MI Choice Waiver Contracting Procedures – Tri County Office on Aging

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About the MI Choice Waiver

The purpose of the MI Choice Waiver is to utilize federal funding to offer services not covered under the State Medicaid plan and to broaden Medicaid Income eligibility to enable persons to remain in the community and out of an institutional setting. The MI Choice Waiver program is available to those aged 65 and over and to adults with disabilities who meet functional and financial criteria. The MI Choice Waiver is available statewide, and potential participants must meet both the Nursing Facility Level of Care requirements and the income and asset eligibility requirements. Tri-County Office on Aging (TCOA) has a contract with Michigan Department of Health and Human Services (MDHHS) to provide MI Choice services to participants residing in Clinton, Eaton, and Ingham Counties.

TCOA Supports Coordinators, participants, and their supports identify needs through a person-centered process and develop a care plan designed to address those needs. With participant approval, supports coordinators arrange for services through providers who meet standards set by the Michigan Department of Health and Human Services (MDHHS). Participants may also choose to participate in Self Determination (SD) and self-direct specialized services. This gives the participant the freedom to choose individual providers they desire and employ them directly. Services to be covered under the MI Choice Waiver include:

Adult Day Health	Assistive Technology	Chore Services
Community Health Worker	Community Living Supports	Community Transportation
Counseling (Mental Health)	Fiscal Intermediary (SD Only)	Environmental Accessibility Adaptations
Home Delivered Meals	Goods and Services (SD Only)	Nursing Services
Private Duty Nursing	Respite Care	Personal Emergency Response Systems
Residential Services	Medical Equipment/Supplies	Supports Coordination
Supports Brokerage	Vehicle Modifications	Training Services

The participant has the freedom to choose the services, location of services (private home or licensed residential setting) and service provider(s) they desire. Explicit appeal rights will be afforded to all applicants and participants.

Initiating a Contract

Contracts with a community service provider under the MI Choice Waiver program at TCOA are initiated either by a provider reaching out to TCOA or by TCOA reaching out to a provider to fill an anticipated service need. Entry into these service contracts, also known as Direct Purchase of Services (DPOS) Agreements, or simply Services Agreements, are governed by the regulations set forth by MDHHS under the MI Choice Waiver Program and supplemented by other guidelines put into place by TCOA in the Services Agreement. These policies can be found in the Michigan Medicaid Provider Manual, MI Choice Chapter, and in the TCOA Services Agreements. (See "TCOA DPOS Agreement" in Appendix A).

To contract with TCOA, a potential provider must submit specific documentation for review and meet other requirements of the program. These requirements include, but are not limited to:

The completion of the services agreement and business associate agreement
A review of required insurance coverages
Submission of tax and billing forms
Successfully completing S a criminal background check review
Completion of the MDHHS monitoring tool
Confirmation of business ownership
Submission and review of any required state licenses E
Enrollment in the Vendor View and Vendor Billing web portals
Enrollment in CHAMPS (For Home Health Care Agencies)
Participation in Electronic Visit Verification (EVV) (For Home Health Care Agencies)

Once contracting documentation is received, reviewed, and approved, the contract will be submitted to the TCOA Executive Director for signatures. These and other related forms can be found in Appendix A.

TCOA prefers its contracted service providers to maintain a business presence, and be able to serve, the tri-county area of Clinton, Eaton, and Ingham Counties. On occasion, exceptions can be made based on participant preferences and availability of the provider to responsibly deliver services in the tri-county area. For enrollment, it is strongly preferred that a potential service provider has a TCOA MI Choice Waiver participant ready and requesting to use that provider's services, in advance of or during the contracting process.

Renewal of Existing Contracts

TCOA Provider Contracts under MI Choice are renewed every two years. Providers must be in good standing with TCOA and have current insurance information on file, as well as complete any other additional paperwork or documentation required during that renewal period. TCOA prepares new contracts which include updates to Medicaid or MDHHS policies and submits the contracts to current providers for review. If the provider wishes to renew their contract for the next two-year cycle, they will return the signed contract to the TCOA Contract Manager for review, who will then forward the contract to the TCOA Waiver Director and Executive Director for final approval and signatures.

Termination of Contracts

TCOA Provider Contracts may be terminated by the provider or by TCOA. Contracts will naturally terminate at the end of the two-year fiscal cycle unless renewed. Providers may terminate contracts with 30 days' advance notice in writing, but must also assist in the transition of any current TCOA participants in their care as they are referred to new providers. TCOA may terminate provider contracts for failure to adhere to Medicaid, MDHHS, or TCOA policies. Upon contract termination, provider is required to maintain records for 10 years and maintain confidentiality of participant information under Health Insurance Portability and Accountability Act (HIPAA) regulations.

Requirements While Contracted

While contracted as a TCOA service provider, each provider must adhere to all MDHHS and TCOA operating standards and regulations. These regulations are outlined in the MI Choice Waiver Chapter of the Medicaid Provider Manual (available online) as well as in the TCOA services agreement. Service providers are also subject to a monitoring visit at any time during their actively contracted status with TCOA. Monitoring visits are conducted at the provider's office and consist of a comprehensive program and billing audit by the TCOA Contract Manager or Contract Specialist, accompanied by a TCOA Billing Specialist. Currently contracted providers are required to maintain records for 10 years for potential review by TCOA or MDHHS staff. Providers are also required to maintain in-service training requirements for staff and are strongly encouraged to attend Quarterly Provider Meetings hosted by TCOA staff, online or in person.

Criminal Background Checks

Medicaid, MDHHS, and TCOA regulations require that all providers adhere to the TCOA Criminal Background Check Policy when hiring staff and direct care workers. TCOA will run a Criminal Background Check of provider ownership entities before executing a new contract with any potential contracted provider. Providers must run criminal background checks on all direct care workers and staff who will, or may, come into contact with TCOA participants in the course of their employment. These criminal background checks must be performed prior to being hired and working with a participant or entering a participant's home.While TCOA only requires the criminal background check be performed upon hire, best practices and TCOA preference is that the background checks be renewed on an annual basis. Providers may adhere to their own internal criminal background check policies when hiring staff to work with private pay clients or any clients funded by other payors, but any staff working directly with TCOA participants must pass the TCOA Criminal Background Check requirements. Depending on the nature of an employee's past criminal convictions, failure to pass the TCOA Criminal Background Check could result in a mandatory lifetime ban, a 10-year ban, or a 5-year ban from providing direct services. TCOA Criminal Background Check Policies are derived from MDHHS regulations and are provided as an attachment to the DPOS Agreement upon contracting. As Criminal Background Check policies are modified, providers will be notified. Any questions on evaluating whether a potential new employee passes the Criminal Background Check may be directed to the TCOA Contract Manager for review. (See "TCOA Criminal Background Check Policy" in Appendix B).

Billing and Reimbursement

Contracted providers are required to submit billing or reimbursement requests within 30 days of the dates the services were provided, but no earlier than the first of the month following the month services were delivered. While TCOA is allowed 30 days for payment of invoices, properly submitted bills are paid in the order they are received, and payments will usually be made within 2-3 weeks of submission, subject to availability of funds and according to TCOA policies of processing payments. TCOA billing staff evaluates submitted bills and will deny payments for any unsubstantiated units or services billed. This includes, but is not limited to, services that were billed when the participant was not at home or when services were not authorized. As the TCOA fiscal year runs from Oct. 1st through September 30th, there is an annual October 31st billing deadline for all past fiscal year billing to be submitted. Any bills received after this deadline cannot be paid. MI Choice provider billing is managed through the Vendor Billing system, located in the Compass web portal. Use of Vendor Billing is required for all contractors, unless notified otherwise.

Electronic Visit Verification (EVV)

MDHHS and TCOA require that all contracted home health agencies must use Electronic Visit Verification to track the hours worked by their Direct Care Worker (DCW) staff while providing authorized services to TCOA participants. Home health agencies are free to select an EVV vendor of their choice, or they may choose to use the EVV vendor contracted with MDHHS. The EVV vendor partnered with MDHHS, HHAeXchange, is currently offered free of charge unless the home health agency chooses to purchase advanced options under that system. Any other EVV vendor chosen by a home health agency (non-MDHHS contracted) must have software and systems that are compatible with the MDHHS EVV systems so data and time worked can be tracked by the state. While paper time sheets with participant signatures to verify hours worked are no longer allowed for home health agencies under the MI Choice Waiver, exceptions can be made, with proper documentation and approval by TCOA, when the caregiver providing services lives with the participant at their home. EVV records are subject to review and audit by TCOA at any time, with or without advance notice.

Overpayment Recoupments

When TCOA staff discovers an overpayment has been made to a provider agency, TCOA will contact the provider to request repayment of the overpaid funds. This overpayment recoupment letter will include a description of the circumstances under which the overpayment was made, along with a billing report or ledger evidencing the overpayment and a deadline for repayment of funds. Failure to repay the funds as requested may result in withholding of future payments to the provider and could result in termination of the provider's contract with TCOA. If a contracted provider agency discovers an overpayment, the provider is required to report the overpayment to TCOA so that TCOA may begin the recoupment process as described above. A non-exhaustive list of possible reasons for overpayments include inaccuracies in provider billing, providers billing for time when participants were not available for services, services provided that were not properly authorized by TCOA, and provider fraud, waste, or abuse. The provider will also receive a copy of the TCOA Appeals Policy along with any overpayment recoupment request. All appeals must be filed within the timeline established by the TCOA Appeals Policy. See "Appeals Procedure for Overpayments" in Appendix C.

Fraud, Waste, and Abuse

TCOA takes active steps to monitor all invoices and payments for any indicators of fraud, waste, and abuse. This monitoring is regularly conducted through via ongoing billing reviews, provider monitoring visits, reviews of tips or grievances, or evaluation of fraud, waste, and abuse tips submitted through the TCOA website. Once evaluated, fraud, waste, and abuse tips may be submitted to the State of Michigan Office of the Inspector General (OIG) for further review or action. Tips on Fraud, Waste, and Abuse may be submitted directly to the OIG office or via the TCOA website at tcoa.org. These tips may be submitted anonymously. See "TCOA Fraud, Waste, and Abuse Policy" in Appendix D.

Annual Monitoring Visits

Monitoring visits of contracted providers are conducted on an annual basis. TCOA will review 20% of its currently contracted providers each fiscal year, using the MDHHS provided Monitoring Tool and any supplemental documentation which serves to aid in the evaluation of the service providers. Monitoring visits are conducted in person, unless desk review is found to be appropriate.

During a monitoring visit, TCOA staff will conduct a complete review of documentation required for contracting with the agency, including a review of employee and participant files. TCOA staff will also conduct a review of the current services agreement and ensure that the provider continues to meet the annual requirements for in-service training and in-home supervisory visits. A billing review of 10 participants or 10% of current participant enrollment (whichever is higher) will be held, covering a 3 month billing period from the current fiscal year. Any discrepancies in documentation or billing will result in follow-up measures which would typically include production of missing program documentation, performance of a required task not yet completed, production of missing timecards, and possible recoupment of unsubstantiated prior payments made to the provider. The monitoring visit also provides TCOA staff and the service provider the opportunity to discuss issues surrounding participant care, contracting, MDHHS service requirements or initiatives, or any other matters which are of concern to the service provider or TCOA.

Results of the monitoring visits are submitted to MDHHS upon completion of each visit and when follow-up measures have been completed. The methodology of the monitoring visits can be found in the MI Choice Waiver subsection of the Michigan Medicaid Provider Manual (MPM). See "MPM Monitoring Visit Methodology" in Appendix E.

