Office of the Auditor General
Performance Audit Report

Medicaid Ambulance, Dental, and Emergency Room Claim Payments

Michigan Department of Health and Human Services

August 2017

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

391-0716-16

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Performance Audit
Medicaid Ambulance, Dental, and Emergency Room Claim Payments
Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0716-16

Released:
August 2017

Ambulance transportation is reimbursable when medical, surgical, psychiatric, or behavioral health emergencies exist or when deemed medically necessary and ordered by a physician because there is no other effective and less expensive means of transportation. Dental and dental-related services are reimbursable to prevent acute problems and irreversible damage to teeth or supportive structures. Emergency room services cover facility fees and services provided by medical professionals. MDHHS processed nearly 4.5 million ambulance, dental, and emergency room Medicaid fee-for-service (FFS) claim payments totaling $450.4 million from October 2013 through June 2016.

Audit Objective			Conclusion
Objective #1: To assess the effectiveness of MDHHS's efforts to ensure the propriety of ambulance, dental, and emergency room Medicaid FFS claim payments.			Effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
MDHHS overpaid 23% of the emergency room evaluation and management services claims reviewed, resulting in potential overpayments totaling $867,287 (Finding #1).		X	Agrees
MDHHS reimbursed 5 ambulance providers for 407 (68.4%) transport services claims, totaling $77,149, for which providers did not have adequate documentation (Finding #2).		X	Agrees

Audit Objective			Conclusion
Objective #2: To assess the effectiveness of MDHHS's efforts to ensure that ambulance, dental, and emergency room Medicaid FFS claims are processed in a timely manner.			Effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
None reported.	Not applicable.		

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August 1, 2017

Mr. Nick Lyon, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Mr. Lyon:

I am pleased to provide this performance audit report on Medicaid Ambulance, Dental, and Emergency Room Claim Payments, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided preliminary responses to the recommendations at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and submit it within 60 days of the date above to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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TABLE OF CONTENTS

MEDICAID AMBULANCE, DENTAL, AND EMERGENCY ROOM CLAIM PAYMENTS

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

PROPRIETY OF AMBULANCE, DENTAL, AND EMERGENCY ROOM FFS CLAIM PAYMENTS

BACKGROUND

The Michigan Medicaid Provider Manual (MPM) provides guidance for ambulance, dental, and emergency room providers regarding eligible services for Medicaid beneficiaries and documentation requirements.

Medicaid beneficiaries can have either fee-for-service (FFS) or Medicaid Health Plan (MHP) coverage:

- For Medicaid beneficiaries who have FFS coverage, the Michigan Department of Health and Human Services (MDHHS) reimburses providers a preestablished rate for actual services provided. Providers submit claims to MDHHS for reimbursement through the Community Health Automated Medicaid Processing System (CHAMPS). To help assess the validity of each claim, CHAMPS subjects each claim to edit checks, such as the propriety of the provider; the eligibility of the beneficiary; the validity of the procedure or service, including frequency limitations; and the duplication of the claim.

- For Medicaid beneficiaries enrolled in an MHP, MDHHS pays each contracted MHP a per-member, per-month fee to provide covered services.

From October 1, 2013 through June 30, 2016, MDHHS paid 4,453,646 ambulance, dental, and emergency room Medicaid FFS claims totaling $450.4 million (see supplemental information).

AUDIT OBJECTIVE

To assess the effectiveness* of MDHHS's efforts to ensure the propriety of ambulance, dental, and emergency room Medicaid FFS claim payments.

CONCLUSION

Effective.

FACTORS IMPACTING CONCLUSION

- All providers and individuals selected for review were eligible to participate in the Medicaid program.

- 99.9% of the ambulance, dental, and emergency room claim payments were for beneficiaries who were not deceased as of the date of service. Only $898 of claim payments were made on behalf of beneficiaries who were deceased as of the date of service for October 1, 2013 through June 30, 2016.

** See glossary at end of report for definition.*

- 100% of the ambulance, dental, and emergency room claim payments reviewed were for beneficiaries who were enrolled in Medicaid FFS as of the date of service.

- Provider documentation was available for 100% of the ambulance and dental claim payments reviewed and 99.2% of the emergency room claim payments reviewed.

