database:

WA = Waiver

The participant is or is expected to be eligible for and enrolled in MI Choice.

Waiver Eligible Status Classifications

Y (Yes)	The participant meets LOCD criteria, the MDHHS Field Office determined financial eligibility, the participant requires at least one MI Choice service in addition to supports coordination, and the participant agrees to enroll in MI Choice. The participant must not be residing in a nursing facility or hospital for this classification.
N (No)	The participant is not enrolled in or does not qualify for MI Choice.
P (Pending)	The participant meets NFLOC and requires at least one MI Choice service in addition to supports coordination, but the waiver agency is awaiting confirmation of financial eligibility from the MDHHS Field Office. Waiver agencies can use the "Pending" status only when the Medicaid application has been completed and submitted to the MDHHS Field Office, and the waiver agency has preliminarily determined (presumed) the participant is likely to meet financial eligibility requirements.
I (Ineligible)	The participant did not meet at least one of the eligibility criteria for MI Choice.

to reflect a disenrollment date. Proper recordkeeping requirements must be followed and reflected in the applicant's or participant's case record.

Medical Eligibility

The MI Choice waiver agency must verify an applicant's functional eligibility for program enrollment using the LOCD application in CHAMPS. Waiver agencies must conduct an LOCD in person with an applicant and submit that information in the LOCD application in CHAMPS, or the agency may adopt an existing provider.

FREEDOM OF CHOICE (FOC)

Prior to MI Choice enrollment, all applicants and their legal representatives must be given information regarding all Medicaid long-term services and supports options for which they qualify through the LOCD, including MI Choice, Nursing Facility, MI Health Link, and the Program of All-Inclusive Care for the Elderly (PACE). Qualified applicants may only enroll in one long-term services and supports program at any given time. Nursing facility, PACE, MI Choice, MI Health Link, and Home Help services cannot be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need

for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options through the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities.

The FOC form must be signed and dated by the supports coordinator and the applicant (or their legal representative) seeking services and is to be maintained in the applicant's case record and a copy provided to the applicant or participant upon request. Additional information can be found in the Nursing Facility Level of Care Determination Chapter.

The FOC form must be completed with each conducted LOCD and any time an LOCD is adopted. While informing the beneficiary of available choices for the receipt of long-term services and supports is the main reason for the FOC form, this form also serves to verify that the waiver agency conducted an LOCD.

Procedure

Easterseals MORC MI Choice Waiver then performs quality checks, including:

- Verification of current Medicaid eligibility;
- A valid LOCD indicating the participant meets nursing facility level of care; and
- The participant is not enrolled in any other long-term care program.

Primary Care Physician Responsibilities

Easterseals MORC does not include Primary Care Physician.

Provider Background Checks

This policy applies to all Easterseals MORC (EM) workforce members including independent contractors, volunteers and interns

To ensure the safety and security of individuals served by programs of Easterseals MORC (EM) through staff background checks which verify the competency, qualifications, physical ability and ethical standards of individuals acting as agents of Easterseals MORC.

Policy: It will be the policy of Easterseals MORC to conduct comprehensive background checks on all staff, including independent contracts, volunteers and interns, to ensure the safety and security of individuals served.

Definitions: None

Procedure:

The Chief HR Officer or designee will ensure that consent forms are signed and that the following background/medical checks are conducted if essential to job functions:

- Criminal Background Checks with the State of Michigan (ICHAT). (Prior to hire/ Annually)
- Motor Vehicle Checks (MVR) with the Michigan Secretary of States Office. (Prior to hire/ Annually)
- Federal Exclusion Checks through Health and Human Services Office of Inspector General. (Prior to hire, Annually, and monthly against the published HHS Federal Exclusion Registry)
- Office of Recipient Rights (ORR) through the appropriate Community Mental Health Agency (CMH). (Upon Hire)
- Employment Physical (Upon Hire and as required by Position Changes)
- Professional Licensure Checks through the State of Michigan (CIS). (Prior to hire and at Renewal)
- Excluded Parties List (Prior to hire/Annually/Monthly)
- National Practitioner Databank (Upon Hire and Every two years).
- Michigan Public Sex Offender Check (Prior to hire/Annually)
- Credit Checks through Hire Right (Prospective ESM Board Members, Leadership and
- Financial staff only – Prior to hire)

The Chief HR Officer or designee will ensure that program directors and program managers are informed of any/all background check findings.

Program directors and program managers will take appropriate action, in consultation with the Chief HR Officer or designee based on findings.

Easterseals MORC will not knowingly employ anyone listed on the HHS Federal Exclusion list.

Easterseals MORC will not employ staff with inadequate driving records where driving is listed as an essential job function. MVR flowchart will be used to appropriately classify drivers in accordance with their driving record.

It is the employees' responsibility to notify Easterseals MORC of any incidents that may impact their continued employment with Easterseals MORC relative to the above background checks.

Employees with DUI and OUIL offenses in last three (3) years will not be considered for driving. If driving is an essential function of the job, the employee will not be able to perform an essential function of their job, which will result to termination.

The Chief HR Officer or designee and appropriate program director must review all felonies or misdemeanors within the past seven years that come back on all new employee and annual criminal background check on current employees. Fair Credit Report procedures will be followed where findings impact ongoing employment.

