Pre-Paid Inpatient Health Plan

Medicaid Services Verification Methodology Report

Fiscal Year 2016

(October 1, 2015 – September 30, 2016)

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Introduction & Background

In accordance and compliance with the Medicaid Managed Specialty Supports and Services Contract[1], Mid-State Health Network (MSHN) submits the Medicaid Event Methodology Report that summarizes the verification activities across the PIHP region. The region includes twelve (12) Community Mental Health Specialty Program (CMHSP) participants; Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Services Authority, Community Mental Health for Central Michigan, Gratiot County Community Mental Health Services Authority, Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee County Community Mental Health Authority, The Right Door (Ionia County Community Mental Health), and Tuscola Behavioral Health Systems. Also within the PIHP region are 84 substance use disorder (SUD) treatment providers that include 12 treatment providers that have multiple service locations and 22 agencies that provide prevention services.

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing an onsite review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all 12 of the CMHSPs and for all substance use disorder treatment providers who provide services using Medicaid funding. Of the 84 SUD treatment providers, only the 60 providers that provided Medicaid eligible services and used Medicaid funding were included in the review. SUD disorder treatment providers that were in another PIHP region and had a MEV review completed in that region were not included in the MEV summary.

Process Summary/Sampling Methodology

Medicaid claims verifications are conducted bi-annually (twice a year) for CMHSPs and annually (once a year) for substance use providers, utilizing a random sample. Sample selection for the CMHSP includes both the direct services provided by the CMHSP and the services provided at a contract provider of the CMHSP. Substance use providers with multiple locations with distinct site licenses were reviewed individually.

The random sample is selected using a non-duplicated sample of 5% of beneficiaries served in the previous 2 quarters. The sample selection is set with parameters not to exceed a maximum of 50 and a minimum of 20 beneficiaries. The amount of claims/encounters for each beneficiary selected in the sample has a maximum of 50 claims/encounters per beneficiary.

The sample selection for CMHSPs includes at least one beneficiary from each of the following programs; Assertive Community Treatment (ACT), Autism, Crisis Residential, Home Based Services, Habilitation Supports Waiver (HSW), Self Determination, Targeted Case Management (TCM)/Supports Coordination Services, Wraparound, and Behavior Treatment Plan. Substance Use Provider samples consisted of at least one beneficiary from each of the following service

[1] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 16 – Attachment P.6.4.1

types as applicable to the provider; Detox, Stabilization, Residential, Out-Patient Services, Case Management, and Medication Assisted Treatment.

The sample is pulled using Microsoft Sequel Server and Excel. Microsoft Server Sequel will use program scripts to pull the beneficiaries served during the previous two quarters from the MSHN Data Warehouse. Every beneficiary will then be assigned a random number within Excel. An additional column will then be created within Excel and the formula "=rand()" will then be used to select the random 6% of beneficiaries. Only the top 5 % of beneficiaries will be used to complete the sample for the review if all of the required program types are met. If the sample does not include one beneficiary from each required program type the last beneficiary will be removed from the 5% sample and the next beneficiary on the sample list that meets the criteria will be used. If all of the program types are not met with the 6% sample pulled, then the process will be ran again to select additional beneficiaries. This will be done until all the required program types are selected.

The summary incorporates services that are documented in the CMHSP electronic health record and those services not documented in the EHR (paper charts and/or contracted providers).

Data Analysis/Summary of Results

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2015 – September 30, 2016. Data presented in the below chart is relative to the 12 CMHSP's and 60 substance use disorder treatment providers reviewed during this time period.

The attributes tested during the Medicaid Event Verification review include: A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

A 90% compliance standard is the expectation per the state technical requirement for Event Verification.

CMHSP

	A	B	C	D	E	F	G
BABHA	99.81	100	100	99.81	81.35	100	100
CEI	100	100	99.45	98.36	76.3	100	100
CMHCM	100	99.92	99.77	99.84	85.85	100	100
Gratiot	100	100	98.8	98.81	68.92	99.6	95.74
Huron	100	100	100	100	90.07	100	100
Ionia	100	100	100	98.28	99.57	81.51	100
Lifeways	100	100	100	99.56	98.52	99.7	100
Montcalm	100	100	100	99.79	78.75	100	100
Newaygo	100	100	81.88	99.87	88.49	100	100
Saginaw	100	100	100	93.12	100	100	100
Shiawassee	100	100	98.28	99.22	93.1	100	100
Tuscola	100	100	100	99.54	99.77	100	100
MSHN Average	**99.98%**	**99.99%**	**98.18%**	**98.85%**	**88.39%**	**98.40%**	**99.65%**