Appeals

When a service provider's contract or agreement has been suspended, terminated, not reviewed for failure to maintain good standing, or when a provider disagrees with a contracting, programmatic, or billing decision made by TCOA, the provider may appeal the decision using the TCOA Appeals Procedure for Service Provider Grievance. The provider must timely file notice of the appeal, with supporting documentation, to the TCOA Assistant Director. TCOA will inform the provider of the decision made on the appeal within 10 business days of the receipt of appeal. If the provider does not agree with the decision rendered on appeal, they may submit an objection to the appeal to the TCOA Administrative Board, which shall issue a decision, in writing, within 30 days of receipt of the objection to appeal. See attachment entitled "Appeals Procedure for Service Provider Grievance" in Appendix F.

Provider Education

Providers are provided with ongoing educational and informational opportunities as needed during the ongoing performance of their current contract with TCOA. The TCOA Contract Manager, with consultation of the TCOA Waiver Director, sends out monthly contracting email updates to the TCOA provider list. This gives the contracted providers an opportunity to remain abreast of any current issues related to participant care or contract performance. Additionally, TCOA conducts a Quarterly Provider Meeting either in person or via Microsoft Teams, addressing current issues in more depth and allowing the providers to ask questions and participate in a more robust discussion with TCOA staff. This meeting also gives the providers an opportunity to bring other concerns to light, exchange ideas and solutions for common problems which may benefit the provider group, and network with each other to share any news from their agency.

Emergency Service Responsibilities

Each provider must have in place policies and procedures for emergencies in the participant's place of residence, whether that be at the participant's home or at another residential facility. More information on emergency preparedness can be found in the MI Choice Waiver Participant Handbook. See , located in Appendix G.

Participant/Enrollee Rights and Responsibilities

Participant/Enrollee Rights and Responsibilities are located in the MI Choice Waiver Participant Handbook, which is issued to all Waiver participants upon entry to the program and upon request thereafter. This handbook contains important information on participant assessments and services, options for receiving services, rights and responsibilities, quality assurance, the reporting of fraud, abuse, and neglect, filing of grievances, emergency preparedness, and advance directives. See "MI Choice Participant Handbook" in Appendix G.

Other Provider Responsibilities

Provider qualifications and delivery are mandated by MDHHS to ensure the safety and wellbeing of participants and the quality of services provided. Services are authorized based on the Person-Centered Service Plan (PCSP). Services can only be paid for if included in the PCSP.

Providers are responsible for adhering to all MI Choice regulations as laid out in the Medicaid Provider Manual, MI Choice chapter, as well as meeting the internal contracting policies and procedures for MI Choice at TCOA before any contracts are authorized. Provider qualifications depend on the service being provided, but must also meet State licensing standards as necessary, as well as the minimum standards for MDHHS under the Michigan Bureau of Aging, Community Living, and Supports (ACLS Bureau) and any applicable Federal governmental standards. These standards apply whether the service is provided through Self-Determination (SD) or traditional service delivery. There are different qualifications depending on the service.

No services will be delivered until there is a signed contract/agreement. All providers must enroll as a Medicaid Provider (MSA-1625). Copies of all required documents, including relevant certifications, are kept on file at TCOA. Verification is updated at each contract renewal or sooner if TCOA deems

necessary. Providers are required to disclose their educational and job history as well as any relevant experience and training.

No providers can provide any services without prior written authorization from TCOA. Supports Coordinators will conduct an assessment of each participant upon joining the MI Choice Wavier program and establish the services authorized for each participant based on that or subsequent assessments and person-centered service plan reviews. See “TCOA Provider Qualification and Delivery Policy” in Appendix H.

In addition to these requirements, providers are expected to maintain contact with TCOA staff, including the Supports Coordinators, Contract Manager, and when applicable, the Waiver Director, in order to ensure ongoing quality of client care and keep current business status and contact information. Some of these ongoing contacts include, but are not limited to, notifying TCOA staff when:

Participant condition or status has changed
Participant emergencies or critical incidents have occurred
Business contact information has changed
Agency insurance coverage is changed or updated
Ownership or management changes are being made with provider
Issuance of new Federal Tax ID number, DUNS number, or NPI
Issues with billing or payments arise
Reporting of Fraud, Waste, or Abuse becomes necessary
Criminal Background Check questions arise with an employee
Responding to documentation requests from TCOA staff
Difficulties arise with a participant’s direct care worker, including absenteeism or suspicion of abuse
Suspicion of financial Fraud, Waste, or Abuse
Problems using web portals for communication or billing are not working properly

Thank you for reviewing the TCOA Contracting Policies and Procedures. If you have any questions please call our main office line at 517-887-1440 and ask to speak to a TCOA staff member about our contracting process.

Appendix A

TCOA DPOS Agreement

TRI-COUNTY OFFICE ON AGING
DIRECT PURCHASE OF SERVICES AGREEMENT

THIS AGREEMENT is entered into by and between the Tri-County Office on Aging, Project Choices, of 5303 S. Cedar St., Lansing, Michigan 48911-3800, hereinafter referred to as TCOA, and:

Provider Agency: _____, hereinafter referred to as Agency.

Contact Person: _____Title:_____

Facility Address:_____

City:_____State:_____Zip:_____

Phone: (____)_____ Fax: (____) _____E-mail:_____

Website:_____

Billing Address:_____

Payment Address: (If different) _____

Type of Provider:

_____ Private for Profit Corporation
_____ Private Non-Profit Corporation
_____ Sole Proprietor
_____ Governmental Affiliation
_____ Partnership
_____ Other _____

Are you a minority business? Yes_____ No _____

Federal ID#_____ DUNS Number: _____

National Provider Identification Number (NPI) _____

Service Delivery Area By County: _____ Clinton _____ Eaton _____ Ingham

I. SERVICE(S) CATEGORY

____ COMMUNITY LIVING SERVICES
____ HOMEMAKER
____ PERSONAL CARE
____ CHORE SERVICES
____ ADULT DAY CARE
____ NURSING SERVICES
____ HOME DELIVERED MEALS
____ COMMUNITY TRANSPORTATION
____ RESPITE
____ COUNSELING
____ TRAINING SERVICES
____ OTHER_____

II. GENERAL SERVICE SPECIFICATIONS

A. Waiver Compliance

1. The Agency shall comply with all Michigan Department of Health and Human Services minimum operating standards for MI Choice Waiver Program ("Waiver") services as set forth in the current version of the Michigan Medicaid Provider Manual, MI Choice Waiver Chapter.
2. The Agency must be enrolled in Medicaid either through the State of Michigan or through TCOA.
3. Services provided must not duplicate services available under Medicare, Medicaid State Plan, or other third-party resources.

B. Care Plan

As an Agent for the Waiver, TCOA shall determine the care plan to be followed by the Agency and monitor care plan adherence on an individual participant basis.

C. Person-Centered Planning

TCOA embraces the philosophy of Person-Centered Thinking. The Agency shall respect the participant's wishes and desires in the delivery of services. The Person-Centered Approach was designed to encourage people working with individuals in Long-Term care situations to view the individual's needs through their eyes and to honor their preferences, choices and abilities.

D. Participant Status

The Agency shall report to TCOA in a timely manner any significant changes in a participant's mental or physical health condition, admittance to a hospital or nursing home, or in caregiver status.

E. Participant Files

1. The Agency shall maintain individual participant files which will include a copy of a current assessment and current service authorization, written summary of visits made, type of services provided, incidents observed, progress notes, and verifiable records of units of services provided, specifically including date and time of day service is provided.
2. The Agency shall ensure that individual participant records reflect documentation of on-site supervisory visits, including name and title of supervisor, staff person, and location of on-site supervision.
3. The Agency shall keep all participant records in controlled access files for 10 years and shall ensure participant confidentiality at all times.
4. The Agency shall comply with the terms of the Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement, fully incorporated and attached hereto as Attachment B.

F. Emergencies and 24-Hour Availability

1. The Agency must have a written policy and procedure for in-home emergencies.
2. The Agency must be available 24 hours per day via a designated after-hours hotline or other reliable telephonic or electronic option.

G. Critical Incidents

1. Critical incidents are defined as an unexpected occurrence involving serious physical or psychological injury (or risk thereof), exploitation, or theft. Serious injury includes, but is not limited to, mental, physical, verbal or sexual abuse, neglect, and suspicious or unexpected death. This also includes caregiver behavior that results in significant risk to

the participant, such as consuming alcohol/drugs on the job, no-show particularly in critical need participant, or illegal activity in the home.

2. The Agency must have policies and procedures that outline what action is taken when a critical incident has been reported or identified.
3. The Agency is required to report all critical incidents within 48 hours of the occurrence or Agency's knowledge of the occurrence to TCOA through the Supports Coordinator or Program Supervisors. Incidents involving abuse, neglect, exploitation, either observed or suspected, must be reported to Adult Protective Services per State law.

H. Agency Grievances

Agency concerns regarding a TCOA clinical decision should be directed to the Social Work or Nursing Supervisor. Any other concerns should be directed to the Contract Manager. If the problem cannot be resolved, the Agency can make a formal grievance, in writing, to the Program Director. A written resolution will be sent within 30 days of the grievance. If the Agency is not satisfied with the written response, it will be referred to the Executive Director who will make a final determination in writing within 30 days of receiving the complaint.

I. Rates

The rate charged per unit shall not vary unless authorized by TCOA staff.

J. Billing

1. The Agency shall submit all bills and rebills via the Compass billing module unless otherwise authorized by TCOA.
2. The Agency shall bill TCOA within 30 days following the latest date of service provided in the month, and shall bill on a monthly basis indicating the name of participant, date, and type of each service on each invoice.
3. Rebills shall be submitted within the following month's billing cycle.
4. TCOA may reject any bills which are submitted more than 30 days following the latest day of service provided in the month.
5. No bills will be submitted more than 90 days following the month of service without prior approval from TCOA.
6. TCOA shall make payments within 30 days of receipt of properly submitted invoices, subject to availability of funds and according to TCOA policies of processing payments.
7. At the end of each fiscal year (September 30th) the Agency shall submit to TCOA all outstanding invoices and rebills for that fiscal year, which must be received by TCOA on or before October 31st. Invoices and rebills received beyond October 31st for each fiscal year ending September 30th will not be paid by TCOA.
8. The Agency agrees to define one unit of service equal to 15 minutes of service provided and will bill accordingly, unless otherwise specified herein.
9. Bills may not be submitted that include dates of service from more than one month.
10. TCOA shall not be charged for services not authorized in the participant care plan.
11. The Agency shall not charge for services not delivered or provided.
12. The Agency shall not charge for any services rendered while the participant is an inpatient of a hospital or nursing home facility.
13. If TCOA makes payments to the Agency for services not performed or for service overcharges, TCOA shall require reimbursement of those funds by the Agency.
14. The Agency shall charge all TCOA participants the herein agreed costs for units of service, regardless of whether the source of funding is private (i.e., participant) or public.
15. The Agency shall accept TCOA payments as payment in full for services rendered and shall not charge participants or families any additional fees or charges.
16. The Agency shall not solicit contributions from Waiver participants.