If an employee or subcontractor is found to be ineligible, the employee will be removed from the direct responsibility/involvement with the Medicaid program and the subcontractor will be terminated.

Responsibility / Action:

Human Resources Department-Will independently secure consent form and conduct the following background/medical checks:

- Criminal Background Checks with the State of Michigan (ICHAT).
- Motor Vehicle Checks (MVR) with the Michigan Secretary of State Office. Employees will then be classified in accordance with their driving record to determine driver status with Easterseals MORC.
- Federal Exclusion Checks through Health and Human Services Office of the Inspector General.
- ORR through OCHN.
- Employment Physical.
- CIS Professional Licensure Check.
- Excluded Parties List
- National Practitioner Databank
- Michigan Public Sex Offender Check
- Hire Right Credit Check (as applicable)

Will maintain background check findings in the confidential section of the employee personnel file.

The Chief HR Officer or designee will notify program directors and program managers of background check findings. The Chief HR Officer or designee will notify program directors and program managers when reasonable accommodations are necessary based on employment medical.

The Chief HR Officer or designee will work cooperatively with program directors and program managers to ensure that appropriate action is taken based on background check findings.

The Chief HR Officer or designee will take any findings of concern to the Leadership Team or president/CEO where appropriate.

Program Directors/Program Managers- Review findings and work cooperatively with the Chief HR Officer or designee and Leadership Team to ensure that appropriate action is taken based on background check findings.

Leadership Team- To ensure that action is taken to protect Easterseals MORC from potential litigation and liability resulting from findings.

The Chief HR Officer or designee- To ensure that action is taken to protect ES from adverse consequences pertaining to Corporate Compliance.

References:

- Consumer and Industry Services Disciplinary Action Reports Binder.
- Medicaid Provider Manual
- CARF Standards: Section 1.I (Human Resources)
- Online Employment Application
- Criminal Background Check Consent
- MVR Check Consent Form
- Office of Recipient Rights Background Check Consent Form
- Conditional Job Offer/Physical Form
- New Hire Procedures
- Employee Handbook/MVR Flowchart and Drug Free Workplace Policy Statement
- Employee Personnel/Confidential Files

Exhibits: None

Other Provider/Subcontractors' Responsibilities

- Waiver agencies have policies and procedures to identify and prevent problems with access to MI Choice services. Access issues include, but are not limited to, problems with provider availability and adherence to the participant approved PCSP. (Kimm)
- Waiver agencies and service providers enter into contractual agreements that include required assurances for nondiscrimination, minimum provider service standards, and contract requirements included in 42 CFR §434, 42 CFR §438, and the MDHHS Medical Services Administration (MSA) provider enrollment agreement. (Jill)
- The waiver agency maintains written minimum service standards for MI Choice services that fulfill licensure and certification requirements mandated by CMS and that comply with the CMS-approved MI Choice waiver application and the MDHHS Minimum Operating Standards for MI Choice Services. (Kimm & Jill)
- The waiver agency has written procedures to secure competitive, per unit rate agreements from qualified service providers. (Kimm)
- The provider enrollment process includes a description of the frequency and method of verifying and monitoring staff qualifications and how the waiver agency documents this verification. MDHHS defines a willing provider as a provider who agrees to accept Medicaid payment as

payment in full for rendering a service, abides by all other Medicaid provider requirements, including executing provider agreements, and adheres to the required service standards. (Jill)

- Waiver agencies must allow Medicaid beneficiaries to select from any qualified provider within the waiver agency's provider network. (Kimm)
- Waiver agencies must provide MI Choice services to any participant who needs the service. Waiver agencies may not limit the number of MI Choice participants who receive a service or deny a needed MI Choice service for any reason (e.g., lack of funds). Waiver agencies must make MI Choice services available on a comparable basis to all MI Choice participants based on need. (Kimm)

Waiver agencies have policy and procedures for identifying, documenting, and addressing noncompliance by providers. This includes identification of the persons responsible for taking appropriate action with providers who continually demonstrate poor performance or who are not qualified to provide services.

Prior Authorization and Referral Procedures

Vendor view as a secure HIPAA compliant communication tool between Easterseals MORC MI Choice Inc., and vendors providing MI Choice services to participants.

Authorized service changes will be entered into MI-Choice Information System (MICIS) which triggers notification via vendor view to the vendor.

Communications regarding service delivery and participant issues will be entered into vendor view via vendor view messaging.

Each individual at the provider agency who has authorization to vendor view MUST use his or her own user ID and password that cannot be shared within the agency.

Center for Information Management (CIM) automatically generates an email at approximately 11:30 a.m. and 3:30 p.m. to Agents and Vendors if there are notices or messages for the agency. Assigned Easterseals MORC MI Choice Inc. office staff and providers must check incoming messages at least twice daily.

Messages received from Vendors regarding MI Choice participants will be forwarded by Easterseals MORC MI Choice, Inc. office staff to the assigned Support Coordinator via Outlook email, copied and pasted into the participants progress note.

Support coordinators will use Vendor View messaging as the notification of authorized service changes to vendors for all service changes through Vendor View messaging.

Easterseals MORC MI Choice Inc. utilizes Vendor View messaging to inform Providers of client service changes. Vendor view is also used as a messaging system to communicate mass distribution of important information to Providers.