- All beneficiaries reviewed who received emergency ambulance transport services were treated at an emergency room on the date of service indicated, thus supporting the validity and existence of the emergency transport service.

- All dental services claim payments reviewed were for allowable services and were reimbursed at the appropriate rate.

- Reportable condition* related to the need to improve controls over reimbursement of emergency room evaluation and management (E/M) services (Finding #1).

- Reportable condition related to providers being reimbursed for ineligible ambulance transport services (Finding #2).

** See glossary at end of report for definition.*

FINDING #1

Improved controls needed over emergency room E/M claim reimbursements.

MDHHS did not ensure that emergency room E/M services claims submitted by attending physicians were reimbursed at the appropriate rate. MDHHS overpaid 23% of the claims reviewed, resulting in potential overpayments totaling $867,287.

The MPM states that emergency room attending physicians who provide E/M services must indicate in the modifier field whether the beneficiary was admitted or discharged and that such claims are reimbursed at different rates. Also, MDHHS indicated that non-attending physicians who provide or supervise E/M services should leave the modifier field blank and that these claims are also reimbursed at different rates.

MDHHS paid 753,630 emergency room E/M services claims totaling $37.9 million from October 2013 through June 2016.

Our review noted that MDHHS reimbursed 23 of 100 emergency room E/M services claims at the "admitted" or "blank" rate even though the documentation that we requested from the providers indicated that the claims should have been reimbursed at the lower discharged rate. These claim overpayments totaled $519. Based on the respective error rates, average overpayments per claim, and total number and amount of emergency room E/M services claim payments for which the modifier field was "admitted" or "blank," we estimated a potential overpayment of $867,287. Although this potential overpayment amount represents only 2.3% of the total amount of claims paid, the fact that 23% of the claims that we reviewed contained an error represents an area for improvement by MDHHS.

MDHHS employs several mechanisms to flag improperly submitted claims; however, these emergency room E/M services claims were not flagged as potential irregularities because the professional claim formats and coding used by attending physicians are the same as all other non-attending physicians and professionals providing emergency room E/M services.

RECOMMENDATION

We recommend that MDHHS implement controls to ensure that it reimburses emergency room E/M services claims at the appropriate rate.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that some payments to attending physicians for their evaluation and management services in the emergency department (ED) settings were not made at the appropriate rate. The finding identified a single health system provider that accounted for 34% of the claim-related modifier issues. MDHHS will provide targeted provider outreach to

assist this provider in improving its billing practices for emergency room attending physician services.

Although MDHHS does monitor data received on claims that may indicate billing trends as part of the Predictive Modeling program, it is not feasible to apply Predictive Modeling program concepts to ED attending physician service claims because these services are billed on two different claim formats which require different data and would create inconsistencies in what is flagged for review. In addition, it would not be cost effective or timely to complete a comprehensive manual review of patient medical records for every ED claim to determine if the claim modifier was properly coded.

FINDING #2

Controls over nonemergency ambulance transport services claim reimbursements need improvement.

MDHHS needs to improve its process to verify the eligibility of nonemergency ambulance transport services claims. MDHHS reimbursed 5 ambulance providers for 407 (69.1%) transport services claims, totaling $77,149, for which providers did not have adequate documentation.

Section 2.9 of the MPM states that ambulance providers may submit a claim for a nonemergency transport only when the provider obtains a certified physician written order form (PWOD), including the attending physician or provider signature; the attending physician's National Provider Identifier number; an explanation of the medical necessity for the transport; and the patient's diagnosis.

From October 1, 2013 through June 6, 2016, MDHHS reimbursed 142 ambulance providers $9.9 million for 84,303 claims submitted for nonemergency transport services.

We reviewed the PWOD documentation for 589 nonemergency transport services claim reimbursements totaling $108,434 for 116 FFS beneficiaries at 5 ambulance providers. The documentation for 407 (69.1%) claim reimbursements, totaling $77,149 (71.1%), did not meet at least one MPM requirement, as follows:

PWOD Requirement	Claims Reviewed	Exceptions
Documented	589	50 (8.5%)
Signed	539	13 (2.4%)
Physician's National Provider Identifier number	539	357 (66.2%)
Diagnosis or explanation of medical necessity	539	44 (8.2%)

From October 1, 2013 through June 6, 2016, MDHHS reimbursed the 5 providers $2.3 million. Although our sampling methodology did not support a statistical projection, the error rates identified in our testing results may be indicative of the remaining nonemergency transport services claim reimbursements for the 5 ambulance providers.