K. Mileage Reimbursement

1. The Agency shall not bill TCOA for mileage unless TCOA staff has preapproved it.
2. The Agency shall reimburse its employees for mileage incurred in the performance of their duties, subject to the following conditions:
   a. The Agency shall reimburse employees for loaded mileage, which is incurred only while the participant is present with the employee, in the employee's vehicle.
   b. The Agency shall reimburse employees for mileage at the full billing rate listed for transportation in Section III(I) of this Agreement.
3. Neither the Agency nor any person in the Agency's employ is permitted to request or accept payments or donations for gasoline, gas mileage, or mileage reimbursement from a participant receiving TCOA services.

L. Bid

Agency agrees to provide the herein described Waiver services at the following costs**: (1 unit = 15 minutes of service**, **regardless of day of week or time of year**).

SERVICE CATEGORY	BILLING RATE Maximum Bid Per Unit (15 minutes)
Community Living Services (CLS)	**$4.50**
Homemaker	**$4.50**
In-Home Respite Services	**$4.50**
Out of Home Respite Services (per day)	**$**
Personal Care	**$4.50**
Chore Services	**$**
Counseling	**$**
Adult Day Care	**$**
Training	**$**
Nursing Services ***Rate does not apply to Memorandum of Understanding (MOU's and SMOU's) with State of Michigan for specialized care.**	**$14.46 RN** **$12.29 LPN**
Transportation	**$.625 per mile**
Other (MDHHS / ACLS Bureau DCW Premium Pay)	**At rate published by MDHHS and ACLS**

III. ADDITIONAL SPECIFICATIONS FOR CLS, PERSONAL CARE, IN-HOME RESPITE SERVICES AND NURSING SERVICES

A. Assessment

The Agency shall accept TCOA's MI Choice Comprehensive Assessment of the participant.

B. Training

Staff of the Agency must receive in-service training at least twice each fiscal year that is specifically designed to improve their skills at tasks performed in the provision of service. The Agency must maintain comprehensive records identifying dates of training and topics covered in each employee's personnel file.

C. Supervision

1. The Agency shall ensure that all personal care aides or LPN's performing services are supervised by a RN.
2. The Agency shall ensure that a RN be available for advice and consultation when LPN's or aides are providing services.
3. The Agency must conduct in-home supervisions of their staff at least twice per each fiscal year. A professional recognized by TCOA must conduct the supervisory visit.

D. Employee Files

The Agency shall keep a file for each employee working with TCOA participants. At a minimum, each employee file must contain copies of the employee's employment application, job references, driver's license, proof of automobile insurance coverage, TB testing results, criminal background check results, and copies of certification, licenses, or registration for professional employees.

E. Employee Background Screening

The Agency agrees to comply with TCOA's Criminal Background Check policies (Attachment C) and thoroughly check references of paid staff that will be entering participant homes. The Agency must also follow the following background screening procedures for any new employee, current employee, or volunteer who will have in-person participant contact, in-home participant contact, access to a participant's personal property, or access to confidential participant information:

1. The Agency must conduct a criminal history screening that produces results similar or substantially similar to information found on a Michigan State Police Internet Criminal History Access Tool (ICHAT) check for all paid staff and volunteers that will be entering participant homes.
2. The Agency must ensure that no staff or volunteers appear on the SAM.gov federal exclusion registry or Michigan Medicaid Sanctioned Provider List before entering a participant home.
3. The Agency must also screen staff and volunteers through the Michigan Public Sex Offender Registry at http://www.mipsor.state.me.us and the National Sex Offender Registry at http://www.nsopw.gov before entering a participant home.

Documentation of all such screenings must be kept in the employee files. Criminal background checks for new hires must be completed prior to the individual working directly with participants or having access to a participant's personal property or confidential participant information.

F. Reporting of Fraud, Waste, and Abuse

It is the duty of the Agency to report any suspected occurrences of Fraud, Waste, and Abuse involving Medicaid funds. Agency shall report any suspected Medicaid fraud to the Office of the Inspector General or to TCOA, and may do so anonymously. Failure to report known fraud may result in disciplinary action including but not limited to

repayment of funds, further education and training, and probation, suspension or termination of this Agreement.

G. Employee Conduct

1. Direct service providers are prohibited from smoking in participant homes.
2. Direct service providers must not use their cell phones for personal use while in a participant home. Exceptions may be made in cases of emergency. The direct service workers should engage with the participant while furnishing services.
3. Direct service providers must demonstrate the ability to communicate adequately, both orally and in writing, with their employers and the participants they serve.
4. Direct service providers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.
5. Direct service providers who enter a participant's home must display proper identification, which consists of either an agency picture card or a Michigan's driver's license and some form of agency identification.

H. Employee Medical Screening

The Agency shall provide TB testing for employees and keep a record of the test in the employee file.

I. Employee Credentials

The Agency shall ensure that all professionals possess credentials required by Michigan laws and regulations.

J. Employee Penalties and Restraints of Trade

The Agency shall not impose restraints on the ability of the workers it employs to work directly for TCOA participants or another agency for TCOA participants. The Michigan Department of Health and Human Services mandates that Waiver Agents prohibit this practice. Restraints include but are not limited to non-competition agreements, financial penalties, and threats of legal action.

K. Employee Time Records & Electronic Visit Verification

1. The 21st Century Cures Act requires all states to use Electronic Visit Verification EVV) for personal care services and home health care services provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. Programs that require the use of EVV must be compliant with the EVV section of the Medicaid Provider Manual, MI Choice Waiver Chapter. Failure to comply with the requirements may result in non payment of Medicaid services.
2. Verification of EVV records must be made available to TCOA upon request.
3. When the Agency is utilizing EVV systems, paper time sheets are not required. However, the Agency must keep procedures in place for obtaining participant signatures on paper time sheets if an exemption from EVV is in place.

L. Confidentiality

Each waiver agency and direct service provider must have procedures to protect the confidentiality of information about participants or persons seeking services collected in the conduct of its responsibilities. The procedures must ensure that no information about a participant or person seeking services, or obtained from a participant or person seeking services by a service provider, is disclosed in a form that identifies the person without the informed consent of that person or of their legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of the participant

information), so long as access is in conformity with the Privacy Act of 1974 and HIPAA. Direct service providers must maintain all participant information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

IV. GENERAL PROVISIONS

A. Licensing

The Agency shall comply with all applicable state and local licensure requirements.

B. Business Status

1. Upon request, the Agency shall provide documentation that it has a legal basis for existence, such as: private non-profit corporation status with appropriate IRS tax-exempt status, a private for-profit corporation, governmental affiliation, partnership, or sole proprietor.
2. Agency shall notify TCOA of any changes in ownership or transfers of business interests no later than thirty (30) days prior to any expected change or transfer.

C. Insurance

The Agency shall maintain and supply evidence that it has insurance policies insuring the Agency against any liability imposed upon the Agency arising out of the performance of work of any nature carried out by the Agency, or anyone directly or indirectly employed by the Agency, under this agreement. Coverage shall include Worker's Compensation, Unemployment, Property and theft coverage, Fidelity bonding (for persons handling cash), No-fault vehicle insurance, General liability and hazard insurance including facilities coverage. Recommended insurance protection by Agency includes insurance to protect TCOA from claims against TCOA or direct service provider drivers and/or passengers, Professional liability (both individual and corporate), Umbrella liability, Errors and Omission insurance for Board members and Officers and Special multi-peril.

D. Hold Harmless

Agency shall, at its own expense, protect, defend, indemnify and save harmless TCOA, the Michigan Bureau of Aging, Community Living, and Supports ("ACLS"), Michigan Department of Health and Human Services ("MDHHS"), its officers, directors, agents, and employees, from all damages, liability, costs and expenses (including attorney fees) that TCOA, ACLS, or MDHHS may incur as a result of any activities of the Agency or its employees or agents that may arise out of this contract, or out of any related agreements such as the Business Associate Agreement, attached hereto as Attachment B.

E. Independent Contractor

1. It is understood and agreed that Agency holds itself out to the general public as a business providing the services described in this agreement. It is expressly understood and agreed that the legal and tax status of the Agency shall be that of independent contractor, and that under no circumstances shall the Agency or the employees of Agency be deemed to be the employees of TCOA. Agency shall fill out and submit to TCOA upon request an Independent Contractor Statement supplied by TCOA. Agency shall retain its business organization status, e.g., private for profit corporation, private non-profit corporation, governmental affiliation, partnership, sole proprietor, throughout the term of this agreement and shall immediately notify TCOA of any change in its business status, or business office address during the term of this agreement. Agency agrees to provide to TCOA any evidence of independent contractor status requested by TCOA.

2. The Agency assumes full responsibility for payment of all withholding tax, social security tax, unemployment tax or any payroll deductions required by law for individuals who perform services for, or on behalf of, the Agency pursuant to this Agreement. Direct care workers are not permitted to provide services as independent contractors.

F. Subcontracts

The Agency shall not assign the agreement or enter into subcontracts with additional parties without obtaining prior written approval of TCOA. Assignees or subcontractors shall be subject to all conditions and provisions of the agreement. The Agency shall be responsible for the performance of all assignees or subcontractors. TCOA shall have the authority to monitor and assess said subcontractors.

G. Bid Acceptance

Agency understands and agrees that acceptance by TCOA of Agency's bid shall create a binding agreement on the terms set forth herein.

H. Effective Date of Agreement

It is understood by and between Agency and TCOA that a binding agreement shall commence on the date of acceptance as indicated by signatures on behalf of TCOA herein and that this agreement shall terminate on **September 30, 2027.**

I. Termination

Either party may terminate this agreement, or any related agreement, such as the Business Associate Agreement, with or without cause, prior to the termination date set forth hereinabove, upon thirty (30) days prior written notice to the other party.

J. Use of Services

Agency understands and agrees that TCOA is not required to use the Agency's services under this Agreement and that the use of Agency's services is entirely within the discretion of TCOA based on existing program needs, participant choice, and other factors.

K. Marketing

Agency shall not use TCOA for marketing purposes or make any assurances that TCOA will pay for a participant's services. Agency may generally publicize its relationship with TCOA as an enrolled service provider.

L. Audit Compliance

Agency shall permit TCOA, Federal or State auditors to inspect books and records related to this agreement and Agency shall retain said records for at least ten (10) years after the termination of this agreement.

M. Federal Regulations

The Agency shall comply with federal regulation 45 CFR Part 76 and certifies to the best of its knowledge and belief that its employees:

1. are not presently excluded from covered transactions by any federal department or agency;
2. have not within a 3-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in performing a public (federal, state or local) transaction or contract;
3. are not presently indicted or otherwise criminally or civilly charged by a government entity; and,

4. have not within a 3-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

N. <u>Assurance of Compliance</u>

Agency shall comply with the assurance of compliance requirements that are set forth at Attachment A, B and C. Attachment A is a document that assures compliance by Agency with the Federal Rehabilitation Act of 1973, the Federal Civil Rights Act of 1964, the Michigan Handicappers Civil Rights Act of 1976 and the Michigan Elliott-Larsen Civil Rights Act of 1976. Attachment B is a Business Associate Agreement that assures compliance with the Health Insurance Portability and Accountability Act of 1996. Attachment C is a document that assures compliance by Agency with TCOA's Criminal Background Check Policy. Attachment A and C are fully incorporated into this agreement as if fully set forth herein and compliance with the provisions of Attachment A and C is assured by the signature of Agency's authorized representative on the signature page of this Agreement. The signature of an authorized representative of the Agency is required on the signature page of Attachment B.

