Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Michigan Focused Program Integrity Review

Final Report

June 2022

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Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Michigan Medicaid managed care program. The primary objective of the review was to assess the level of program integrity oversight of efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs), referred to as MHPs in Michigan, that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In August 2021, CMS conducted a virtual focused review of Michigan's single state Medicaid agency, the Michigan Department of Health and Human Services (MDHHS), which is responsible for program integrity oversight of Michigan's Medicaid program. This focused review helped CMS to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected Medicaid Health Plans (MHPs) under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MHPs Special Investigations Units (SIUs), as well as other primary data, to assess the state's and selected MHPs' program integrity practices. CMS also evaluated the status of Michigan's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

During this review, CMS identified a total of three recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MHP investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Michigan Medicaid

The MDHHS is the single state agency responsible for providing oversight of the Medical Assistance Program and the contracted MHPs in Michigan.

The MDHHS Office of Inspector General (OIG) is the organizational unit responsible for the overall program integrity operations for the managed care program.

In FY 2019, Michigan's Medicaid expenditures were approximately $16 billion, and the state had approximately 1,738,182 beneficiaries enrolled. The traditional Federal Medical Assistance Percentage matching rate was 64.45 percent but does not include CHIP. Approximately 76 percent of the Medicaid population was enrolled in eleven managed care plans under the Medicaid program. Michigan's managed care expenditures were approximately $8,021,218,690, which included both Medicaid and the State Children's Health Insurance Program (SCHIP), representing approximately 50 percent of Michigan's total Medicaid expenditures.

Three of Michigan's eleven operating MHPs in FY 2019 were selected for interview during the virtual Program Integrity review, based on size and expenditures: Meridian Health, Molina Healthcare, and Total Healthcare. CMS did not interview McLaren Health Plan, Aetna Better Health, HAP Empowered, Blue Cross Complete, Priority Health Choice, Upper Peninsula Health Plan, and United Healthcare Community Plan. Table 1 and Table 2 provide enrollment/SIU and expenditure data for each MHP that CMS interviewed.

Table 1. Summary Data for Michigan MHPs[2]

	Meridian	Molina	Total Health Care
Beneficiary enrollment total	495,404	360,990	48,829
Provider enrollment total	36,550	66,142	5,029
Year originally contracted	2016	2015	1976

[2] The beneficiary enrollment numbers for each plan are as of 12/20/2020, 1/19/2019, 09/19/2020, respectively.

	Meridian	Molina	Total Health Care
Size and composition of SIU (FTEs)	10	33	1
National/local plan	National	National	Local

Table 2. Medicaid Expenditure Data for Michigan MHPs[3]

MHP	FY 2017	FY 2018	FY 2019
Meridian	$1,978,297,065	$1,552,640,997	$1,459,736,022
Molina	$951,299,008	$837,207,073	$838,207,276
Total Health Care	$216,135,084	$205,616,651	$192,118,260

Results of the Review

CMS evaluated the following six areas of Michigan's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MHP investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified three areas of concern with Michigan's managed care program integrity oversight that may create risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. State Oversight of Managed Care Program Integrity Activities

The MDHHS contracts with the MHPs, which are selected through a competitive bid process, to provide services to Medicaid beneficiaries. In accordance with the state's managed care contract, the MDHHS performs annual compliance reviews of the MHPs. The Managed Care Plan Division oversees the annual compliance review process. There are two sections within this division: the Quality Improvement and Program Development Section, and the Plan Management Section.

The MDHHS-OIG has primary responsibility for providing program integrity oversight for the MHPs, the managed care program and all fee-for-service (FFS) Medicaid services. The MHPs, also known as physical health plans or comprehensive plans, are contracted with the state of Michigan to manage (provide or arrange for) the medical needs of Medicaid beneficiaries enrolled in the MHP. The MHPs are required by their contract with the state of Michigan to be subjected to audit by the MDHHS-OIG. The

[3] Each of the MHPs submitted the expenditure data reported in Table 2. The state confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to development of this report.

Program Integrity Audit outlines compliance standards and various methods used to evaluate an MHP's compliance with 42 CFR 438.608 and state contractual requirements. The Program Integrity Audit is segmented into two parts – Staffing/Administrative Standards, and Monitoring/System Standards.