Easterseals MORC MI Choice, Inc. MUST be notified immediately (on day of occurrence) of any changes in authorized users that occur within the provider's agency. When notified, Easterseals MORC MI Choice, Inc. will send you a enrollment form to your agency to approve these changes.

Participant Status Changes – Provider must notify Easterseals MORC MI Choice on day of occurrence or within 24 hours of being made aware via vendor view any of the following status changes:

- Provider missed visits,
- Participant refuses services
- ER visits,
- Hospitalizations,
- Nursing facility admissions,
- APS Referrals
- Critical Incidents
- Significant change in a medical or health status
- Medication changes
- Notification upon noting any other providers in the home such as hospice, skilled care or other community programs.

Claim Submission Protocols and Standards (including clean claim)

Encounter Data Reporting

Each waiver agency must submit all encounter data to MDHHS within 180 calendar days of the date that services were rendered. Waiver agencies must resolve issues related to encounters that are rejected by CHAMPS within 30 calendar days of notification by MDHHS or its designee. Agencies have 10 calendar days after the expiration of the 30-day resolution window to report on issues that cannot be resolved.

Administrative Expense and Other Financial Reporting

Each waiver agency must submit an Administrative Expense Report (AER) to MDHHS as specified in the Contract. The expenses reported must be actual expenses incurred by the waiver agency. Each AER shall cover one calendar month and is due within 30 calendar days after the conclusion of that month. Waiver agencies must submit additional financial reports and information as requested by MDHHS. MDHHS

must communicate requirements for such additional information to the waiver agency in writing and allow sufficient time for a response.

Financial Audit Requirements

MI Choice waiver agencies are contractually obligated to comply with, and ensure compliance by, its subcontractors with all requirements of the Single Audit Act and any amendments to this act. Waiver agencies must submit to MDHHS a Single Audit, Financial Statement Audit, or Audit Status Notification Letter. If submitting a Single Audit or Financial Statement Audit, waiver agencies must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs and a management letter (if issued) with a response.

Waiver agencies that expend $750,000 or more in federal awards during the agency's fiscal year must submit to MDHHS a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Title 2 CFR Subpart F and include all components described in 2 CFR §200.512(c).

Waiver agencies exempt from the Single Audit requirements that receive $750,000 or more in total funding from MDHHS in state and federal grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with Generally Accepted Auditing Standards (GAAS). Waiver agencies exempt from the Single Audit requirements that receive less than $750,000 of total MDHHS grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that negatively impact MDHHS-funded programs including, but not limited to, fraud, financial statement misstatements, and violations of contract and grant provisions.

Waiver agencies exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template for the Audit Status Notification Letter and further instructions are available on the MDHHS website. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

The required audit and any other required submissions (i.e., Corrective Action Plan and management letter with a response, or Audit Status Notification Letter) must be submitted within nine months following the end of the contractor's fiscal year to MDHHS.

Waiver agencies and each of their contractors are subject to the provisions of, and must comply with, the cost principles set forth in OMB Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and E.

Record Retention

To specify the proper handling and maintenance of MORC Home Care & Provider Agency participant records.

Policy:

MORC Home Care records are maintained in accordance with agency and Michigan Department of Health Human Services Program Guidelines.

Definition: None

Procedure:

Reporting forms and formats are utilized as required by MDHHS Guidelines.

All participant records will be maintained in the a locked file room, which are only accessible to authorized staff members.

MORC Home Care/ Providers will follow strict confidentiality standards outlined in the MORC HIPAA Policy.

MORC obtains a signed copy of the Release of Information. Providers are required to obtain a signed Release of Information when discussing participant protected health information. This Release contains the participant's name and signature, the date, signature of support coordinator or provider representative completing form and one-year time limit for release.

Program and fiscal records and files including source documentation to support program activities, and all expenditures are maintained for at least 10 years from date of contract termination.

Program and fiscal records will be maintained for longer periods of time based on the following circumstances: until the final expenditure report is submitted or until litigation and audit findings have been resolved.

Any appeals which occur as a result of MI Choice Waiver Program administration will be maintained for a minimum of 10 years from the date of occurrence.

All participant records must be maintained for ten years.

Reference: None

Exhibit: None

Medical Record Standards

Each enrolled MI Choice participant has an individual case record. All forms required in the case record must be properly completed according to policy or form instructions. The case record shall include, but is not limited to, the following required information:

- NF LOC determination results
- Assessments and reassessments
- Freedom of choice form, participant consent to enroll
- Participant consents to release confidential information
- Plans of service and service plans
- Work orders and instructions to providers
- Progress notes, contact logs or other notes that serve as a log-in documenting pertinent contacts with participants, providers and others involved with furnishing services and supports to the participant
- Any correspondence pertaining to the services and supports provided to a participant
- Transfer and closure documentation

Additional requirements for case records include:

- Waiver agencies maintain MI Choice case records in a manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow up.
- Writers enter hard copy case record information in ink.
- Electronic Health Records (EHR) or Health Information Systems (HIS) (such as MICIS, COMPASS, or other systems for collecting case record documentation electronically) must have a method to lock records upon submission of data into the EHR that conforms to industry standards. The system must track all changes made to all the information entered into the system including the date, time, and user making the change.
- Waiver agency staff either signs or initials each entry in the case record. When using initials, the waiver agency maintains a signature log sheet with employees' names and initials. EHR shall record the user information for data entered in the case record.
- Writers make corrections to case record entries by drawing a line through the incorrect information and entering corrected information above, below or adjacent to the previous entry. Whether written or electronic, under no circumstances shall information included in the case record be permanently erased. Electronic records shall include a method to correct information without erasing that information, such as using a strikethrough font. Additionally, electronic records shall include a backup system to retrieve any lost data due to system errors.
- Writers identify late entries. MDHHS allows waiver agencies to make late entries in the case record as long as the writer notes that they made the entry sometime after the contact occurred. Writers may not enter previously omitted information as a late entry more than seven (7) days after the contact occurred (see how to amend a record below).