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF AGENCY:

NAME	**TITLE**	**DATE**

ACCEPTANCE BY TCOA:

	Executive Director	
NAME	**TITLE**	**DATE**

File: DPOS FY 27.1 HHA Rev.8/2025

Appendix B

TCOA Criminal Background Check Policy

Attachment C

TRI-COUNTY OFFICE ON AGING CRIMINAL BACKGROUND CHECK POLICY

Length of Time Barred from Working	Types of Conviction
Mandatory Exclusion (Lifetime Ban)	**State or Federal Felony Conviction related to:** -Crimes against a "vulnerable adult" as set forth in MCL 750.145n *et. seq.* -Violent crimes including, but not limited to, murder, manslaughter, kidnapping, arson, assault, battery, and domestic violence; -Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion; -Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution; -Cruelty or torture; -Abuse or neglect; or, -Felony involving the use of a firearm or dangerous weapon.
Other Felony Convictions Conviction within the preceeding 10 years from the date of the background check	**State or Federal Felony conviction including, but not limited to**: -Crimes involving state, federal, or local government assistance programs; -Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion; or, -Drug crimes including, but not limited to, possession, delivery, and manufacturing.
Misdemeanor Convictions Conviction within the preceeding 5 years from the date of the background check	**Misdemeanors including, but not limited to**: -Crimes involving state, federal, or local government assistance programs; -Crimes against a "vulnerable adult" as set forth in MCL750.154n *et. seq.;* -Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion; -Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion; -Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution; -Drug crimes including, but not limited to, possession, delivery, and manufacturing; -Cruelty or torture; -Abuse or neglect; -Home invasion; -Assault or battery; or

	-Misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.
*Tri-County Office on Aging reserves the right to convene a meeting to determine the advisability of employment for any criminal infraction, and to render a decision to the client regarding a negative decision. Clients have the right to appeal that decision. *Clients have the right to choose not to hire or to terminate employment based on the information from a Criminal Background Check, and must inform the employee of the information they received if negative action is taken.	

Criminal Conviction

Arrest records, by themselves, do not disqualify an individual. For purposes of the excluded offenses identified above, an individual is considered to have been convicted of a criminal offense when:

1. A judgment of conviction has been entered against the individual or entity by a federal, state, tribal, or local court regardless of whether there is an appeal pending;
2. There has been a finding of guilt against the individual by a federal, state, tribal, or local court; or,
3. A plea of guilty or nolo contendere by the individual has been accepted by a federal, state, tribal, or local court.

*All questions on positive criminal background check results should be directed toward the TCOA Contract Manager for review.

Appendix C

Appeals Procedure for Overpayments

Tri-County Office on Aging
Appeals Procedure for MI Choice Waiver Overpayments

I. SCOPE

The following appeals procedure applies to a contracted MI Choice Waiver service provider which has received a demand from TCOA for repayment of funds and believes the demand to be made in error or otherwise disputes the overpayment and wishes to request relief.

II. NOTICE

When TCOA discovers an overpayment was made to a provider, it will provide written notice to the provider for a demand or repayment. Such notice shall describe the nature of the overpayment, identify and support the amount due, include the reasons for the repayment request, and include a notice of the right to appeal.

III. FILING OF APPEAL

A written notice in the form of a letter must include the reasons for appeal. The written notice must be submitted within ten (10) working days following the date of official TCOA action. The letter must provide an explanation for the appeal and supporting documentation as appropriate.

IV. WHERE TO SEND NOTICE

Appeals shall be mailed or emailed to the TCOA Contract Manager with a copy to the TCOA Project Choices Director.

V. REVIEW OF APPEAL

TCOA shall review overpayment appeals based upon all relevant information in its possession as well as all supporting documentation and information provided by the appellant filed with the initial appeal. TCOA will not review or consider any documentation or information provided by the appellant after the appeal deadline.

VI. DECISION

TCOA shall notify appellant of its decision within ten (10) days of receipt of the appeal. Notice of the final decision must be in writing and inform the appellant that they may appeal to arbitration, except for appeal of administrative complaints which may be appealed directly to the Michigan Bureau of Aging, Community Living, and Supports (ACLS Bureau), which will provide a written response to the appellant with a final decision on the appeal.

Appendix D

TCOA Fraud, Waste, and Abuse Policy

Tri-County Office on Aging

Policy Name	Medicaid Fraud, Waste, and Abuse
Current Revision Date	December 2024
Historical Revision Dates	July 2024 December 2023 November 2022 October 2021 April 2021 May 2020 April 2019

Purpose

TCOA has a commitment to prevent/detect Medicaid fraud, waste, and abuse through the development of a comprehensive compliance plan. This plan is intended to provide a compliance roadmap for the agency and its providers. TCOA combats Medicaid fraud, waste, and abuse by investigating complaints, raising awareness of anti-fraud initiatives, and assuring compliance with state and federal laws.

Definitions

FWA: Fraud, Waste, and Abuse

HIPAA: Health Insurance Portability and Accountability Act

MDHHS: Michigan Department of Health and Human Services

OIG: Office of Inspector General

SIU: Special Investigative Unit

TCOA: Tri-County Office on Aging

Overview

Tri-County Office on Aging (TCOA) and its providers strive to provide quality, cost-effective outcomes for the region's senior and persons with disabilities population, while adhering to the highest ethical standards and complying with all applicable federal and state laws. To support this commitment, TCOA has developed and implemented this policy which establishes the following:

- An administrative framework for conducting an effective and diligent compliance effort through the TCOA Compliance Plan
- The designation of the Project Choices Director, as the Agency's Compliance Officer reporting to the Executive Director and Board Compliance Committee, charged with the responsibility of operating and monitoring the Compliance Program.
- A commitment to ongoing education for all personnel regarding compliance requirements and how to conduct their job activities in compliance with the state and federal law and according to the policies and procedures of the Compliance Plan.
- Effective communication channels to deliver the agency's commitment to ethical business practices and receive feedback regarding.
  adherence to these practices.
- A framework for timely responses to reported problems and any associated corrective action.
- Monitoring and auditing functions to measure the effectiveness of
  The Compliance Plan and to address problems in an efficient and timely manner.
- Enforcement and discipline ensure that all personnel take their compliance responsibilities seriously.

The Tri-County Office on Aging Compliance Committee is responsible for the overall operation and oversight of the Compliance Plan reporting to the Tri-County Office on Aging Consortium Board Finance Committee, acting as the Board Compliance Committee; however, the day-to-day responsibility for the operation and oversight of the Compliance Plan rests with the Compliance Officer under the direction of the Executive Director. The Compliance Officer can seek legal advice/assistance from the contracted agency attorney as needed.

Administrative Structure

The compliance efforts for TCOA are managed and overseen by the Board Compliance Committee/Finance Committee, the Compliance Committee and Compliance Officer.

Compliance Committee/Special Investigative Unit (SIU)
The Compliance Committee is responsible for supporting the Compliance Officer in developing, monitoring and assessing the Compliance Plan. The committee consists of the Contract Manager, Quality Director, Nursing Supervisor, Social Work Supervisor, Reimbursement Manager, Finance Director, Quality Analyst and Human Resources Director. The committee has a general "open door" approach to compliance with staff. The committee reports to the Tri-County Office on Aging Consortium Board Finance Committee, acting as the Board Compliance Committee. The committee meets at least quarterly, or more frequently as necessary, and has the following duties and responsibilities:

- Acts as the Special Investigative Unit (SIU) for claims of Fraud, Waste and Abuse when needed; the investigators in the unit must detect and investigate Fraud, Waste and Abuse by its MI Choice enrollees and providers.
- Continually analyze the Agency's risk environment, the legal requirements with which it must comply, and in specific risk areas as the need arises.
- Assess and revise existing compliance policies and procedures to ensure compliance with the State and Federal law, regulations, and policies & procedures.
- Assist the appropriate staff in coordinating internal and external compliance reviews and monitoring activities.
- Review the results of investigations and resulting corrective action plans for the Agency or its providers.
- Assess and revise policies and procedures at least annually, to promote compliance and encourage reporting of suspected fraud, waste, and abuse to ensure proper response to reports of non-compliance.
- At least annually, conduct program integrity training to improve information sharing between departments within TCOA and to enhance referrals to the SIU (general training to agency staff). The training will include a component specific to Michigan Medicaid and TCOA's approach to address fraud, waste, and abuse within the program.
- Maintain the confidentiality of any sensitive or proprietary information learned.
- Acts as the HIPAA Compliance Team for the agency.

Compliance Officer

The Project Choices Director has been designated as the Compliance Officer. The Compliance Officer is responsible for directing and assuring the active functioning of the agency's compliance efforts. The Compliance Officer will remain duty-bound to report on and correct alleged fraud and other misconduct. General responsibilities include the following:

- Supervise implementation of the Compliance Program and coordinate all compliance efforts.
- Chair of the Compliance Committee
- Answering routine questions regarding compliance or ethical issues
- Assure that all agency employees and providers receive a copy of the TCOA Medicaid Fraud and False Claims Policy, and any other written compliance policies and guidelines that may be relevant to their position.
- Works with TCOA Human Resources to ensure that the Agency holds employees accountable who do not adhere to the Medicaid Fraud and False Claims Policy.
- Coordinate compliance education and training materials; work with TCOA Human Resources to implement tracking mechanisms for documentation of required training and oversee annual employee attestations regarding commitment to compliance.
- Coordinate compliance personnel issues with the Agency's departments to ensure that compliance is an integral part of individual performance assessment, and U.S.

General Services Administration System for Award Management (SAM), and MDHHS Sanctioned Provider List are checked with respect to all employees and providers.
- Develop communications that encourage employees to report possible improper or illegal conduct.
- Implement and operate retaliation-free reporting channels.
- Identify areas that present the greatest compliance risk and prioritize resources to address those risk areas.
- Monitor and evaluate the Compliance Plan's effectiveness through internal and external audits.
- Oversee and document any compliance investigations.
- Report to the Tri-County Office on Aging Consortium Board Finance Committee, acting as the Board Compliance Committee regarding day-to-day compliance efforts and to promptly report the results of material or significant investigations, as needed.
- Keeps current with laws, regulations, and policies applicable to compliance to ensure that the Agency's compliance policies reflect the guidance provided by the OIG.
- Periodically assesses the adequacy of the Agency's Policy and Procedures manuals and Compliance Plan and helps revise them as necessary.

Communications

TCOA's commitment to an active compliance effort is communicated to employees through a variety of channels to encourage communication and the reporting of incidents of potential fraud, waste, and abuse. This also includes the Compliance Officer/Team informing employees of procedure, regulatory, and contractual changes.

Communications to Employees:
In addition to formal compliance training, all employees and outside providers receive frequent reminders of the agency's commitment to compliance, the various avenues for reporting concerns, and the Agency's policy of nonretaliation for reporting potential compliance issues. Such communications may take the following forms:

- Periodic memos/emails from agency staff
- Compliance postings in the building's common areas

Communications from Employees:
Processes are in place as referenced in TCOA's Employee Handbook and Policy and Procedure Manuals to ensure that employees and providers know about the various communication channels they may use to express compliance concerns. Anyone who suspects improper or illegal activity is expected to report it. In some circumstances, a failure to report such activity may be grounds for discipline.

Seeking Clarification of Policy:
Agency employees are encouraged to seek clarification from a supervisor, the Compliance Officer, any member of the Compliance Committee or the Executive Director, regarding any confusion or questions about a compliance policy or procedure. Questions directed to the Compliance Committee, if appropriate, will be documented and shared with other staff so that standards, policies, and procedures can be updated and improved to reflect necessary changes or clarifications.