The state also contracts with an independent External Quality Review Organization (EQRO) that validates the state's compliance reviews. The EQRO also conducts independent reviews for the PIHPs. The PIHPs administer mental health benefits for people with intellectual/developmental disabilities, adults with serious mental illness, children with serious emotional disturbances, and people with substance abuse prevention and treatment needs.

In Michigan, the MHPs are contractually required to have a compliance plan that meets the requirements of 42 CFR 438.608(a)(1). Compliance plans are required to be provided annually as part of the annual MHP compliance review. In addition to reviewing criteria that pertains to the contract, state law, and federal regulations, the MDHHS-OIG will also appraise the formal documentation and application of policies and procedures. CMS observed all three MHPs interviewed had the required compliance plans in place that met the requirements of 42 CFR 438.608(a)(1).

CMS did not identify any findings or recommendations for this area of review.

2. Provider Screening and Enrollment

To comply with §§ 438.602(b)(1) - (b)(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, the Michigan model contract states that all network providers of the contractor must enroll with the Michigan Medicaid Program. The Michigan MHP contract § XVIII.I specifies provider enrollment requirements pursuant to § 438.602(b)(1), as well as active screening and monitoring requirements. As per the contract, the state will screen and enroll, and periodically revalidate all enrolled Medicaid providers. The MHP must require all its network providers be enrolled in the Michigan Medicaid Program via the State's Medicaid Management Information System, and the Community Health Automated Medicaid Processing System (CHAMPS). The MHP must ensure that all providers are registered in Michigan's provider enrollment system prior to contracting and credentialing with the provider. This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

The MHP must require its providers and subcontractors to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in § 455 Subpart B and E. The MHP must comply with the requirements detailed at § 455.436, requiring the MHP to, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE) and other federal databases (1) at least monthly for its non-Medicaid enrolled providers, (2) before contracting with providers, and (3) at the time of a provider's credentialing and re-credentialing.

The MHP must obtain federally required disclosures from all non-Medicaid enrolled network providers and applicants in accordance with § 455 Subpart B and §1002.3, as related to ownership and control,

business transactions, and criminal conviction for offenses against federally related health care programs including Medicare, Medicaid, or CHIP. The MHP must screen all individuals listed on the disclosure form including providers and non-providers, such as board members, owners, agents, and managing employees. The information shall be obtained through provider enrollment forms and credentialing and re-credentialing packages. The MHP must maintain such disclosed information in a manner that can be periodically searched by the MHP for exclusions and provided to MDHHS in accordance with relevant state and federal laws and regulations. The MHP must conduct monthly checks and shall require subcontractors to conduct monthly checks to screen non-Medicaid enrolled providers for exclusion, using the Social Security Administration's Death Master File (SSA-DMF), the National Plan and Provider Enumeration System (NPPES), the LEIE, the System for Award Management (SAM), and any other databases as the state may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. The MHP must also check the MDHHS provider file or conduct its own checks against the federal exclusion files (named above) to ensure that any of its network providers who are "Medicaid enrolled" providers remain enrolled with MDHHS.

The MHP's screening process must also include: verifying licenses, conducting revalidations at least every three years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk, criminal background checks as required by state law, federal database checks for excluded providers at least monthly, and reviewing all ownership and control disclosures submitted by subcontractors and providers.

CMS regulations at § 455.432 requires that the state Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program. **However**, **the Michigan MHP contract does not outline that the MHP's screening processes shall include site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk.** All three MHPs interviewed indicated that they are not currently conducting site visits in relation to high risk designations. Meridian and Molina both conducts announced provider visits when there is a credible allegation of fraud, waste, and abuse, while Total Health Care indicates that they do conduct pre/post enrollment site visits, this action is not based on a provider designation criterion. The MHP must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled. The MHP must immediately notify the MDHHS about any action taken by the MHP to exclude, based on the provisions of this section, an entity currently participating.

The MHP must inform providers and subcontractors about federal requirements regarding providers and

entities excluded from participation in federal health care programs (including Medicare, Medicaid, and CHIP). In addition, the MHP should inform providers and subcontractors about the federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/. This is where providers/subcontractors can screen managing employees and contractors against the HHS-OIG website monthly to determine whether any of them have been excluded from participating in federal health care programs. Providers and subcontractors should also be advised to immediately report to the MHP any exclusion information discovered.