MDHHS indicated that unless a claim or provider is flagged as a potential risk, it does not review provider documentation because of the magnitude of the number of claims.

RECOMMENDATION

We recommend that MDHHS improve its process to verify the eligibility of nonemergency ambulance transport services claims.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that it needs to improve its processes for verifying the eligibility of non-emergency ambulance transport services. MDHHS will take the following actions:

- *A provider L-letter will be sent to all ambulance providers reminding them of the requirements for the physician written order as defined in Medicaid policy. Providers will also be reminded that failure to comply with these requirements may result in denial of payment or recoupment of funds.*

- *MDHHS will investigate options for flagging non-emergency ambulance claims under the Predictive Modeling program in order to review documentation of the service.*

- *The MDHHS Office of Inspector General (OIG) is aware of this issue and will continue to review physician written orders for completeness any time an ambulance provider's records are under review.*

TIMELY PROCESSING OF AMBULANCE, DENTAL, AND EMERGENCY ROOM CLAIMS

BACKGROUND

MDHHS processes Medicaid FFS claim payments through CHAMPS.

The Medicaid Payments Division works to ensure the timely and accurate payment of Medicaid claims, particularly FFS claims from Medicaid enrolled providers, through its Policy Implementation and Medicaid Claims Processing Sections, as follows:

- The Policy Implementation Section works to ensure that CHAMPS adjudicates claims consistent with Medicaid policy. This requires researching federal and State legislation and working closely with agency staff to verify the intent of published regulations and policy. Analysts in the Policy Implementation Section request system changes to implement new policy, correct defects, and implement enhancements; identify test scenarios and test changes prior to implementation; and monitor changes after implementation.

- The Medicaid Claims Processing Section processes Medicaid claims that have been suspended from CHAMPS.

Title 42, Part 447, section 45(d)(1) of the *Code of Federal Regulations* (*CFR*) requires that all claims must be submitted within 12 months of the date of service. Federal regulations 42 *CFR* 447.45(d)(2) through (4) require that MDHHS pay 90% and 99% of all clean claims* from practitioners within 30 and 90 days, respectively, of the date of receipt and 100% of all other claims within 12 months of the date of receipt.

AUDIT OBJECTIVE

To assess the effectiveness of MDHHS's efforts to ensure that ambulance, dental, and emergency room Medicaid FFS claims are processed in a timely manner.

CONCLUSION

Effective.

FACTORS IMPACTING CONCLUSION

- MDHHS met the federal timeliness standards by processing 97.0%, 99.8%, and 100% of all ambulance, dental, and emergency room claims within 30 days, 90 days, and 12 months, respectively, of the date of receipt.

** See glossary at end of report for definition.*

SUPPLEMENTAL INFORMATION

MEDICAID AMBULANCE, DENTAL, AND EMERGENCY ROOM CLAIM PAYMENTS
Michigan Department of Health and Human Services

FFS Claim Payment Data
October 2013 Through June 2016[1]

	Ambulance	Dental	Emergency Room	
			Outpatient	Professional
Fiscal Year 2014:				
Number of beneficiaries	36,597	425,024	157,649	186,668
Number of providers	282	787	237	958
Number of claims	62,183	928,062	239,564	390,808
Claim payments	$12,190,433	$75,537,324	$55,657,760	$16,636,576
Fiscal Year 2015:				
Number of beneficiaries	47,159	389,531	214,317	241,597
Number of providers	270	747	205	993
Number of claims	80,055	843,092	317,308	496,572
Claim payments	$15,182,052	$64,451,621	$73,106,691	$21,066,195
Fiscal Year 2016[1]:				
Number of beneficiaries	36,085	241,194	161,303	172,241
Number of providers	258	788	212	839
Number of claims	60,888	462,139	230,354	342,621
Claim payments	$11,082,057	$35,443,551	$55,169,654	$14,868,364
Total:				
Number of beneficiaries[2]				
Number of providers	306	947	304	1,382
Number of claims	203,126	2,233,293	787,226	1,230,001
Claim payments	$38,454,543	$175,432,496	$183,934,105	$52,571,134

[1]Through early June 2016.
[2]We did not attempt to obtain the unique number of beneficiaries for the audit period.