How to Report Potential Wrongdoing:
Reports of concerns may be made orally or in writing and should initially be directed to an employee's supervisor. If an employee is not comfortable reporting concerns to a supervisor, or if an employee is not satisfied with the response to his or her inquiries, the concerns should be directed to the Agency's Compliance Officer or to a Compliance Committee member. The Agency expects all Service Providers to report possible cases of Fraud, Waste, or Abuse immediately to an appropriate agency contact.

Responsibilities of Managers and Supervisors:
Managers and Supervisors are expected to respond appropriately and honestly when suspected wrongdoing is brought to their attention. It is their responsibility to relay reports of noncompliance to the Compliance Officer. In keeping with the policy allowing anonymous reports, a manager or supervisor may decline to identify the employee who originally made the report. In keeping with the Agency's Non-Retaliation Policy, no disciplinary action or other form of retaliation with be taken against any Agency employee who reports in good faith an issue or concern.

Communicating Compliance Activities to the Agency's Consortium Board Members:
The Compliance Officer maintains a tracking log of all concerns and complaints received, as well as the results of any investigations conducted, and the outcome of the investigation. The Compliance Officer reports as needed to the Agency's Consortium Board Members regarding compliance efforts. Such reports may include, a report on the results of any investigations conducted, and any subsequent disciplinary or remedial action taken.

Protection of Employees:
Every effort is made to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct when anonymity is requested. There will be no retribution or discipline for anyone who reports a possible violation in good faith.

Fraud Reporting:
TCOA has established a reporting mechanism within the TCOA website, TCOA.org. Concerned employees, participants/enrollees, and providers can remain anonymous or provide contact information to report suspected Medicaid Fraud, Waste, and Abuse. Once reported an email is sent to the Compliance Officer and the Contract Manager to initiate an investigation. TCOA will refer any potential enrollee fraud, waste, and abuse to MDHHS via this link: https://www.Michigan.gov/fraud (File a Complaint - Medicaid Complaint Form) or via the local

MDHHS office. TCOA will report all fraud, waste and abuse referrals made to MDHHS on quarterly submissions. Employees and providers are reminded of this at least annually via email communication and in person; participants/enrollees are provided this information via the MI Choice Participant handbook annually.

Responding to Detected Offenses:

The Compliance Officer will review allegations of potential wrongdoing when reported or discovered via agency audits. The Compliance Officer and the Special Investigative Unit (SIU), conduct or oversees the initial investigation. The Executive Director is immediately notified if a serious allegation appears valid. Records of an investigation may contain:

- Documentation of the alleged violation
- A description of the investigative process
- Copies of interview notes and key documents
- A log of the witness interviews and the documents reviewed
- The results of the investigation

If the investigation indicates that a violation has occurred, appropriate corrective action will be taken, which may include the following:

- Prompt restitution of any overpayments
- Notification to government agencies, when appropriate
- Review of current policies and procedures to determine if clarification is needed
- System modification
- Staff education
- Referral to criminal and /or civil law enforcement authorities
- Possible disciplinary action of involved employees, up to and including termination

Education and Training

Program integrity training is provided on an annual basis to ensure that all employees, including officers, directors, managers, supervisors, and long-term temporary employees are educated on the requirements of the Compliance Program. The training program consists of two components: general training and supplemental training. The Compliance Officer, working with the Compliance Committee (SIU) develops and continuously updates training information to enhance referrals to the Compliance Committee (SIU) regarding fraud, waste, and abuse with the Medicaid funded program at TCOA and improve information sharing between departments within TCOA. General training covers the material contained in the Employee Handbook, including the code of conduct, the Medicaid Fraud, Waste, and Abuse Policy. The training reinforces the need for compliance with Medicaid applicable statutes, regulations, contractual requirements, policies, and procedures and advises employees about disciplinary action that may result from failure to comply. New employees are required to complete general compliance training, as a part of the new employee orientation which must be completed within 90 days, and annually thereafter.

All MI Choice employees are expected to take general Compliance training annually and supplemental training on those items that may present a heightened risk of noncompliance, particularly those directly affected by the statutes, regulations, policies, procedures and program guidelines for Medicare, Medicaid, and all other federal healthcare programs. Likely areas for potential supplemental training may include the following:

- Government and private payer reimbursement principles
- Proper documentation of services rendered
- Duty to report misconduct
- Participant confidentiality
- Other areas identified by this Plan or by the Compliance Committee as representing high risk areas

Upon completing initial Compliance Program training, each employee is required to sign a written attestation of adherence to agency compliance guidelines and failure to comply with the Compliance guidelines may result in disciplinary action, up to and including, termination of employment.

The Compliance Officer will employ additional fewer formal means for communicating its compliance message such as posters, newsletters, and email communications. The Compliance Officer is responsible for the content of the compliance messages and materials distributed to employees and managers.

Tri-County Office on Aging Consortium Board will receive compliance training no less frequently than on a quarterly basis focusing on the structural elements of the Compliance Plan by the Compliance Officer in conjunction with the Executive Director.

The Contract Manager will provide non-employee agents and providers/subcontractors compliance training when applicable, along with providing ongoing reminders of their roles in compliance and reporting mechanisms.

The Compliance Officer may attend seminars, participate in web-based training, and attend quarterly meetings at the OIG office for ongoing training related to fraud, waste, and abuse. The Compliance Officer must not perform their own training and education.

Auditing and Monitoring Compliance Efforts:

TCOA actively uses monitoring and auditing functions to assess the effectiveness of its Compliance Program, both internally (agency and staff) and externally (providers and beneficiaries). The types of audits and areas to be audited are determined each year by the Compliance Committee according to need and may be in addition to any audits normally required for participation in any State program. Audits can be conducted by using outside resources or through an internal audit function. Statistical models, complex algorithms, and pattern recognition programs will be used to detect possible fraudulent or abusive practices. Audits may include, but are not limited to, data mining (must be performed annually), staff

interviews, and trend analysis studies. Audit results are presented to the Compliance Committee, as needed, which reviews and analyzes the results and recommends any necessary corrective measures. Such corrective measures may include additional auditing, monitoring, new policies, additional training and education. Monitoring efforts may also be used to ensure compliance with governing laws. All data mining activities performed (including all program integrity cases opened as a result) will be reported on a quarterly basis to MDHHS-OIG.

Compliance Monitoring is also conducted through an Exit Interview Questionnaire that includes questions regarding whether the 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. The Compliance Committee/SIU will review any positive responses to questions regarding compliance violations.

While the Compliance Officer and Compliance Committee periodically assess the Agency's risk areas to determine which areas may warrant a compliance audit, certain areas by their nature present significant risk potential. Accordingly, billing audits for agency providers are conducted at least annually and more frequently when warranted or required by State agency. At least annually, a review is performed by the Compliance Committee to assess whether the Compliance Program's elements have been satisfied, e.g., whether there has been appropriate dissemination of the program's standards, training, ongoing education programs, code of conduct reviewed and disciplinary action as well as adherence to contractual compliance and other MDHHS requirements.

Enforcement and Discipline

Any employee who violates the Compliance Program or healthcare laws, regulations, or program requirements is subject to disciplinary measures, up to and including termination. Certain violations, such as intentional misconduct or retaliating against an employee who reports a violation, carry more stringent disciplinary sanctions. Such measures will be applied on a case -by-case basis and in a consistent manner consistent with the Agency's documented discipline policies reflected in the Employee Handbook.

If an Agency provider violates regulations, or program requirements, the Agency will take appropriate measures such requiring repayment of funds, requiring additional training and education or terminating the contract.

TCOA has established a process to ensure that it does not knowingly have a director, officer, partner, managing employee, person or contract with any individual or entity whom the company knows or should have known, or who is affiliated with another person who has been disbarred or suspended, after reasonable inquiry, (a) has been convicted of a criminal offense related to healthcare (unless the individual or entity has been reinstated to participation in Medicare after being excluded because of the conviction), or (b) is currently listed by a federal agency as excluded, suspended or otherwise ineligible for participation in federal or federally funded programs such as Medicare and Medicaid.

- TCOA agrees and certifies that it does not employ or contract, directly or indirectly, with: Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U. S. C. § 1320a-7) or 1128A (42 U. S. C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;
- Any individual or entity discharged or suspended from doing business with Michigan Medicaid; or
- Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

HIPAA Privacy and Security Rules

Tri-County Office on Aging is subject to detailed rules that govern the use and disclosure of individuals' health information and standards for individuals' privacy rights to understand and control how their health information is used. These rules can be found at http://www.hhs.gov/ocr/hipaa. Penalties for failing to comply with these rules are significant. The Agency has developed privacy procedures to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and HITECH rule and has instituted training programs to educate all employees of their obligations with respect to these requirements. TCOA will maintain a contract with a regulatory compliance company focused on information security compliance.

Appendix E

MPM Monitoring Visit Methodology

9.21 Provider Monitoring Requirements for Waiver Agencies

9.21.A. On-Site Provider Reviews

Waiver agency staff conducts annual on-site monitoring reviews for a minimum of 20% of enrolled providers of recurrent services. This includes adult day health, chore, community living supports, counseling, fiscal intermediary, home delivered meals, transportation, nursing facility transition, nursing services, personal emergency response systems, private duty nursing, in-home and out-of-home respite, supports coordination when not using agency employees, and training. This monitoring plan is to ensure:

Provider compliance to minimum service standards and conditions of participation. This includes compliance to the CMS regulations regarding home and community-based services settings as defined in 42 CFR §441.301(c)(4) and the Home and Community-Based Services Chapter of this Manual.

- Delivery of services according to the authorized MI Choice participant PCSP.
- Provider maintenance of adequate staff recruitment, training plans and staff supervision.
- Provider maintenance of participant case record documentation to support provider claims.

Waiver agency staff evaluates providers of non-recurrent services (durable medical equipment, medical supplies, goods and services, and home modifications) based on frequency and volume of usage at least once every two years to ensure:

- Provider compliance to minimum service standards and conditions of participation
- Delivery of services according to the authorized MI Choice participant PCSP
- Provider maintenance of participant case record documentation to support provider claims

9.21.B. Methodology

The waiver agency assigns one or two staff with primary responsibility for conducting provider reviews using the standardized monitoring tool developed for this purpose (refer to the Directory Appendix). The waiver agency notifies providers in writing at least two weeks in advance of the date scheduled for the review. The waiver agency selects a sample of 10 participant case records or 20% of the provider case records (whichever is greater) to evaluate. The waiver agency staff reviews three months of provider billings to payments for each case record. The waiver agency may choose to monitor more providers as necessary to ensure the quality of services delivered to MI Choice participants. Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-residential surveys provided by MDHHS.

Provider records to review include participant case record documentation, service claims, and reimbursements. The waiver agency compares payment records to MI Choice person-centered service plan authorizations and MI Choice case record documentation.

Waiver agency reviewers evaluate provider records for date of service, time of service delivery, staff providing the service, supervision of staff providing the service, and any discrepancies noted during the review.

The waiver agency reviewers provide written findings of the review and corrective action requirements (as necessary) to the provider within 30 days following completion of the initial review. The waiver agency sends all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. The written review includes citations of both positive findings and areas needing corrective action.

When results of the initial case record/bill review indicate any irregularities, the reviewer and waiver agency financial staff conducts further review of provider case records covering a specified time. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and sent to the provider and MDHHS within 30 business days following completion of the review. Waiver agency staff schedules a follow-up review within a three to six month timeframe for providers deficient in any part of the review to ensure that the provider initiates and implements corrective action.