Recommendation #1: The MDHHS should ensure compliance with the risk designation requirements in § 455.450, and subsequent enhanced screening requirements further listed in § 455.432. The contract should be revised to include the detailed requirements for compliance.

3. MHP Investigations of Fraud, Waste, and Abuse

State Oversight of MHPs

As required by § 438.608(a)(1)(vii), Michigan has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MHPs. Michigan's Medicaid contracts with its MHPs state, "Contractor must implement and maintain administrative and management arrangements or procedures designed to detect and prevent Fraud, Waste, and Abuse, including a mandatory compliance plan."

The contract also specifies that the MHPs must submit to MDHHS-OIG an annual Program Integrity Plan. The plan must include the MHP's plan of activities for the upcoming year including, but not limited to, the following activities: data analytics and algorithms, clinical reviews, audits, investigations planned, services requiring prior authorization, payment edits and audits, provider credentialing, and third-party liability identification.

The MDHHS Managed Care Plan Division holds bi-weekly program integrity workgroups with the MHPs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The attendees include representatives from the MHPs' program integrity divisions (the designated program integrity lead). Beginning in June 2019, MDHHS-OIG, in collaboration with MFCU, began monthly meetings to discuss MHP fraud referral files as well as develop specific policies and procedures to ensure accuracy in records. Additionally, tri-annual meetings are held with MFCU to train MHP staff on any new or pending changes to contract language, compliance submissions, or reporting requirements as a result of concerns by MFCU regarding the quantity and quality of fraud referrals. Both MDHHS-OIG and MFCU have seen an improvement in MHP case referral quality over the past three years, as currently, all referrals for suspected fraud and abuse are submitted by the MHPs to both MDHHS-OIG and MFCU simultaneously. **CMS noted during the review that the memorandum of understanding (MOU) agreement currently in place between the MFCU and MDHHS-OIG does not address the responsibilities of the MHPs referring directly to the MFCU.**

Section 1-XVIII.B.2 of the contract states, "Notwithstanding the obligation to report suspicions of provider and subcontractor Fraud directly to MDHHS-OIG as required by this Contract, Contractor

must, on a quarterly basis, submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a report detailing all allegations of provider and subcontractor Fraud received and reviewed by the Contractor during the previous quarter." The report must include any improper payments identified and overpayments recovered by the MHP during the course of its program integrity activities.

As discussed during the review, upon submission from the MHPs, MDHHS reviews the Quarterly Program Integrity report, Quarterly Encounter Adjustment Validation report, and the OIG Annual Program Integrity Report. If MDHHS-OIG identifies discrepancies pertaining to reporting and encounter correction/adjustment processes, the State will pursue liquidated damages. This evaluation examines ongoing reporting, as well as the contents of the report to ensure that all contractual requirements are being met.

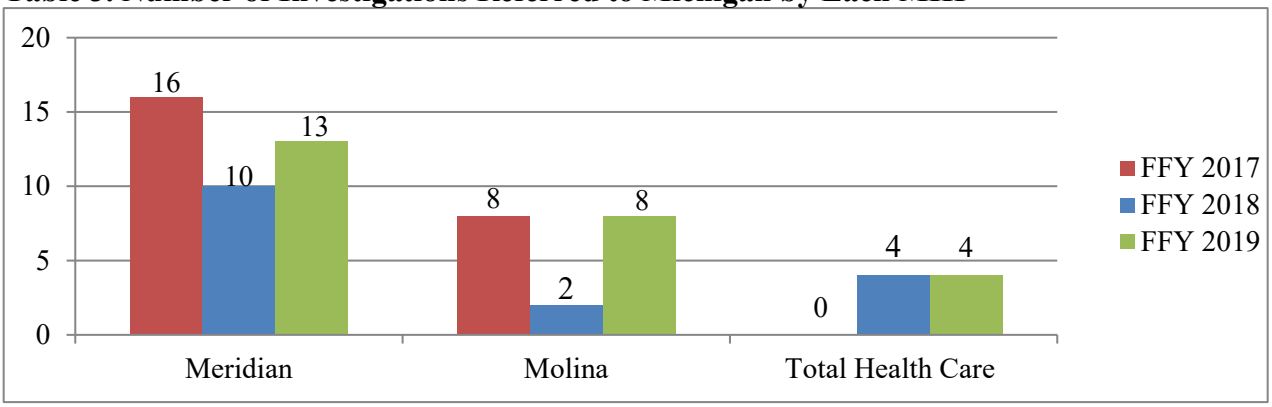
In accordance with § 455.20, the Michigan state agency must have a method for verifying with beneficiaries whether services billed by providers were received. The SMA reported that, per the general contract, MHPs must maintain lines of communication with beneficiaries to verify services billed have occurred and were appropriately rendered. Each plan is required to report the number of EOBs sent to their beneficiaries on a quarterly basis to MDHHS OIG.