Note: A) The code is allowable service under the contract, B) Beneficiary is eligible on the date of service, C) Service is included in the persons individualized plan of service, D) Documentation of the service date and time matches the claim date and time of the service, E.) Documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

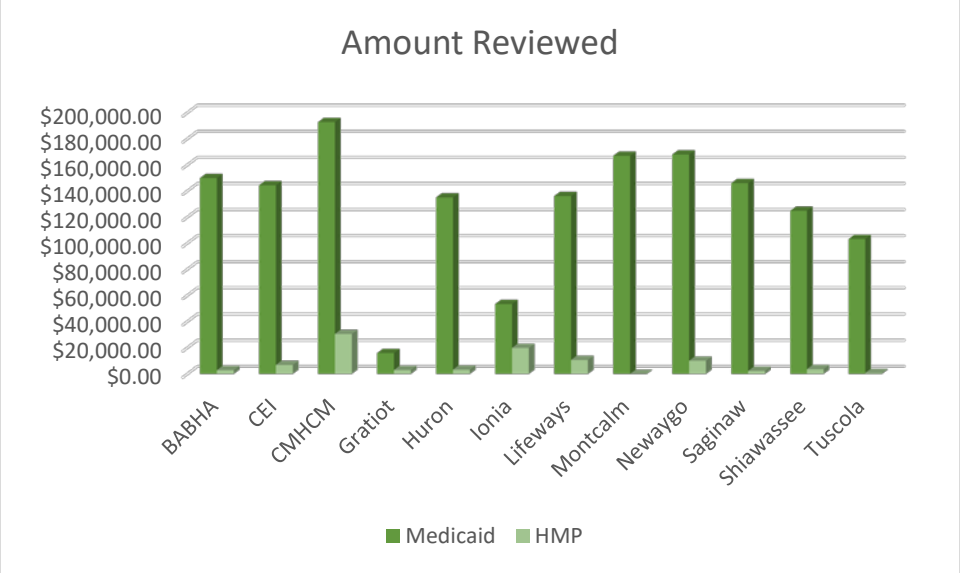
SUD

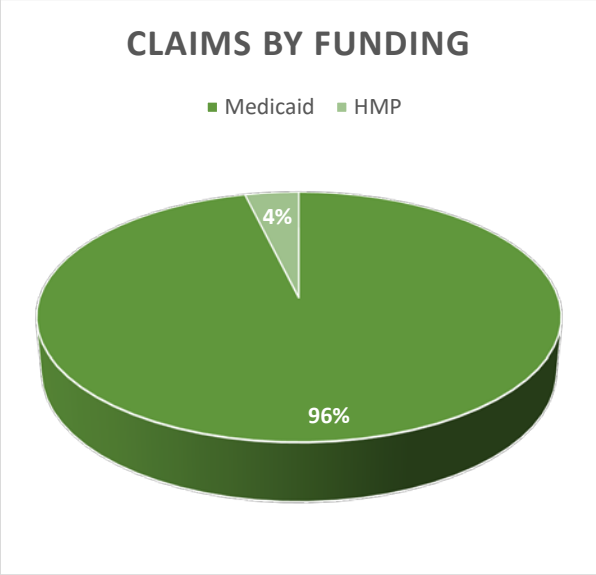
	A	B	C	D	E	F	G
SUD Providers	**99.94%**	**99.38%**	**99.95%**	**97.50%**	**98.55%**	**99.83%**	**98.83%**

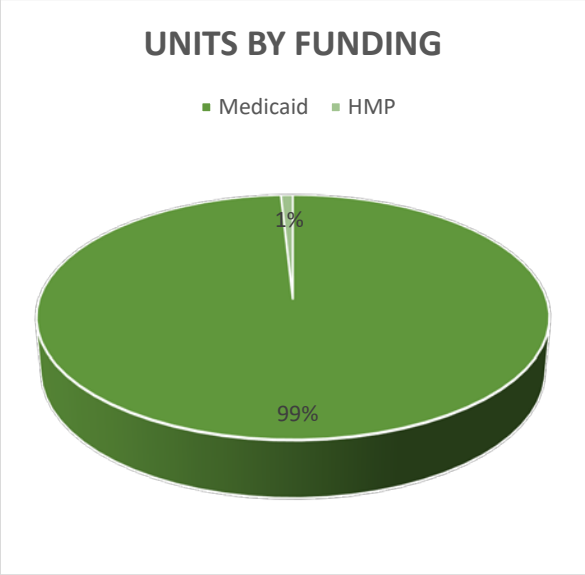
Summary of CMHSP Claims Reviewed by Funding Source:

In total 7,427 claims were reviewed. Of the 7,427 claims reviewed 7,142 of the claims were billed as Medicaid and 285 of the claims were billed using Healthy Michigan Plan Funding. The 7,427 claims included 79,938 units of service. Of the 79,983 units reviewed 79,248 were billed as Medicaid and 690 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $1,630,975.05. Of the $1,630,975.05 reviewed 1,536,820.66 was billed using Medicaid funding and $94,154.37 was billed using Healthy Michigan funding.

Note: Montcalm Care Network did not have any claims reviewed that were billed as Healthy Michigan Plan.

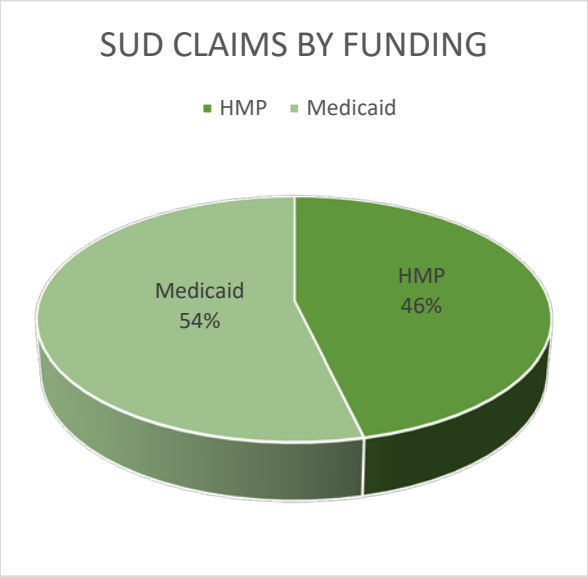


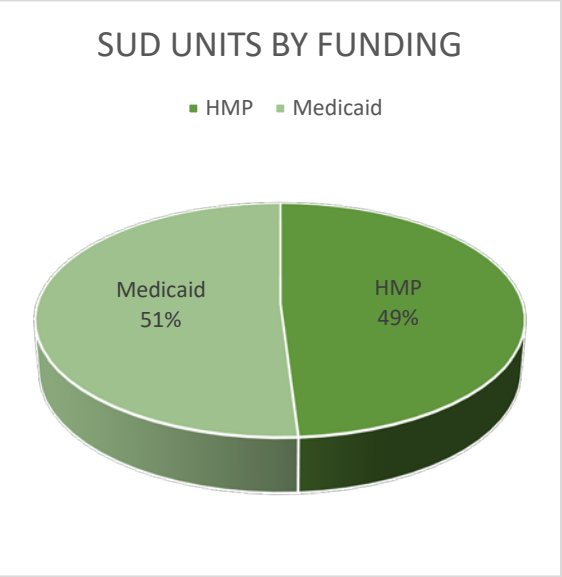




Summary of SUD Claims Reviewed by Funding Source:

In total 17,853 claims were reviewed. Of the 17,853 claims reviewed 8,260 of the claims were billed as Medicaid and 9,593 of the claims were billed using Healthy Michigan Plan Funding. The 17,853 claims included 27,043 units of service. Of the 27,043 units reviewed 13,795 were billed as Medicaid and 13,248 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $1,250,962.87. Of the $1,250,962.87 reviewed $678,210.61 was billed using Medicaid funding and $572,752.26 was billed using Healthy Michigan funding.





Deficiencies/Corrective Action

Fiscal Year 2016 Deficiencies

MSHN requires deficiencies found during the Medicaid Event Verification process be resolved immediately through one or more of the following methods:

- Billing records re-billed with correct information (e.g. code change, funding source change);
- Billed services in error voided;
- Person centered plans updated with correct authorization; and
- Reduction to future payments on subcontractor claims as necessary

For deficiencies found as a system issue, network providers are required to document a corrective action plan and demonstrate sufficient monitoring and oversight to ensure implementation. Corrective action plans may consist of education and training, data software system changes, and process changes along with related expected timelines for implementation.