Service issues/activities identified for corrective action require the waiver agency to:

- Clearly identify formal findings, state compliance issues, and provide recommendations for corrective action.
- Establish due dates when the provider is scheduled to be in full compliance with the standards and conditions for continued participation.
- Monitor the provider's performance in completing the necessary corrective action.
- Suspend new referrals to the provider agency or transfer participants to another provider when findings warrant immediate action to protect the participant's health or welfare.
- Adjust provider billings on the agency's information system using individual adjustments to date of service or gross adjustment. Deduct overpayments made to a provider from the next warrant issued the provider from the waiver agency. Adjust encounter data submitted to CHAMPS to accurately reflect adjustments made to provider billing.
- Suspend or terminate the providers who demonstrate a failure to correct deficiencies following a second review. The waiver agency can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required.

Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-Residential surveys provided by MDHHS. If the setting remains compliant, the waiver agency only needs to maintain the surveys in a file at the waiver agency. The waiver agency must send to MDHHS the completed home and community-based settings survey in the following circumstances:

- The setting is a new setting and has not had a previous survey completed and reviewed by MDHHS and deemed compliant.
- There has been a change in ownership for the setting.

- There have been major changes in how the setting operates their business.

The waiver agency notifies MDHHS immediately of any provider-owned setting that is no longer compliant with the home and community-based services settings regulations as assessed using the Residential Survey for MI Choice Waiver or the Non-Residential Survey for MI Choice Waiver as appropriate. Provider-owned settings include licensed and non-licensed assisted living, AFCs or Homes for the Aged, and adult day health providers. The notification will include the corrective action plan and timeline for implementing the corrective action plan. The waiver agency will be responsible for ensuring the corrective actions have been implemented in a subsequent in-person visit to the setting. The waiver agency will forward the results of the subsequent in-person visit to MDHHS within one to two weeks of completing the visit. The waiver agency will immediately notify MDHHS if the subsequent visit indicates the provider continues to be non-compliant with the ruling and will require MI Choice participants to transition from the setting.

9.21.C. In-Home Participant Visits

To gauge the effectiveness of service delivery accurately, it is necessary to obtain comments regarding service provision from the perspective of the participant and caregiver. From the sample of participant case records reviewed, the waiver agency reviewer selects a minimum of two waiver participants with which they shall conduct home visits. These visits determine participant satisfaction with supports coordination activities and services and verify that providers deliver services as planned.

The in-home visit may correspond to a time when the provider is working in the participant's home. The scheduling of a participant home visit in tandem with the actual service provision allows the waiver agency reviewer to observe the provider at work and the interaction between the worker and the participant. The reviewer interviews the provider to determine their understanding of the tasks they should perform as specified in the PCSP and MI Choice work order. The reviewer also verifies with the participant and caregiver that the provider is delivering services as planned.

The waiver agency reviewer ensures the participant's supports coordinator is aware of pertinent information such as concerns regarding service delivery that the reviewer gathers during the home visit interviews. Supports coordinators follow-up with participant concerns identified during the home visits.

For participants who reside in provider-owned settings (assisted living, AFC, HFA, etc.), waiver agencies complete the additional questions at the end of the participant survey. Any "No" answers provided by the participant (or their authorized representative) require follow-up with the provider to ensure continued compliance to the home and community based services setting requirements.

9.21.D. Coordination with Supports Coordinators

Before or immediately after conducting the on-site provider review, the waiver agency reviewer meets with supports coordinators to discuss utilization of the provider and any problems encountered in using the provider. Additionally, the waiver agency reviews

Appendix F

Appeals Procedure for Service Provider Grievance

Tri-County Office on Aging

Appeals Procedure for Service Providers

I. SCOPE

The following appeals procedure applies to a service provider's disagreement with a Tri-County Office on Aging (TCOA) decision regarding the provider's contract. This may include a decision relating to a contract that has been suspended, terminated or not renewed, but also includes other adverse actions under the existing contract and the denial of potential service provider.

II. NOTICE

TCOA shall give written notice to the annual contractor or service provider of the adverse action under the provider's current contract. Such notice shall include the reasons for the action as well as notice of the right to appeal.

III. FILING OF APPEAL

A written notice in the form of a letter must include the reason(s) for appeal. The written notice must be submitted within ten (10) working days following the date of official TCOA action. Appeals of administrative complaints may be made within sixty (60) days of adoption of the administrative action. The written letter must provide an explanation for the appeal and supporting documentation as appropriate. The letter shall constitute the first stage of the appeal.

IV. WHERE TO SEND APPEAL

Appeal letters shall be mailed or emailed to the TCOA Assistant Director.

V. APPEAL REVIEW

TCOA shall review provider appeals based upon all relevant information in its possession as well as all supporting documentation and information provided by the appellant filed with the initial appeal. TCOA will not review or consider any information or documentation submitted by the appellant after the appeal deadline.

VI. DECISION

TCOA shall notify appellant of its decision within ten (10) days following the receipt of the appeal. Decisions and recommendations shall be based on all the information pertaining to the appeal prior to and during the review. Notice of the final decision must be in writing. If appellant does not agree with the final decision, they may appeal to the TCOA Administrative Board, which shall provide a written response to the appellant within thirty (30) days.

Appendix G

MI Choice Participant Handbook

MI Choice Waiver Participant Handbook

MDHHS
Michigan Department of Health & Human Services

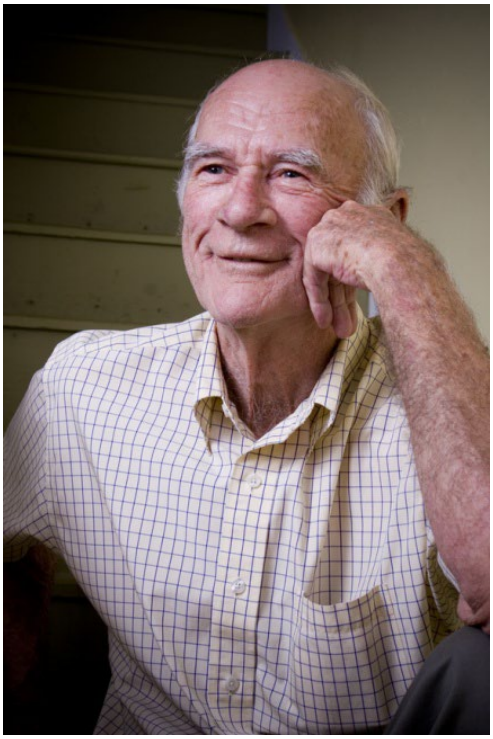
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, disability, healthcare programs or activities.

DCH-1433 (rev 5/24)

MI Choice Waiver Participant Handbook

This handbook is about your rights and responsibilities when you choose the MI Choice Waiver program. Please read this booklet and keep it. It has helpful things that you need to know as a MI Choice participant.

If you have any questions about what you read, contact your supports coordinator.



Note: Your supports coordinator must also provide you with the MDHHS Privacy Notice for Medicaid & Other Medical Assistance Programs in conjunction with this handbook. You may also view the Privacy Notice online at www.michigan.gov/hipaa.

MI Choice Waiver Participant Handbook

Table of Contents:

MI Choice Basics

The MI Choice program provides services and supports to people in their homes. Your home could be a house, apartment, condominium, adult foster care, or a home for the aged. MI Choice services are not available to people who live in a nursing home.

MI Choice serves adults aged 18 or older who need services like those provided in a nursing home. If you are younger than 65, you must have a disability. You also have to qualify for Medicaid.

When you enroll in MI Choice, you can get Medicaid services, plus MI Choice services. The services and supports available through the MI Choice program include:

- Adult Day Health (Adult Day Care)
- Assistive Technology
- Chore Services
- Community Health Worker
- Community Living Supports
- Community Transportation (medical or non-medical)
- Counseling
- Environmental Accessibility Adaptations (Home Modifications)
- Fiscal Intermediary
- Goods and Services
- Home Delivered Meals
- Personal Emergency Response System
- Nursing Services (Preventative Nursing)
- Private Duty Nursing/Respiratory Care
- Residential Services
- Respite
- Specialized Medical Equipment and Supplies
- Supports Brokerage
- Supports Coordination
- Training
- Vehicle Modifications

There are many waiver agencies in Michigan that can enroll you in the MI Choice program. These waiver agencies can help you decide which MI Choice home

and community-based services are right for you. They each have a contract with the Michigan Department of Health and Human Services.

What to Expect

Assessment

A nurse and a social worker will meet with you and friends or family you want to include. We call these professionals “supports coordinators” because they will help you get the services and support you need to stay at home. You will need to tell them how you do things like bathing, eating, and getting dressed every day. They will ask you about people who help you do these things. The supports coordinators will suggest other services and supports that may help you. You choose the supports and services you need in your home and can make your own suggestions.

Arranging Services

Once you choose the services you want to have in your home, the supports coordinators will make sure you start getting them. They will work with your friends and family who help you to make sure they keep helping you. MI Choice wants to make it easier for others to help you, not replace them.

If you live in a place that already has service providers like doctors, hairstylists, church, nail artists, physical therapists, or other types of providers that come to your home, you may choose to use these providers or get different providers to meet your needs and wishes. You do not have to use the providers already in place in the home where you live. You may change providers at any time.

After Services Are In Place

You and your supports coordinator decide how often they should call you to make sure you are doing well. Usually they call about once a month. They will also visit you at home a couple of times each year or as often as you want. They will make sure your services and supports are working for you. You should let them know about any problems you have or changes that you might need in your services. Remember, supports coordinators are there to help you stay at home.

Person-Centered Planning

Person-centered planning is a way of talking about and planning for your life. It focuses on what you *can* do, what you want your life to be like, and who you want involved. It builds on your strengths and honors your choices and preferences.

With person-centered planning, you choose who is invited to your planning meetings. You choose what services you want, who will deliver those services, and when and how to deliver them. Your supports coordinator will help you develop a plan that will allow you to stay at home and be a part of your community.

Self-Determination

Some people want to control more than what is included in their plan. They want to control their budget, arrange their services, and hire their aides. Self-determination is a way for people to have this level of control and responsibility for their services and supports.

You can ask your supports coordinator for more information about the self-determination option.

Continuity of Care When Switching from One Waiver Agency to Another Waiver Agency

You may be able to have the same services that you had before you changed to the new waiver agency. You may also to keep the same providers for a while if the providers are not in the network of the new waiver agency. The new waiver agency will help you find new service providers to meet your needs.

Know Your Rights

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.

Informed Choice:
Medicaid Funded Long-Term Care Options in Michigan

Michigan has many options for Medicaid eligible people who need long-term services and supports. These are included in the list below. If you would like more information about any of these options, please ask your supports coordinator. Also, it is important to tell your supports coordinator if you use any of these options now or in the future.

- Adult Foster Care
- Homes for the Aged
- Hospice
- Home Health (Medicare Skilled Home Care)
- *Nursing Home*
- *Home Help*
- *MI Choice*
- *Program of All-Inclusive Care for the Elderly (PACE)*
- *MI Health Link*
- *Habilitation Supports Waiver*

Please note: If you enroll in MI Choice, you cannot also use nursing home services, Home Help, PACE, MI Health Link, or Habilitation Supports Waiver services at the same time. You may only choose ONE of these at a time.

If you are 55 years of age or older and receive long-term care services, you may be subject to Estate Recovery. Contact your supports coordinator for more information.

