MSHN

Mid-State Health Network

Annual Compliance Summary Report

October 2020 – September 2021

Prepared By: MSHN Compliance Officer – December 2021
Approved By: MSHN Compliance Committee – January 12, 2022
Reviewed By: Regional Compliance Committee – February 11, 2022
Operations Council – February 28, 2022
MSHN Board – March 02, 2022

Table of Contents

Introduction

The Compliance Summary Report provides an overview of the activities performed during Fiscal Year 2021 as part of the Compliance Program and identified within the Compliance Plan. Those activities include monitoring and oversight of the provider network completed as part of the internal site reviews, site reviews of the PIHP completed by external agencies; customer service complaints; compliance investigations and compliance related training and review.

Each section includes an overview of the activity, summary of the results, trends, and analysis of the data and recommendations for areas of quality improvement.

Recommendations for FY2022

The following recommendations include focus areas from the MSHN Compliance Plan and tasks/activities related to MSHN's strategic plan objectives that are supported by findings and outcomes identified during internal site reviews inclusive of the Delegated Managed Care (DMC) Interim review and the Medicaid Event Verification (MEV) review, external site reviews inclusive of the Health Services Advisory Group (HSAG) and the Michigan Department of Health and Human Services (MDHHS) reviews, contractual requirements and issues identified through the Customer Service and Compliance System.

Area of Risk: Claims are submitted in accordance with Medicaid rules and regulations.

> *Recommendation:* The Medicaid Event Verification site review results will be analyzed for trends of non-compliance with required standards on a quarterly basis and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.

Area of Risk: MSHN staff and provider network training/education on compliance regulations and rules.

> *Recommendation:* Develop a compliance webpage on MSHN's website providing current information on healthcare rules and regulations, education on current trends of non-compliance as identified through internal and external site reviews and identification of trainings on compliance related activities. The webpage will be updated as new information is available, including links to information regarding high-risk areas such as the Deficit Reduction Act (DRA).

Area of Risk: Compliance with program integrity activities as defined by the Office of Inspector General (OIG).

> *Recommendation:* Identify trends of non-compliant activities as reported on the Office of Inspector General quarterly activity report and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.
>
> *Recommendation:* Research options and determine feasibility for the completion of a compliance risk assessment region wide.

Area of Risk: Compliance with Person Centered Planning standards defined in the MDHHS Person-Centered Planning (PCP) Practice Guideline, Delegated Managed Care site review and the MDHHS waiver site review.

> *Recommendation:* PCP toolkit/training resource will be updated on a quarterly basis and made available to the provider network.
>
> *Recommendation:* Identification of additional training(s) and resources based on findings/outcomes from annual internal (DMC) and external (MDHHS) site reviews.
>
> *Recommendation:* MSHN will provide templates, formats and/or guidelines as identified through semi-annual review by CLC and QIC.

Area of Risk: Security/Privacy of Remote Work Environments

> *Recommendation:* Review process for Home Office/Off Site Office security and privacy of protected health information to ensure compliance with established standards, policies, and procedures.

Area of Risk: Adherence to telehealth rules

> *Recommendation:* Monitor for compliance with rules outlined during the state of emergency and those continued past the state of emergency.

Status on FY2021 Recommendations

The following recommendations are made based on findings and outcomes identified during internal site reviews inclusive of the Delegated Managed Care (DMC) Interim review and the Medicaid Event Verification (MEV) review, external site reviews inclusive of the Health Services Advisory Group (HSAG) and the Michigan Department of Health and Human Services (MDHHS) reviews, contractual requirements and issues identified through the Customer Service and Compliance System.

Each recommendation identifies the audit or compliance related activity that supports the recommendation and are intended to focus on an area of risk of non-compliance.

Internal Site Reviews

CMHSP Delegated Managed Care Reviews

Area(s) of Risk: Staff training completed according to requirements for Self Determination arrangements managed through Fiscal Intermediary Service (FMS) Providers.

> *Recommendation:* Require use of MDHHS Self-Direction Technical Implementation Guide (October 2020) which identifies roles of the FMS and provides information specific to training oversight. MSHN has recently updated the monitoring protocol to include this technical implementation guideline. CMHSPs will have more oversight and monitoring for the training.
>
> *Status: The MDHHS Self-Direction Technical Implementation Guide was not implemented by MDHHS during FY2021 due to concerns expressed from PIHPs and CMHSPs. Once the guide is released for implementation, then this will be revisited to ensure compliance with standard.*

SUD Delegated Managed Care Reviews

Area(s) of Risk: Providers not consistently and correctly using the adverse benefit determination (ABD) notices.

Recommendation: Education to be provided to the SUD Providers on proper use of ABD notices. SUD Provider will begin submitting quarterly data to MSHN (Customer Services) regarding the use of ABD notices which will allow for ongoing monitoring.