CMS confirmed that each of the MHPs interviewed has a Special Investigative Unit (SIU). The SIU staffing levels reported by all three plans ranged between 1 to 33 full-time employees dedicated to Michigan Medicaid. The program integrity efforts of one of the three reviewed SIUs, in terms of provider referrals and investigations, appear to be adequate.

MHP Oversight of Network Providers

Table 3 describes the number of referrals that Meridian, Molina, and Total Health Care made to the state in the last three FYs. Overall, the number of MHP provider case referrals of the reviewed SIUs appears to be adequate for Meridian. However, Molina and Total Health Care provider case referrals are minimal in relation to the total annual Medicaid expenditure amounts, along with beneficiary enrollment totals, and the total number of providers reported for all three plans in FY 2017-2019.

Table 3. Number of Investigations Referred to Michigan by Each MHP



There was an overall low number of case referrals by the MHPs. In 2018, the MFCU sent a memo to the

MHPs requiring them to submit fraud referrals directly to the MFCU in addition to submitting them to MDHHS-OIG. The MHPs continued to utilize the fraud referral template when making their referrals. The MFCU reportedly did not consider these to be actual referrals and therefore did not feel the need to formally accept or deny each referral.

Overpayments

Consistent with § 438.608(d), the state MHP contract must specify that MHPs have an overpayment retention policy in place. The MHP general contract addresses this requirement in § XVIII.A.2, which includes information pertaining to the treatment of recoveries and reporting requirements. This section also states that MDHHS-OIG will perform post payment evaluations of the MHP's network providers for any potential fraud, waste, or abuse and will recover overpayments made by the MHP to their network providers when the post payment evaluation was initiated and performed by MDHHS-OIG.

Overall, the amount of overpayments identified and recovered by each MHP appears to be exceedingly high, indicating that the state is sufficiently identifying and collecting overpayments. Further, although the MHPs are not normally required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. (§ 438.608(d)(4)) Without these adjustments, MHPs could be receiving inflated rates per member per month. Tables 4-A, 4-B, and 4-C describe each MHP's recoveries from program integrity activities.

Table 4-A Meridian's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	484	57	$3,929,978	$3,929,978
2018	365	10	$5,915,983	$5,915,983
2019	213	39	$15,452,629	$15,452,629

Table 4-B. Molina's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	194	319	$29,382,221	$29,355,458
2018	183	139	$27,471,742	$24,406,539
2019	279	291	$36,958,125	$34,410,039

Table 4-C. Total Health Care's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	2281	2229	$1,492,104	$1,492,104
2018	2520	2687	$3,201,081	$3,373,841
2019	2461	5404	$2,214,674	$2,303,652

Recommendation #2: The state, in conjunction with MFCU, should develop and implement an MOU to formally document the case referral agreements. The MOU should include details regarding regular training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers and timelines for submission.

4. Encounter Data

The MDHHS receives complete encounter data from the MHPs at least monthly. The timeframe for MHPs to submit encounter data to the state is within 30 days of MHP claims payment. Encounter data is submitted via an electronic Health Insurance Portability and Accountability Act compliant format and pharmacy encounter data must include data elements as required by MDHHS Pharmacy 340B policy and claim submission requirements. The MDHHS reviews and validates all submitted encounter data for accuracy and completeness. The MDHHS-OIG Integrity Division utilizes encounter data when performing Medicaid provider investigations and the Investigative Analytics Unit (IAU) includes encounter data in their data mining to identify high risk billing activities for investigation The state reported that the IAU primarily utilizes Teradata Suite where SQL is utilized to create algorithms/scenarios (e.g., rules-based algorithms, outlier analysis, impossibility scenarios, geo-analysis). All encounters are loaded to the MDHHS data warehouse and are available for reporting by other divisions (functional areas) within the agency.