Quality Assurance/Consumer Advisory Teams

The MI Choice program relies on the help and input of participants, family members, and advocates. There are workgroups at local waiver agencies and at the statewide level who meet throughout the year to discuss good things about the program and ways the program could improve. If you or someone you know wants to join one of these groups, let your supports coordinator know. Both groups are always looking for people who want to help discuss ways to improve the MI Choice program.

For more information in participating:

Quality=Choice, Satisfaction, Independence Committee (CSI)

Meetings on the 3rd Thursday of each month at TCOA

Contact your Supports Coordinator for more information

Or call Heidi Dadow 517-887-1335

Statewide MI Choice Quality Management Collaborative

Quarterly meetings in Lansing

Contact your supports coordinator for more information

Or call 517-241-8474 or email mdhhs-michoice@michigan.gov

Abuse & Neglect

Everyone deserves to feel safe from harm and be treated with respect.

Every woman, man and child has the right to feel safe from physical, emotional, mental and verbal harm from those they live with, those who care for them and those who interact with them on a daily basis.

Am I Being Abused?

Please think about how you are being treated.

Is someone...

- embarrassing you or making fun of you in front of others?
- making you feel like you are unable to make a decision?
- using intimidation or threats to gain compliance?
- treating you roughly (pushing, grabbing, hitting, pinching, shoving etc.)?
- blaming you for how they feel or act?
- making you feel like there is no way out?
- preventing you from doing things you want to do, like spending time with friends and family?
- limiting your use of the telephone?
- breaking assistive devices or denying health care?

Do You...

- sometimes feel scared about how another person will act?
- find yourself constantly making excuses for another's behavior?
- believe you can help the other person change only if you change something about yourself?
- try not to do or say anything you think might cause conflict?
- always do what the other person wishes instead of doing what you would like to do?

If you answered yes to any of these, please talk to someone. Without help, the abuse will continue.

If you are in immediate danger, call 911!

To report abuse, call:

Statewide Centralized Intake for Abuse and Neglect
1-(855)-444-3911

- Anonymous
- Toll Free
- 24 Hours/7 Days
- Emotional Support
- Information & Referral
- Adult Protective Services Reporting

Your supports coordinators are mandated by the state to report abuse, neglect & exploitation.

This means they must tell Adult Protective Services or another agency when they think someone might be hurting you, not taking care of you as planned, or taking advantage of you.

For more information, call your supports coordinator. You can also contact these organizations:

National Center for Elder Abuse (NCEA) – www.ncea.aoa.gov or 1-855-500-3537 (ELDR)

Ageless Alliance – http://www.agelessalliance.org or 1-844-992-4353

To Report Fraud:

Report Medicaid fraud to the Office of Inspector General, Michigan Department of Health and Human Services by calling (855) 643-7283, online at

www.michigan.gov/fraud, or in writing to:

Office of Inspector General
PO Box 30062
Lansing, MI 48909

Emergency Preparedness:

Be prepared and avoid life-threatening situations!

GET A KIT OF EMERGENCY SUPPLIES

Be prepared to use what you have on hand to make it on your own for **at least three days**, maybe longer. While there are many things that might make you more comfortable, think first about fresh water, food and clean air.

Recommended Supplies to Include in a Basic Kit:

- **Water:** one gallon per person per day for drinking and sanitation
- **Non-perishable food:** at least a 3-day supply
- **Flashlight** and **extra batteries**
- **First Aid kit**
- **Whistle** to signal for help
- **Filter mask** or cotton t-shirt, to help filter the air
- **Moist towelettes, garbage bags** and **plastic ties** for personal sanitation
- **Wrench** or **pliers** to turn off utilities
- Battery-powered or hand crank **radio** and a NOAA Weather Radio with tone alert and **extra batteries**
- **Manual can opener** if kit contains canned food
- **Plastic sheeting** and **duct tape** to shelter -in-place
- **Important family documents**
- **Items for unique family needs,** such as daily prescription medication or pet food

Include Medications and Medical Supplies: If you take medicine, make sure you have enough to last you for at least a week. This includes medical treatments too. Keep a copy of your prescriptions and dosage or treatment information with you.

Include Emergency Documents: Make copies of important papers and put them in your emergency kit. Include family, medical, and tax records and wills, deeds, social security numbers, charge and bank account information.

Additional Items: If you use eyeglass, hearing aids and hearing aid batteries, wheelchair batteries or oxygen, be sure you always have extras in your kit. Also, have copies of your medical insurance, Medicare, and Medicaid cards readily available.

For more information, call your supports coordinator, visit ready.gov or call 1-800-BE-READY

Advance Directives

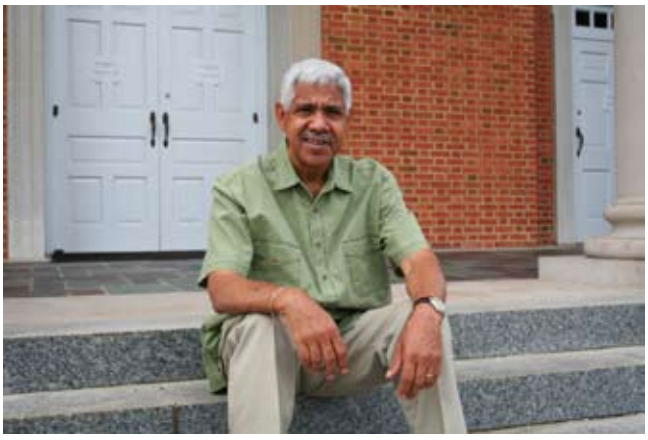
Advance Directives are legal documents. They are a way for you to tell your family, friends, and health care providers about your wishes for end-of-life care. There are two types of advance directives.

Durable Power of Attorney for Health Care (DPOA-HC) - This legal document names another person to make health decisions for you when you are not able. This is called a “health care proxy”. The proxy should be someone who will follow your wishes.

Do-Not-Resuscitate (DNR) Declaration – This legal document lets others know that you do not want anyone to try to revive you if you stop breathing or if your heart stops.

A “living will” is not a legally binding Advance Directive in Michigan. However, a living will is sometimes used with a valid Durable Power of Attorney for Health Care to help the Patient Advocate named in the DPOA-HC to understand your wishes.

You need to tell your supports coordinator if you have an Advance Directive. The waiver agency will keep a copy in your record. You and your DPOA should also keep a copy at home in a safe place. If you have any questions about Advance Directives or if you need help finding an Advance Directive form, please call your supports coordinator.



Grievances and Appeals

Grievances:

When you are unhappy with your services, you may file a **grievance**. Grievances are complaints about things like how you are treated or how your worker does their job. The waiver agency must tell you how to file a grievance and can help you fill out forms. The waiver agency will let you know they received your grievance and will work with you to resolve your complaint. The waiver agency has 90 days to resolve your complaint.

Appeals:

You can appeal any decision about your services and supports that your waiver agency makes. This includes denying a service that you asked for and reducing, suspending or terminating services that you already have. When the waiver agency makes these decisions, they must send you a letter called an **adverse benefit determination.** This letter contains information about the changes in your services and your rights. When you do not agree with the changes or the decision made, you can ask for an **appeal**.

It is important that you ask for an appeal within 60 days from the date of the adverse benefit determination letter. You can ask for an appeal orally or in writing. The letter will explain this process to you. Your provider or authorized representative may also file an appeal on your behalf. If someone is filing an appeal for you, you must give him or her written consent to do this. If you do not provide this consent, the waiver agency will deny the appeal request.

If you would like your services to continue without any changes when you ask for an appeal, you must ask for the appeal before the effective date of the action (usually 10 days after the date on the letter). When you do this, your services will not change until after a decision is made about your appeal.

The waiver agency must make a decision and send you a letter telling you about it within 30 days from the day you ask for an appeal. The letter they send is called the **Notice of Internal Appeal Decision**.

You can request a fast appeal if you feel the changes to your services will harm you. If a fast appeal is granted, the waiver agency must make a decision and send you the Notice of Internal Appeal Decision within 72 hours. In cases where taking longer than 72 hours may benefit you, the waiver agency may ask for a longer time to make their decision.

- ***PUBLIC HEALTH:*** As authorized by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- ***LAW ENFORCEMENT:*** We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.
- ***VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE:*** We may disclose information about you to a government authority, such as a social service or protective agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.
- ***TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:*** If there is a compelling need, we may disclose information to prevent a serious threat to your health or safety or the health and safety of the public or another person.
- ***HEALTH OVERSIGHT***: We may disclose health information to a health oversight agency for activities authorized by law.
- ***INMATES:*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

SPECIAL SITUATIONS: Consistent with applicable law, we may disclose health information to funeral directors, coroners, medical examiners; as required by military command authorities; and for national security activities. A mental health services recipient's information will be disclosed only as allowed under Michigan law.

If we use or disclose your information for any purpose that is not described in this notice, we will do so only with your permission. For example, we will not sell, market, or use your information for fundraising without your permission.

YOUR PRIVACY RIGHTS

You have the following rights regarding the health information that we have about you. Your requests must be made in writing to the Michigan Department of Health and Human Services at the address below. You have a right to:

Inspect and Copy	In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.
Amend	You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.
A List of Disclosures	You have the right to ask for a list of disclosures made in the six years before the date of your request. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your permission.
Request Restrictions on Our Use or Disclosure of Information	You have the right to ask for limits on how your health information is used or disclosed. We are not required to agree to such requests unless (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and (2) the protected health information pertains solely to a health care item or service for which you, or a person other than a health plan on your behalf, has paid us in full. We will notify you if we are unable to agree to a requested restriction.
Request Confidential Communications	You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. We may deny your request unless you clearly state your safety is at risk.
Revoke Authorization	If you give us permission to use or disclose your health information, you have the right to change your mind and revoke it. This must be in writing. We cannot take back any uses or disclosures already made with your permission.

If you want to ask for an Internal Appeal, you can either call or send in a written request to:

Tri-County Office on Aging- Appeals

5303 S. Cedar St., Suite 1

Lansing, MI 48911

1-800-405-9141

Fax number: 517-887-8071

State Fair Hearings:

There are two situations where you may ask for a State Fair Hearing.

1) You receive an Notice of Internal Appeal Decision that is not in your favor

   The waiver agency will send you information about how to ask for a hearing with your Notice of Internal Appeal Decision. If you do not ask for a State Fair Hearing, your services will change as planned.

   You can ask for a State Fair Hearing for up to 120 days from the date of the Notice of Internal Appeal Decision. You can only keep your services if you ask for the hearing within 10 days of the Notice of Internal Appeal Decision **AND** ask to keep your services. If you do not ask for a State Fair Hearing within 10 days or if you do not ask for your services to continue, the waiver agency will make the changes as planned.

2) You asked for an appeal, but the waiver agency did not make a decision within 30 days, or 45 days if an extension was granted.

For more information about State Fair Hearings, you may contact the Michigan Administrative Hearing System at **1 (877) 833 – 0870.**

MI Choice Waiver Ombudsman Program

Ombudsman programs offer **free** information and legal aid to people who are enrolled in or using Medicaid-funded services. In Michigan, the Michigan Elder Justice Initiative (MEJI) offers these services to MI Choice clients.

The Ombudsman can help you with issues about enrollment, disenrollment, eligibility, the amount and quality of services, coordination with other programs and benefits, grievances and appeals, and other issues. They can also help you find the right agency if your issue is outside of what they do.