- Writers may amend the record at any time by identifying an entry as a record amendment and describing previously omitted information. This type of entry should describe why the entry is being made (i.e., after peer or supervisory review) and who is making the amendment.
- Writers may add entries to the record to correct earlier entries of electronic records that contained erroneous or inaccurate information.
- Only the person that entered the original data into the EHR may edit that data. If this is not possible, other users may include a corrective note in the EHR that explains the error in the original data but may not change the original data.
- The system must date, and time stamp all EHR entries and include the username under which the entry was made. The agency must keep a list of all usernames, and the identification of the individual associated with that username.
- Waiver agencies maintain a copy of participant enrollment files to support capitated payments made through CHAMPS.
- Waiver agencies maintain a record of payments made to providers.
- Waiver agencies monitor contractors and subcontractor activity and maintain records and reports of reviews and findings.
- Waiver agencies maintain necessary records that disclose fully the extent of service provided to each participant for a period of ten (10) years for the purpose of subsequent audit.

Payment Policies

SEE iii

Participant Rights & Responsibilities

MI Choice participants have the right to:

- Always be treated with respect and dignity by people who are helping you.
- Be free from abuse, restraints, seclusion, and the misuse of your property.
- Choose where in the community you would like to receive your services and supports.
- Choose the services and supports included in your plan and help develop that plan.
- Have your cultural and religious choices respected and addressed.
- Involve anyone in your service planning process.
- Receive a complete copy of your plan for services and supports.
- Understand the services and supports suggested in your plan and that you may refuse any of them.
- Talk about ideas you have to replace suggested services and supports that you do not want.

- Have your health, social and financial records kept confidential.
- Refuse to provide any information you do not wish to share. (Some information is required to make sure you qualify for the program. If you refuse to provide this information, you might not be able to be in the program.)
- Ask about or request copies of policies and procedures from your supports coordinator.
- Ask about costs, worker credentials, and how workers are supervised.
- Look at bills for your services, regardless of how those bills are paid.
- Contact your supports coordinator with
- questions or complaints.
- File a grievance when you are unhappy with your supports and services or your workers.
- Appeal adverse decisions made about the services you receive or your eligibility.
- Your Responsibilities

MI Choice participants have the responsibility to:

- Choose the services and supports included in your plan, help develop that plan and know and follow what is in that plan.
- Tell your supports coordinator about changes in what you need.
- Tell your supports coordinator about other services and supports you may have.
- Tell your supports coordinator about any other insurance you have.
- Know the information in this handbook.
- Ask questions or let us know when you do not understand something.
- Be available so that you can receive your services.
- Let us know as soon as possible when you will not be available to receive a service.
- Keep valuable things such as keepsakes, money, credit cards, jewelry, and guns or other weapons in a safe place.
- Tell your supports coordinator when you are concerned about your workers.
- Make sure your home is safe and non-threatening for people who are helping you. This includes:
- Being respectful to workers who come into your home.
- Not verbally or physically abusing the people trying to help you.
- Not using profane or offensive language toward the people who are trying to help you.
- Keeping pets outside or otherwise secure so that your worker can give you the services and supports you need.
- Being a responsible gun or weapon owner. This means that all weapons will not pose a threat, intended or unintended, real or implied, to the people helping you.
- Making sure there are no illegal or illicit activities happening in your home. Some of the people who come to your home will have to report these things to Adult Protective Services.

Self-Reporting Mechanisms and Policies

This policy applies to all Easterseals MORC (EM) workforce members, independent clinical contractors and agencies under contract with EM

Policy Purpose: The Easterseals MORC(EM) Corporate Compliance Program assures that EM and all of its contracted providers comply with all laws and regulations of the United States and all state and local subdivisions.

All agents of Easterseals MORC have a duty to understand, participate in, and comply with the EM Corporate Compliance Program and related government laws and regulations that impact the performance of their jobs.

Policy Standards: It is the policy of EM to comply with all laws, regulations of the government of the United States and all state and local subdivisions as applicable. It is the policy of EM that proactive administration and programmatic measure is implemented to ensure that such compliance will take place. It is also the policy of EM to internally investigate any suspected violation of the law and take necessary corrective action if a violation has been substantiated.

Definitions:

- Fraud: Knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
- Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical. practices, and result in an unnecessary cost to the payer, or in. reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the payer.

Procedure

The following procedures apply to all EM employees.