MSHN reviews and monitors the corrective action plans during the following review cycle to ensure implementation of the plan indicated. For substance use disorder providers, the claims/encounters are voided immediately by MSHN for any claims/encounters determined to be invalid. The CMHSPs complete their own corrections and voids for claims/encounters found to be invalid and MSHN reviews to ensure this has been completed correctly. If deemed necessary by MSHN, additional follow up and sampling of selected elements is completed in an effort to ensure system and process change.

Based on the MEV review for FY2016, 12 CMHSPs were placed on a plan of correction and 53 substance use disorder treatment providers were placed on a plan of correction. There were not any providers removed from a plan of correction during the 2016 MEV reviews, as the provider will be reviewed for compliance during FY2017.

The overall findings included a total of 1,482 claim lines identified as invalid claims/encounters based on one or more of the established review criteria. This included a total of 16,242 units of service and a total dollar amount of $197,753.51. Of the invalid claims/encounters, 1,081 claim lines of service were from reviews of CMHSPs direct and indirect services and 401 claim lines were from substance use disorder treatment providers. The total of invalid units included 14,643 units of service from CMHSPs and 1,599 units of service from substance use disorder providers. The total dollar amount of invalid claims identified included $170,781.11 for CMHSPs and $26,972.40 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

NOTE: This is the first year the MEV process has been completed directly by MSHN (previously a delegated function to the CMHSPs and the Sub Regional Entities) and many of the invalid claims related to documentation was due to a lack of understanding what documentation was needed to support the claims. In these instances, additional documentation was sent with the plan of correction to justify the claims originally found to be invalid. These units and dollars are included in the summary of disallowed amounts as they were original findings that documentation did not support during the review.

If suspicion of fraud or abuse was apparent, the CMHSPs were required to report to MSHN for further review and follow up. As part of MSHN's ongoing compliance process, MSHN completes an initial investigation to determine if reporting to MDHHS and/or the Office of Health Service Inspector General is required. This process occurs throughout the year as the reports are received.

Repeated Deficiencies

At this time, it would not be an accurate process to compare deficiencies from FY2015 to FY2016 as a secondary review of MEV process occurred in FY2015 and a primary review occurred in FY2016. Once reviews are completed for FY2017, MSHN will review the identify areas of repeat deficiencies.

However, a summary of the deficiencies identified by the CMHSPs during the FY2015 MEV review was used to compare to the deficiencies identified during the FY2016 MEV review completed by MSHN.

A review of the elements tested from the MEV reviews completed by each CMHSP during FY2015 indicated that 6 CMHSPs have repeated deficiencies. The deficiencies were services not identified in the PCP (6 CMHSPs), billed services matching the documentation (6 CMHSPs), Medicaid eligibility (1 CMHSP), and the service being identified in the Medicaid Provider Manual (1 CMHSP).

Note: As FY2016 was the first year the MEV review was completed directly by MSHN for SUD treatment providers a comparison was unable to made.

Performance Improvement

Performance improvement over previous MEV results was not measured as each CMHSP and Sub-Regional Entity tested varying standards prior to the development of the Medicaid Event Verification Process identified by the state in FY2016. The standardized elements being evaluated across the region will be measured for improvement going forward.

There were some common findings identified during the MEV reviews completed during FY2016 that included the lack of documentation for per diem and 15-minute community living supports, personal care, and skill building. This finding led to the creation of new documentation standards/forms by many of the providers who were found out of compliance with the requirement. Another issue that contributed to some deficiencies being noted was a lack of appropriate documentation being available during the MEV review. MSHN provided education and clarification as to what supporting documentation is needed to complete the primary reviews as well as shared best practices among the provider network. These actions, along with process changes and improvements in automated system verifications, is expected to increase the validation results and show improvement in the quality of documentation during the reviews completed for FY2017.

MSHN also reviews the verification results with the following council and committees:

Note: MSHN council and committee membership consists of representatives from each CMHSP.

- MSHN Regional Consumer Advisory Council
- MSHN Quality Improvement Council

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Future Outlook

MSHN is beginning its second year of reviews and will focus on plans of corrections from previous reviews to ensure indicated quality improvement is taking place. MSHN will work with the CMHSPs and the SUD provider network to collaboratively develop consistent documentation that adheres to best practice standards across the region. MSHN will evaluate the internal MEV policy and procedure on an ongoing basis to ensure compliance with Federal and State standards as well as to ensure consistency and best practices are followed.