With respect to the encounter data used for actuarial soundness of rates, MDHHS will establish actuarially sound capitation rates developed in accordance with the federal requirements. The MDHHS requires that rates be developed by someone who holds credentials by the American Academy of Actuaries. The capitation rate development methodology must incorporate the following: MHP annual financial filings, FFS data, and encounter data. Out-of-Network Provider and any subcontractor or financial institutions that are located outside of the United States are not considered.

CMS did not identify any recommendations regarding Michigan's use of encounter data for Medicaid oversight.

5. Payment Suspensions Based on Credible Allegations of Fraud

Consistent with § 438.608(a)(8), Michigan's MHP model contract includes a provision regarding the suspension of payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23. Specifically, Michigan's MHPs are contractually required to suspend payments to network providers at the state's request if the state determined a credible allegation of fraud exists in accordance with § 455.23. Suspension of payments must be implemented immediately and applies to all Medicaid claims (FFS and encounter/managed care) submitted by the network provider.

The MDHHS MHP contract requires, "Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR § 455.23," Of the MHPs interviewed, none reported any good cause exceptions during the

review period, nor was any language found in the contract as to what they would do if a good cause exception were to arise. There was no payment suspension on referred cases until FY 2020.

All three MHPs have a suspension policy; however, one MHP (Molina) advised CMS that they do not suspend providers. When a provider has an adverse action, Molina places a "No Pay" contract on that provider's record within the claims adjudication system, which results in denied claims. No claims are reviewed in this protocol, all are zero paid.

CMS did not identify any findings or recommendations for this area of review.

6. Terminated Providers and Adverse Action Reporting

Consistent with §§ 438.608(b) and 455, subparts B and E, Michigan's MHP model contract requires MHPs to meet CMS' provider enrollment and screening requirements, including the requirement at § 455.416 to terminate network providers in certain circumstance, including for cause, which may include, but is not limited to, fraud, integrity, or quality. Specifically, the MDHHS model contract states in section 1 - XVIII.B.6, "Contractor must submit to MDHHS-OIG, in a format determined by MDHHS-OIG, a Quarterly Provider Disenrollment Log including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; provider terminations for convenience; and providers who self-terminated."

Further, section 2.1 - II.D of the contract states, "Contractor must not include persons who are currently suspended or terminated from the Medicaid program in its Provider Network or in the conduct of the Contractor's affairs. Contractor must not employ, or hold any contracts or arrangements with, any individuals who have been suspended, debarred, or otherwise excluded under the Federal Acquisition Regulation as described in 42 CFR 438.610."

Finally, there is currently a process and procedure that involves the referral of providers with adverse actions within twenty business days of any adverse actions taken by the MHP against a provider. These referrals are submitted on the Provider Adverse Action and Exclusion Reporting Form to MDHHS for further review for recommendation to deny, continue, or terminate enrollment for a provider. The MDHHS-OIG unit loads terminated providers into CMS' Data Exchange System also known as DEX.

Overall, the number of providers terminated "for cause" by the plans appears low, compared to the number of providers enrolled with the MHPs and compared to the number of providers dis-enrolled or terminated for cause. Table 5 depicts the number of provider terminations by MHP.

Table 5: Provider Terminations in Managed Care

MHPs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs	Total # of Providers Terminated for Cause in Last 3 Completed FYs
Meridian	2017 2010 2018 2179 2019 1633	2017 65 2018 70 2019 63

MHPs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FYs	Total # of Providers Terminated for Cause in Last 3 Completed FYs
Molina	2017 1148 2018 1871 2019 1887	2017 18 2018 82 2019 4
Total Health Care	2017 272 2018 562 2019 501	2017 11 2018 6 2019 10

CMS did not identify any recommendations regarding Michigan's terminated providers and adverse action reporting policies and procedures.

Status of Michigan's 2015 Corrective Action Plan

Michigan's previous focused program integrity review was in January 2015, and the final report was issued in February 2016. The report contained seven recommendations. CMS completed a desk review of the corrective action plan (CAP) in June 2017; however, several items remained outstanding, and due to anticipated dates of completion, the CAP was closed with understanding that the items would be addressed at the next scheduled focused PI review.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Michigan to consider utilizing:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Conclusion

CMS supports Michigan's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified six areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

CMS looks forward to working with Michigan to build an effective and strengthened program integrity function.