- The key areas of review for the Corporate Compliance Program include, but are not limited to as follows: Internal Revenue Service rules and regulations
- HIPAA Privacy and Security

- Federal and state legislation impacting EM, including but not limited to physician self-referral and fee splitting laws (Stark I and II Legislation), etc.
- Medicaid, Medicare, and all other 3rd party insurance conditions of participation
- Requirements of HHS, CMS, the State of Michigan, and the Department of Community Health
- Professional credentialing
- Conformance with federal health care fraud and abuse legislation
- All funding agreements

The Easterseals MORC Corporate Compliance Program is comprised of the following elements:
Elements Summary:

- Commitment to Compliance:
- Policies, Procedures, and Standards of Conduct
- Medical Necessity
- Billing
- Reliance on Authorizations
- Fraud, Waste and Abuse Prevention
- Marketing
- Anti-Kick Back/Inducements
- Retention of Records/Documentation
- HIPAA Privacy and Security
- Designation of a Compliance Officer/Team
- Conducting Training and Education Programs
- Compliance Communication / Internal Reporting and Investigative Processes
- Disciplinary Guidelines
- Auditing and Monitoring
- Corrective Action
- Response to Special Agent's Visit for the Purpose of Investigating Allegations of Fraud, Waste and Abuse

Detailed Elements:

Commitment to Compliance

EM policies, procedures, and standards of conduct related to compliance are found on the EM SharePoint. All agents of EM are required to become familiar with these documents and comply with stated requirements. Employees, Members of the Board of Directors, and other agents of EM are also required to sign an annual Conflict of Interest acknowledgement form indicating that they have read and understand the Code of Ethics/Conflict of Interest policy, which also includes an annual acknowledgement of responsibility for understanding all agency policies and procedures. Agency

wide policies and procedures reflect federal guidelines which include but are not limited to medical necessity, billing, reliance on authorizations, fraud waste and abuse prevention, marketing, anti-kickback/inducements, retention of records/documentation, and HIPAA privacy and security

False Claims Act: The federal False Claims Act prohibits the knowing submission of false claims or making of false statements in order to secure payment from the government or agent of the government. The definition of "knowing" includes those individuals who "should have known" based on responsibility of managing or supervising an individual responsible for committing the act. This Act includes a provision to protect individuals from retaliation as a result of reporting what they believe to be an incident of fraud, waste, and/or abuse involving Medicaid or Medicare funds (i.e., Whistleblower Protections). False claims can result from knowingly (actual awareness of falsity, deliberate ignorance of truth or falsity, or reckless disregard of truth or falsity):

- Presenting, or causing the presentation of, a false claim for reimbursement by a Federal health care program.
- Making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim.
- Employing or contracting with suspended or excluded providers
- Avoiding or decreasing payment obligation.
- Examples of False Claims may include:
    - A physician who submits a bill to Medicare or Medicaid for medical services s/he knows s/he has not provided.
    - A government contractor who submits records that s/he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements.
    - Stark Legislation: Prohibits physicians from referring individuals to clinical laboratories or other healthcare facilities/services in which they or a member of their family has a financial interest.
- Anti-Kickback Statute: Prohibits an individual from knowingly or willfully soliciting or receiving any remuneration, or offering or paying remuneration, directly or indirectly, overtly, or covertly, in cash or in kind for which payment can be made under Medicare or Medicaid for any of the following reasons:
    - In turn for a referral.
    - For inducing a referral of an individual for services.
    - For purchasing, leasing, ordering, or arranging for or recommending any goods, facility, item or service.

Designation of a Compliance Office and Committee

EM's Corporate Compliance Committee shall be led by the Chief Compliance Officer and shall include at least the following employees:

- Chief Compliance Officer
- Chief Human Resources officer
- Chief Information Officer
- HIPAA Privacy Officer
- HIPAA Security Officer

The Corporate Compliance Committee reports to the Chief Compliance Officer and provides consultation to the Senior Leadership Team that also functions as the organizations' Risk Management Team. Other organizational members may be asked to participate as ad hoc members of the Compliance Team and/or activities required by such. The Chief Compliance Officer shall report directly to the President/CEO.

Agency management duties and responsibilities include promoting compliance among employees and responding to reports of noncompliance by immediately notifying the corporate compliance officer/team of any compliance issues reported to them, submitting summary of audit findings to the corporate compliance officer/team and enact departmental changes as necessary to ensure compliance. Staff will ensure full cooperation with the conduct of business of the Compliance Team. The Corporate Compliance Team initially reports any apparent or potential compliance issues directly to the president/CEO.

The Corporate Compliance Officer and Team are responsible for the following:

- Developing monitoring tools, processes, and policies and procedures to implement the compliance program.
- Developing, coordinating, and participating in educational training programs that focus on the elements of the compliance program to ensure that staff is knowledgeable of, and comply with, pertinent Federal, State and EM guidelines.
- Providing reports to the Board Quality Committee/BOD on the operations of the Compliance Program, annually.
- Revising the compliance program, as needed, to assure alignment with the needs of EM and changes in laws, and policies and procedures of the government.
- Conducting internal investigations, as needed, and acting on matters related to compliance.
- Developing policies and processes to encourage employees, contractors, and individuals receiving services from EM to report suspected wrongdoing and improprieties without fear of retaliation.
- Ensuring monthly review of the Office of Inspector General, Excluded Provider Listing to ensure that contractors and any individuals with ownership or control interests in a contractual relationship with EM are not excluded from participating in Federal programs.
- Annual security risk assessments to identify potential areas of risk and exposure.