Source: The OAG prepared this exhibit using data obtained from the Enterprise Data Warehouse.

AGENCY DESCRIPTION

Medicaid is a joint federal and state program that provides health coverage to eligible beneficiaries. The State of Michigan Medicaid expenditures totaled $17.9 billion for fiscal year 2016.

Under the authority of the Medicaid State Plan, MDHHS reimburses providers for ambulance, dental, and emergency room services, as follows:

- Ambulance services - When medical, surgical, psychiatric, or behavioral health emergencies exist or when deemed medically necessary and ordered by a physician because there is no other effective and less expensive means of transportation.

- Dental services - Dental and dental-related medical services to prevent acute dental problems and irreversible damage to teeth or supportive structures.

- Emergency room services - Facility fees and services provided by medical professionals.

As of April 2016, MDHHS's Medicaid Payments Division had 60 employees.

From October 2013 through early June 2016, MDHHS processed the following ambulance, dental, and emergency room Medicaid FFS claim payments:

Claim Type	Number of Claim Payments	Amount of Claim Payments
Ambulance	203,126	$ 38,454,543
Dental	2,233,293	175,432,496
Emergency Room:		
Outpatient	787,226	183,934,105
Professional services	1,230,001	52,571,134
Total	4,453,646	$450,392,278

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine the records and processes related to MDHHS's payment of ambulance, dental, and emergency room Medicaid FFS claims. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The scope of this audit did not include the verification of Medicaid eligibility or a review of payments made to MHPs. Medicaid eligibility is determined by MDHHS's local offices and is generally audited as part of the annual State of Michigan Single Audit.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered October 1, 2013 through June 30, 2016.

METHODOLOGY

We conducted a preliminary survey of ambulance, dental, and emergency room claim payments to formulate a basis for defining our audit objectives and methodologies. During our preliminary survey, we:

- Visited 3 judgmentally selected ambulance providers, dental providers, and hospitals that provided emergency room services; interviewed their staff; and reviewed their recordkeeping procedures for claim payments related to their Medicaid FFS patients.
- Interviewed MDHHS Medicaid Payments Division staff regarding their responsibilities for processing ambulance, dental, and emergency room claim payments.
- Reviewed applicable sections of the Michigan MPM, the Medical Care Advisory Council meeting minutes, laws, appropriations acts, and similar audits performed of other states' Medicaid programs.

OBJECTIVE #1

To assess the effectiveness of MDHHS's efforts to ensure the propriety of ambulance, dental, and emergency room Medicaid FFS claim payments.

** See glossary at end of report for definition.*

To accomplish this objective, we conducted the following procedures in the respective areas:

a. Ambulance

- Analyzed ambulance transport FFS claim payment data from October 1, 2013 through June 6, 2016.

- Visited 6 ambulance providers, obtained an understanding of their processes, and reviewed their documentation of services provided to 143 FFS beneficiaries. We judgmentally selected the 6 ambulance providers based on their geographical location and populations and those with higher total number and dollar amount of claims paid. Also, we excluded providers that had recent MDHHS Office of Inspector General visits. Therefore, we could not project the results of our tests to the entire population.

- Tested the 170 emergency and 589 nonemergency ambulance transport services claims paid for 143 FFS beneficiaries for compliance with selected criteria outlined in the MPM. We judgmentally and randomly selected the 143 FFS beneficiaries. Therefore, we could not project the results of our tests to the entire population.

- Reviewed 90 beneficiaries from 3 of the 6 ambulance providers visited to determine if they were enrolled in an MHP at the time of their emergency ambulance transport. We randomly and judgmentally selected the 90 beneficiaries, therefore, we could not project the results to the entire population.

- Reviewed the FFS coverage status of 38 FFS beneficiaries for whom MDHHS made ambulance transport services payments. We judgmentally selected the 38 beneficiaries, therefore, we could not project the results to the entire population.

- Matched the FFS ambulance transport beneficiaries with the State Death Record database and with State incarceration records.