You may call the Ombudsman program at

1-888-746-6456

between 9:00 a.m. and 5:00 p.m. weekdays

When you call the phone number during business hours a trained lawyer will answer. The lawyer will give you information and advice and try to fix your concern. If you say it is OK, the lawyer may contact your supports coordinator or others who might be able to help. Sometimes your case may be given to another agency if it cannot be fixed quickly. All services are confidential and free of charge.

Notice of Compliance with Title II of the Americans with Disabilities Act (ADA)

The Michigan Department of Health and Human Services does not discriminate on the basis of disability in admission to, access to, or operations of its programs, services, or activities.

Questions, concerns, complaints, or requests for additional information regarding the ADA may be directed to your supports coordinator.

The U.S. Department of Justice also provides information about the ADA at http://www.ada.gov/ or through a toll-free ADA Information Line at 1-800-514-0301 (voice) or 1-800-514-0383 (TTY).

PRIVACY NOTICE

For Medicaid and Other Medical Assistance Programs

Effective December 1, 2018

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ٣١٩٥-٦٤٢-٨٠٠-١

CALL BENEFICIARY HELP LINE 1-800-642-3195

Understanding the Type of Information We Have. We get information about you when you enroll. It includes your date of birth, sex, ID number and other information. We also get bills, reports from your doctor and other data about your health care.

Our Privacy Commitment To You. We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices, to follow these practices, and to notify affected individuals following a breach of unsecured protected health information. Only people who have both the need and the legal right may see your information. We may disclose your information without your permission for purposes of treatment, payment, health care operations or when we are required by law to do so. For examples of some of the disclosures referenced below, go to www.michigan.gov/mdhhs, click on Assistance Programs, then Health Care Coverage, and look under Protected Health Information.

- **Treatment.** We may disclose health information about you to coordinate your health care.
- **Payment.** We may use and disclose information so the care you get can be properly billed and paid.
- **Health Care Operations**. We may need to use and disclose information to operate the program.
- **Exceptions.** For certain kinds of records, such as psychotherapy notes, your permission may be needed even for release for treatment, payment and health care operations.
- **As Required By Law.** We will release information when we are required by law to do so.
- **With Your Permission.** If you give us permission in writing, we may use and disclose your health information. If you give us permission, you have the right to change your mind and revoke it. This must be in writing, too. We cannot take back any uses or disclosures already made with your permission. With your consent, we may notify or release information about you to a friend or family member who is involved in your care.

ADDITIONAL EXAMPLES OF DISCLOSURES THAT MAY BE MADE WITHOUT YOUR PERMISSION

- ***BUSINESS ASSOCIATES:*** There are some services provided in our organization through contracts with Business Associates. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- ***RESEARCH:*** Information will not be provided to researchers without your signed informed consent, or unless the research has been approved by an institutional review board or a privacy board and the researchers ensure the privacy of your information.
- ***FOOD AND DRUG ADMINISTRATION (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- ***WORKER COMPENSATION:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Changes to this Notice

We reserve the right to revise this notice. A revised notice will be effective for health information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website. Go to www.michigan.gov/mdhhs, click on Assistance Programs, then Health Care Coverage, and look under Protected Health Information. If the changes are material, a new notice will be mailed to you before it takes effect.

How to Use Your Rights Under this Notice

If you want to make a Privacy Rights request or file a complaint, your request or complaint must be in writing. If you are writing a complaint, tell us your name (and the name of the person affected, if you are filing the complaint for another person), identification number, what right you believe was violated, who you believe committed the violation, what you want done to correct the problem, and an address and telephone number were you can be contacted. You may get a complaint form by going to www.michigan.gov/mdhhs, click on Assistance Programs, then Health Care Coverage, click on Protected Health Information. Requests and complaints should be sent to:

Privacy Officer/Compliance Office Michigan Department of Health and Human Services PO Box 30195 Lansing, Michigan 48909	**OR**	Phone: 517-284-1018 Michigan Relay Center: 711

You also have the right to file a complaint with the federal government. Written complaints should be sent to:

Centralized Case Management Operations U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201	**OR**	Phone: 800-368-1019 TDD: 800-537-7697 Email: OCRComplaint@hhs.gov

You will not be penalized or retaliated against for filing a complaint with either MDHHS or the federal government.

Copies of this Notice

You have the right to receive an additional copy of this notice at any time. Please call or write to us to request a copy.

Acknowledgement

I have received the MI Choice Participant Handbook. I have been informed of my rights and responsibilities as a participant in the program. I know about information on Abuse & Neglect, Grievances & Appeals, Advanced Directives, and Self Determination. I also know about my Privacy Rights. I understand that I should keep this handbook for future reference. I can ask for another copy of the handbook at any time.

Signature

Date

Print Full Name

Witness Waiver Agency Staff

Date

Print Full Name

Participant Name

Appendix H

TCOA Provider Qualifications and Delivery Policy

Tri-County Office on Aging- Medicaid Waiver Program

Policy Name	Provider Qualifications and Delivery
Current Revision Date	October 2024- Reviewed, no changes
Historical Revision Dates	February 2024 October 2023- Reviewed, no changes February 2023 October 2022- Reviewed, no changes October 2021 January 2021 February 2020 November 2019 January 2019 November 2018 August 2018 December 2017

Purpose

Provider qualifications are mandated by the Michigan Department of Health and Human services (MDHHS) to ensure the safety and wellbeing of participants and the quality of services provided. Services are authorized based on the Person-Centered Service Plan (PCSP). Services can only be paid for if included in the PCSP.

Definitions

ACLS- Bureau of Aging and Community Living Supports

Contract Manager- Person at TCOA who works with obtaining and monitoring Provider adherence to contract standards

COMPASS- Electronic participant casefile

MDHHS: Michigan Department of Health and Human Services

PCSP- Person Centered Service Plan

Provider- Agency or organization that provides a specific service or item, as authorized, to a participant of TCOA

Self-Determination (SD)- Program offered within MI Choice that allows participants to hire/fire/manage their own workers

Service Authorization- Description of services to be provided to participants

TCOA- Tri-County Office on Aging

General Procedure

Provider Qualifications

Providers must meet and work within the minimum operating standards and limitations as set forth by the Michigan Department of Health and Human Services (MDHHS) in the MI Choice chapter of the Michigan Medicaid Provider Manual[1]. These standards apply whether the service is provided through Self-Determination (SD) or traditional service delivery. There are different qualifications depending on the service. All providers must meet the program and service standards, certifications, and licensure requirements as described in the MDHHS Michigan Medicaid Provider Manual before any contracts are authorized. No services will be delivered until there is a signed contract/agreement. All providers must enroll as a Medicaid Provider (MSA-1625). Copies of all required documents, including relevant certifications, are kept on file at TCOA. Verification is updated at each contract renewal or sooner if TCOA deems necessary. Providers are required to disclose their educational and job history as well as any relevant experience and training. Criminal history reviews are required prior to any service delivery.

Background Checks

Providers and their employees must submit to background checks and criminal history reviews prior to service delivery. All providers must be screened through the State Police Criminal History database. Providers are also screened through out of state criminal databases and local sex offender, Adult Protective, Child Protective, commercial, Department of Motor Vehicles (DMV) or FBI registries as necessary. Providers must be cleared through federal and state exclusion lists, including SAM.gov[2] and the Michigan Medicaid Sanctioned Provider List, which is checked monthly, to verify they are not barred from providing services. Employees of providers must provide references and evidence of job history as part of an initial interview and must pass criminal background checks prior to hiring and service delivery.

Provider Reviews

The Contract Manager develops a yearly schedule of provider monitor reviews to conduct monthly throughout the fiscal year. The schedule is submitted to MDHHS by December 1, yearly. The TCOA Contract Manager, clinical staff, other staff members conduct provider reviews by notification in writing at least 2 weeks in advance of the date scheduled for review. 20% providers are reviewed on an annual basis. TCOA selects a sample of 10 participant case records or 10% of the provider records (whichever is greater) to evaluate. TCOA uses the MDHHS Attachment J, Provider Monitoring Tool, for conducting provider reviews. During the monitoring review TCOA checks to see that providers keep in-home logs for each participant. Provider monitoring includes a minimum of 2 home visits to participants.

Service Delivery

[1] https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-provider-manual#using
[2] https://sam.gov/

Provider will deliver services based on the schedule or amount delineated by the Service Authorization received through Vendor View or the supports coordinator. Service delivery is expected to be person centered, respecting the participant's choices whenever possible. Providers are required to report to the supports coordinator any discrepancies in the delivery of service in comparison to the Service Authorization. TCOA requires that provider agencies do not seek additional compensation or contributions from any participant affiliated with a TCOA program for services purchased utilizing TCOA funds. Providers have access to the TCOA 24-hour after-hours hotline providing access to on-call TCOA staff to receive immediate telephone assistance related to delivery of services or to address any emergencies.

Complaints from Participants

Complaints from participants, their supports, and/or supports coordinators will be documented through e-mail to the Nurse or Social Work Supervisor and the Contract Manager. Supports coordinators will offer the participant the option to file a formal grievance as outlined in the Grievances Policy. Supports coordinators will still work directly with participants and providers to resolve minor complaints to the participant's satisfaction if the participant declines a formal grievance. If at any time a complaint or grievance fits the criteria for a critical incident, the supports coordinator will include the Nurse or Social Work Supervisor and the LRS Specialist, as applicable, to find a resolution, and report to MDHHS as required. When providers continuously demonstrate poor performance the Contract Manager will contact the Provider to outline the identified problems and develop a plan of corrective action. The plan will include a specific time frame in which to resolve the identified problems and will include a schedule for monitoring and follow-up by the Contract Manager. Consequences of not meeting the goals of the corrective action plan will be outlined, up to, and including, termination of the agreement/contract. Appropriate documentation will be made in the Progress Notes section of COMPASS by the supports coordinator and kept with the Contract Manager. All incidents will be tracked, trended, and addressed with Program Director and Service provider, as needed. The data will be shared with the individuals/vendors involved, as appropriate.

Complaints from Providers: If a provider has a concern about a decision made by TCOA they can contact the Social Work or Nursing Supervisor. If the problem cannot be resolved within 15 days the provider can make a formal complaint, in writing, to the Contract Manager. The Contract Manager will involve the Program Director to investigate the complaint and work with the provider on a resolution. A written resolution will be sent within 30 days of the formal complaint. If the provider is not satisfied with the written response the complaint can be taken to the TCOA Executive Director for a final determination. A final determination will be made 30 days from the Executive Director receiving the complaint.

Critical Incidents: Providers must have policies and procedures that outline what action is taken when a critical incident has been reported or identified. Critical incidents are defined as an unexpected occurrence involving serious physical or psychological injury (or the risk thereof), exploitation, or theft**.** Critical incidents specifically include exploitation, illegal activity in the home, neglect, physical abuse, provider no show, sexual abuse, suspicious death, theft, verbal abuse, worker drug/alcohol, medication error, suicide attempts, and use of restraint or seclusion. All critical incidents must be reported to TCOA through the supports coordinator or program supervisors. Incidents involving abuse, neglect, exploitation, either observed or suspected, should be reported to Adult Protective Services, per state

law. Agencies are expected to report Critical Incidents within 48 hours of the occurrence or the agency's knowledge of the occurrence. Incidences involving agencies and their employees will also be reported to the Contract Manager who will take action based on the nature of the complaint.

Quality Assurance Planned Activities:

Agency Monitoring Visits
Chart Review
Peer Review
Compliance Committee Activities