As compliance concerns in the healthcare field primarily pertain to business operations related to billing, coding, cost reporting and other fiscal or reporting operations, an individual that directly controls or has a significant role in performing these functions will not serve in the role of the Corporate Compliance Officer or supervises corporate compliance functions. This is to ensure that the independence and objectivity of the CCO is not compromised.

The Corporate Compliance Committee maintains an awareness of organizational and environmental changes related to compliance issues. Information obtained by the committee may result in the recommendation, development and monitoring of additional systems and controls to promote corporate compliance efforts. The committee evaluates the effectiveness of the compliance program on at least an annual basis. The compliance officer/team remain duty-bound to report on and correct alleged fraud and other misconduct.

Conducting Training and Education Programs

All agents of EM receive training on at least an annual basis regarding the overall Corporate Compliance Program, and more specific training on issues that have a direct impact on their duties and responsibilities. Annual refresher training will re-emphasize Medicaid statutory, regulatory, and contractual requirements and the EM code of conduct. Annually EM shall communicate with employee, individuals served and providers that fraud, waste, and abuse should be reported to EM and MDHHS-OIG and that this can be accomplished (including anonymously) via phone by calling 1-877-778-5463 (EM) or 855-MI-FRAUD (MDHHS-OIG), and online at michigan.gov/fraud. The purpose of the training is to provide clear guidelines for all agents of EM, to ensure understanding of compliance issues, and reinforce organizational commitment to compliance efforts. Specific topics addressed in the training will include, but is not limited to the following:

- EM Code of Ethics.
- Compliance reporting mechanisms, including the “Report It!” Hotline.
- Organizational expectations for reporting problems and concerns.
- non-retaliation/non-retribution policy.
- Summary information on recent corporate compliance related activity.
- An update on recent changes to Federal and/or State regulations, Medicaid statutory regulatory and contractual requirements and the EM code of conduct pertaining to corporate compliance.
- The compliance officer is responsible for the content of the message and materials distributed for Informal on going compliance training these communications can be found in the be the good newsletter and “y” comply segments that are distributed via emails to employees and managers.

Compliance Communication / Internal Reporting, Investigative Processes, and Disclosures by Whistleblowers

EM will implement and maintain a process to report instances of possible non-compliance, anonymously if desired. This includes the establishment of a corporate compliance hotline and other measures for receiving complaints, and for protecting “whistle blowers” from retaliation. EM supports and encourages open communication regarding compliance matters. Any staff member, volunteer, or independent contractor (e.g., Whistleblower) who becomes aware of any real or assumed compromise of corporate compliance or any illegal conduct of behavior in violation of EM Codes of Ethics should report such immediately to:

- The Corporate Compliance Committee members or email distribution: CorporateCompliance@eastersealmorc.org.
- The Corporate Compliance Committee through the published “Report It!” confidential hotline:
- Using the report it App Text “ESSMICHIGAN” to 63975 Call 1-888-600-8070
- Through the chain of command via his/her supervisor, program manager, program director, or to the president/CEO.

Any staff member, Individuals served who become aware of such will report such concerns to the Corporate Compliance Officer, either directly or through the “Report It” Hotline. Members of the governance Board who become aware of behavior in violation of the EM Code of Ethics will report such concerns directly to the president/CEO or designee. EM will maintain itself in full compliance with Federal and State “Whistle Blowers” statutes. Individuals will not be subject to any form of retaliation for making what they believe in good faith to be a truthful and accurate report.

EM will investigate any reported allegation of fraud, waste and abuse related to services purchased with Medicaid funds. EM will notify the relevant community mental health organization within 48 hours of becoming aware of any such allegation and notify them of the outcome of any such investigation(s) upon completion.

Employees, volunteers/interns, and business associates that report suspected compliance violations will be protected under whistleblower laws and non-intimidation/non-retaliation for good faith participation in the compliance program.

An individual may report a suspected corporate compliance matter via telephone to the Corporate Compliance Officer at 248.475-6400 or the CC team via CorporateCompliance@eastersealsmorc.org. A full description of the matter being disclosed must be provided and must include the following:

- Name, address, and phone number of reporter. *
- A description of the problem (e.g., type of claim, transaction, or misconduct).
- What caused the problem? How did it happen, and how was it allowed to continue?
- Name of entities and individuals implicated (e.g., who was involved? Participants that encouraged or were aware of concern).

- Time period involved.
- A description of how the matter was discovered.
- A listing of any other external entities notified of the matter.

Anonymous disclosures are permitted with the understanding that the above required information (items 2-7) must be provided.

The provisions of this section do not preclude individuals from pursuing other legal actions as provided by federal, state, or local statutes.

Any improper conduct by an employee of EM which results in suspension or termination is reported to the appropriate authorities.

Investigative Process:

EM will implement a system to respond to allegations of improper/illegal activities and to enforce appropriate disciplinary action. EM is committed to prompt and thorough investigation of all potential problems that are reported. The CC Team will complete the investigation (consult signed) within 30 calendar days for routine reviews. For urgent cases this investigation will be completed within 14 calendar days. For those cases where a staff member is suspended with pay, these consults will be completed within five (5) business days. In some circumstances, issues are brought to the CC team that do not constitute a formal consult, however guidance and feedback is provided regarding the issue(s) in question. These are labeled as advisement only since there is no policy violation.