- Reviewed the federal System for Award Management and the federal Office of Inspector General's List of Excluded Individuals for the 6 ambulance providers.

b. Dental

- Analyzed dental FFS claim payment data from October 1, 2013 through June 13, 2016.

- Visited 3 dental providers, obtained an understanding of their processes, and reviewed their documentation of services provided to 67 FFS beneficiaries. We judgmentally selected the 3 dental providers based on their geographical location and populations and those with higher total number and dollar amount of claims paid and judgmentally selected the 67 FFS beneficiaries. Therefore, we could not project the results of our tests to the entire population.

- Tested 143 dental claim payments for compliance with selected criteria outlined in the MPM. We judgmentally and randomly selected the 143 claim payments. Therefore, we could not project the results of our tests to the entire population.

- Reviewed the FFS coverage status of 60 FFS beneficiaries for whom MDHHS made dental services payments. We judgmentally selected the 60 beneficiaries, therefore, we could not project the results to the entire population.

- Reviewed the dental chapter of the MPM and discussed policy interpretation with MDHHS personnel.

- Matched the FFS dental beneficiaries with the State Death Record database and with State incarceration records.

- Reviewed the federal lists of excluded parties, individuals, and entities for 9 dental providers (the 3 that we visited and 6 other randomly and judgmentally selected) and 17 individuals (10 from the 3 providers that we visited, and 7 other randomly and judgmentally selected). Therefore, we could not project the results of our tests to the entire population.

c. Emergency Room

- Analyzed emergency room FFS claim payment data from October 1, 2013 through June 9, 2016.

- Visited 3 hospital emergency rooms, obtained an understanding of their processes, and reviewed documentation of services provided to 54 FFS beneficiaries. We judgmentally selected the 3

emergency rooms based on their geographical location and populations and those with higher total number and dollar amount of claims paid and judgmentally selected the 54 FFS beneficiaries. Therefore, we could not project the results of our tests to the entire population.

- Tested the appropriateness of the rate paid for 100 emergency room E/M services claim payments. We randomly selected 50 claim payments for which the modifier was "admitted" and 50 claim payments for which the modifier was left blank.

- Reviewed 568 outpatient emergency claims for compliance with selected criteria outlined in the MPM.

- Reviewed all E/M services procedure codes for all emergency room professional services claim payments to ensure that the corresponding claims were paid at, or below, the approved professional rate outlined on the Practitioner and Medical Clinic Fee Schedule.

- Reviewed the FFS coverage status of 24 FFS beneficiaries for whom MDHHS made emergency room services payments. We judgmentally selected the 24 beneficiaries, therefore we could not project the results to the entire population.

- Reviewed the emergency room chapter and the Billing and Reimbursement for Professionals section of the MPM and discussed policy interpretations with MDHHS staff.

- Matched the FFS emergency room outpatient and professional beneficiaries with the State Death Record database and with State incarceration records.

- Reviewed the federal lists of excluded parties, individuals, and entities for the 3 hospitals that we visited; 7 emergency room providers that were identified on the claim payments that we reviewed for the 3 hospitals; and 5 randomly selected physicians from each of the 3 hospitals. Therefore, we could not project the results of our tests to the entire population.

OBJECTIVE #2

To assess the effectiveness of MDHHS's efforts to ensure that ambulance, dental, and emergency room Medicaid FFS claims are processed in a timely manner.

To accomplish this objective, we:

- Researched federal timeliness requirements for processing Medicaid claim payments.
- Analyzed the timeliness of ambulance, dental, and emergency room FFS claim payments.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions* or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 2 findings and 2 corresponding recommendations. MDHHS's preliminary response indicates that it agrees with both of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information that relates to our audit objectives. Our audit was not directed toward expressing a conclusion on this information.

** See glossary at end of report for definition.*

GLOSSARY OF ABBREVIATIONS AND TERMS

CHAMPS	Community Health Automated Medicaid Processing System.
clean claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.
effectiveness	Success in achieving mission and goals.
E/M	evaluation and management.
FFS	fee-for-service.
material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid Health Plan.
MPM	Medicaid Provider Manual.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision-making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
PWOD	physician written order form.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the audit objectives; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.

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