If an investigation of an alleged violation is undertaken, and the Corporate Compliance Team believes the integrity of the investigation may be hampered by the presence of individuals under investigation, those individuals should be removed from their current work activities pending completion of that portion of the investigation. These individuals will be temporarily suspended with pay pending the outcome of the investigation.

The CC Team are responsible for the implementation of such internal investigations and will ensure that a complete and accurate record is prepared, logged, and maintained for each investigation. The findings of such investigations will be reported to the president/CEO or designee who will maintain responsibility for response and corrective action of such through delegation to organizational members.

The investigation will include and document:

- A determination of how the problem/alleged violation was discovered.
- A review of relevant policies and procedures, including Breach Notification requirements.
- Utilization of outside resources, if needed.
- Interviews with agents of EM or individuals served.

- Review of relevant documentation (e.g., data, case records, sign-in sheets, etc.) 4.18.1.6 A review of information gathered to determine potential liability or other pertinent issues with members of the Corporate Compliance Team.
- A determination of appropriate recommended courses of action, including the corrective actions implemented or information provided to the program director or designee, and HR to determine the next course of action, in accordance with EM disciplinary and sanctions policies.
- Report outcome of investigations and related findings to internal and/or external parties as appropriate.

Additionally, the Corporate Compliance Team will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If the results of the internal investigation identify a problem, the response may be immediate referral to criminal and/or civil law enforcement authorities, licensing boards, development of a corrective action plan, a report to the government, and submission of any overpayments, if applicable. If potential fraud or violations of the False Claims Act are involved, the Corporate Compliance Officer/Team will report the potential violation to the Office of the Inspector General or the Department of Health & Human Services.

The over reporting will be corrected by pulling back the data. Overpayment will be corrected through reimbursement. The organization should inform the payer of the following: (1) the refund is being made pursuant to a voluntary compliance program; (2) a description of the complete circumstances prompting the overpayment; (3) the methodology by which the overpayment was determined; (4) any claim-specific information used to determine the overpayment; and (5) the amount of the overpayment.

The President/CEO and/or designee(s) shall have the authority and responsibility to direct reimbursement to payers and the reporting of misconduct to enforcement authorities as is determined, in consultation with legal counsel, to be appropriate or required by applicable laws and rules.

If the President/CEO or designee(s) discover credible evidence of misconduct and has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Corporate Compliance Officer/Team will promptly report the matter to the appropriate government authority in accordance with funding requirements, but not more than 60 days after determining that there is credible evidence of a violation.

MDHHS-OIG 855-MI- FRAUD (MDHHS-OIG), and online at michigan.gov/fraud, and if applicable Office of Inspector General Hotline: 1-800-HHS-TIPS (1-800-447-8477)

When reporting misconduct to the government, the compliance team will utilize OIG's Health Care Fraud Self-Disclosure Protocol in determining when to provide evidence relevant to the potential

violation of applicable federal or state laws and the potential cost impact. This protocol is found here: https://oig.hhs.gov/compliance/self-disclosure-info/

The Corporate Compliance Team will also be responsible for responding to requests for information from the federal, state, or local government entities in matters of corporate compliance. When a request for information is received by other organizational members, they will notify the Compliance Team immediately before making any response or acknowledgement. The Compliance Team will then be responsible for coordinating the organization's response to such inquiries.

<u>Non-Corporate Compliance Related Issues:</u>

There is a distinction between routine policy/procedural violations and corporate compliance sanctions:

- Corporate Compliance sanctions involve violations that impact Fraud, Waste and Abuse.
- non-corporate compliance related issues, such as those that pertain to staff not following specific policies, procedures found in the identified operations manuals or the EM Employee Policy Manual, should be handled through employee performance requirements. Examples of these may be a signature not obtained on a consent, the correct signatures not obtained for consents, cutting/pasting content from one clinical record to another where service description still supports CPT code, etc.
- When non-corporate compliance related issues are brought to the CC team for review, they will be redirected to the program administration for follow up from a policy violation perspective.
- Sanctions may be modified based on extenuating factors as determined by the corporate compliance team. These factors might reflect increased or decreased damage caused by the violation and thus work in favor or against the violator modifying the penalty.
-
- Examples that may increase sanctions include:
    - Violations of specialty information such as HIV, substance abuse, genetic data
    - High volume of data or people affected
    - High exposure for EM
    - Large organizational expense incurred, such as breach notifications
    - Hampering the investigation and lack of truthfulness
    - Negative influence on others for personal gain
    - History of performance issues and/or violations

  Examples that can mitigate sanctions include:

    - Violations Violators knowledge of corporate compliance factors (e.g. inadequate training, training barriers, or Limited English Proficiency

- Culture of surrounding environment, (e.g., investigation determines inappropriate practices throughout the agency/program)
- Violations occurred as a result of attempting to help an individual (e.g., victims sufer no financial or reputational or other personal harm,
- Violator voluntarily admitted the information in a timely matter & violator showed remorse,
- Action was taken under pressure of an individual in authority

Auditing and Monitoring

EM will implement an auditing and monitoring system to evaluate for compliance and identify potential issues. This includes internal and external monitoring systems such as background checks, audits, interviews with organizational members, and other reviews. Monitoring activities will be conducted internally through the Compliance Team in conjunction with the EM Leadership Team. Cooperation will be provided in the conduct of external monitoring under the auspices of appropriate governmental units and to entities subcontracted for such purposes. Cooperation will ensure not only compliance with applicable law, policy, or regulation, but also appropriately protect the agency from risk relative to the conduct of such monitoring.

Report of the audit findings/recommendations are provided to the Compliance officer, Compliance committee and senior management.

Corrective Action

Investigation and correction of identified problems and development of policies and procedures as needed to assure compliance. This includes the enforcement of standards through training and well-publicized disciplinary procedures for non-compliance, maximizing the lines of communication in the identification of corporate compliance risk areas and assuring prompt response relative to circumstances indicating possible or actual risk. Any EM member who is found to be in violation of the provisions of this policy is subject to disciplinary action, up to and including termination. The Corporate Compliance Officer will review the findings of the investigation with the Corporate Compliance Team and make a referral to the relevant program director to develop and follow up on recommendations for disciplinary action against any individual found to be in such violation. The above corporate compliance sanction levels provide guidance to the corporate compliance team to ensure that violations are handled consistently across the organization. Please refer to # 3 'Disciplinary Guidelines' section for a list of the corporate compliance sanction levels.

Response to Special Agent's Visit for the Purpose of Investigating Allegations of Fraud, Waste and Abuse

In the event special agents visit Easterseals MORC for the purpose of investigating fraud, waste and abuse allegations, the following steps will be adhered to:

- Request a copy of the search warrant and the affidavit supporting it.
- Record names of all agents and agencies they represent.
- Ask the agent to secure the premises but to delay the search until counsel can be notified. If this request is refused, do not deny admission to the premises, which could be construed as obstruction of justice.
- Ask for a delay until all persons served have been seen.
- Accompany the agents during the search.
- Record beginning and ending times of the search, items taken, areas searched, types of documents taken, photographs, taken, questions asked, or comments made, and requests made by agents.
- Identify and request copies of items essential to daily operation.
- If employees are interviewed, debrief them after or during the search.

Medicaid Program Integrity: Disclosures of Ownership and Control

In March 2010, Congress passed the Affordable Care Act, which required Federal agencies to dramatically change its regulatory policies relating to Medicare and Medicaid. In March 2011, policies were implemented that addressed several issues including additional screening requirements for disclosures made to Medicaid/Medicare agencies, additional enrollment requirements for ordering and referring providers, change in application fees, and a requirement for revalidation of enrollment for all providers every five years. As part of these enactments, the government created additional disclosure requirements in 42 CFR 455.104, the regulation that this Memorandum addresses.

The 42 CFR 455.104 provisions (Disclosures of Ownership and Control) were enacted to reduce or eliminate fraud, waste and abuse and are sometimes referred to as “Medicaid Program Integrity Regulations.” Indeed, a Medicaid agency may refuse enrollment to a provider who fails to fully make disclosures under the regulation and a State may be refused Federal reimbursement for payments to providers that have not provided the required ownership and control disclosures under 42 CFR 455.104. Thus, failure to comply with these regulations can have serious consequences for both the providers and the State (either can lose funding). While Medicaid agencies have long since had disclosure requirements, these recent amendments require additional information, including social security numbers for “persons with an ownership or control interest” and “managing employees.” 4

As part of this requirement, EM is mandated to disclose to its contracting agencies (e.g., CMH’s), managing Medicaid funds, sensitive information of any person (individual or corporation) with an ownership or control interest in the disclosing entity. In addition, EM is mandated to obtain from its contracted providers providing services funded through Medicaid, sensitive information of any person (individual or corporation) with an ownership or control interest in the disclosing entity. This sensitive information may be included as follows:

  - Name

- Address
- Date of birth
- Social security number
- Other tax identifying information

For additional information about the Medicaid Program Integrity requirements, please reference 42 CFR 455.100-106.

Easterseals MORC will electronically secure the information obtained from individuals with an ownership or controlling interest in EM and from contracted providers in a folder with access provided only to EM's Corporate Compliance Team and President/CEO. Paper copies of these documents will not be maintained, only electronic files. Once paper copies of these documents are obtained, they will be scanned, fled, and shredded based on EM Policy A8.024 Retention and Destruction of Confidential Records - Information.

In the event that the information listed above is compromised, EM will follow the Breach Investigation and Notification processes identified in this policy.

References:

- EM Corporate Compliance Plan and Program
- EM Safety, Health & Accessibility Plan and Program
- EM Risk Assessment and Action Plan
- ESM Policy A8.003: Disclosures by Whistle Blowers (Rescinded)
- False Claims Act, (Stark I (1989) and Stark II (1993)
- Federal Anti-kickback Statute
- U.S. Organizational Sentencing Guidelines (1991)
- Health Insurance Portability and Accountability Act (HIPAA)
- Balanced Budget Act (BBA) of 1997
- OCHN Policy CC 1.1: Corporate Compliance Program
- American Recovery and Reinvestment Act (ARRA)
- HiTECH Act
- Office of Inspector General (OIG) Federal Exclusion listing
- MCCMH MCO Policy 1-001: Overview: Compliance Program/ Code of Ethics

Exhibit: None

MANUAL RESOURCES

- Provider Application
- Credential Review Application
- Subcontractor Enrollment Agreement
- Vendor View Enrollment Application with Instructions