Status: The process of developing the ABD notices in REMI for the SUD providers to complete was completed during FY2021. Effective April 1, 2021, MSHN's Information Management System (REMI) began to be utilized to issue Adverse Benefit Determination (ABD) notices for MSHN's SUDSP provider network. Training to the SUD providers has been provided. The SUD providers will be required to complete ABD notices within REMI for FY2022 which will allow MSHN to provide better oversight and monitoring to ensure the requirements are being met.

Area(s) of Risk: Providers do not have a process for immediate reporting to the MSHN Compliance Officer regarding suspected fraud and abuse.

Recommendation: MSHN Compliance Officer to provide ongoing education via Constant Contact and SUD Provider quarterly meetings on what to report to the MSHN Compliance Officer and when.

Status: Education has been provided to providers via updates to the Compliance Plan, during the Regional Compliance Committee meetings and through the compliance training in Relias. During FY2022, further education will be provided through review of the MSHN compliance plan at an SUD quarterly provider meeting and semi-annual reminders through the Constant Contact.

Area(s) of Risk: SUD Providers not identifying and reviewing risk and critical events.

Recommendation: MSHN has a newly developed policy on requirements for reviewing and submitting critical events for SUD Providers. This policy should increase the understanding of the requirements. MSHN Quality Manager will work with SUD Providers in properly identifying critical incidents and in completing the required root cause analysis.

Status: This process has been implemented with the incident review policy for SUD providers. The quality manager has provided education during the SUD quarterly provider meetings and will continue to provide education on the reporting requirements and assisting with the completion of a root cause analysis on an individual basis.

Area(s) of Risk: Recovery Housing not consistently demonstrating coordination of care.

Recommendation: Provide ongoing education to SUD Providers on the both the requirement and benefits of completing proper coordination of care. For those who have repeat findings, consider doing review of implementation of corrective action plan prior to next annual review.

Status: For the Recovery Houses that had findings during the DMC review, they were required to submit a plan of correction on how they would show improvement within this area. Education was provided as part of the DMC reviews for those who were not meeting the standard as well as being referred to the MSHN SUD Treatment Team for follow up with the providers. Follow up on the implementation of the corrective action plans will need to occur prior to the next scheduled DMC site review.

External Site Reviews- Michigan Department of Health and Human Services

Area(s) of Risk: Behavior Treatment Plans being developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees for those on the Habilitation Supports

Waiver (HSW) was a repeat citation. This has been a citation during the full site reviews completed during FY2016, FY2018 and FY2020.

Area(s) of Risk: Plan of Service and Documentation Requirements for those on the Habilitation Supports Waiver (HSW) was a repeat citation. This included having services align with assessed needs, having measurable goals and objectives and amount, scope and duration implemented as specified in the plan.

Area(s) of Risk: Individuals on the Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP) and the Serious Emotional Disturbance Waiver (SEDW) were out of compliance with the standards for ensuring non-licensed service providers meet the provider qualifications identified in the Medicaid Provider Manual and the training requirements. This was a repeat citation.

Area(s) of Risk: Individuals on the Serious Emotional Disturbance Waiver (SEDW) received a repeat citation for Implementation of Person-Centered Planning (PCP) that included having plans developed through a PCP process consistent with Family Driven and Youth Guided Practice and Person-Centered Planning Policy Practice Guidelines.

> *Recommendation:* The Michigan Department of Health and Human Services (MDHHS) will be conducting a follow up review within 90 days following the end of the FY2020 review. Any additional findings will require a plan of correction and could result in additional action. MSHN should look at additional monitoring needs, training and education opportunities, standardization of practices where necessary, and appropriate council/committee/workgroup involvement to ensure compliance with these standards.
>
> *Status: The Behavior Treatment Plan Review Committee is now being chaired by MSHN's HCBS Manager and reviewed through the MSHN Clinical Leadership Committee to assist with ensuring compliance with the standards. In addition, MSHN is working on ongoing development of training and education resources for Person Centered Planning, goal writing, etc. MSHN received full compliance during the FY2021 MDHHS Waiver follow up site review.*

External Site Reviews- Health Services Advisory Group

Area(s) of Risk: The Performance Improvement Project "Patients with Schizophrenia and Diabetes who had an HbA1c and LDL-C test" received a score of "Not Met" for the remeasurement 1 period as the improvement shown was not statistically significant.

> *Recommendation:* MSHN will review the interventions quarterly to ensure improvement towards the goal is being achieved. MSHN will also ensure ongoing validation of data for this and all future projects to ensure the appropriate data is being collected and reviewed in alignment with the identified measures.
>
> *Status: The interventions and data were reviewed quarterly by the Regional Quality Improvement Council during FY2021 to ensure the data was validated and the interventions were showing improvements towards the identified goals. The increased efforts of review and validation of data led to full compliance for the PIP during FY2021.*

Customer Service

Area(s) of Risk: Ensuring the Provider Network follows timeliness standards related to grievances and appeals and the issuance of Adverse Benefit Determinations. This was also an issue noted during the HSAG Compliance review.

> *Recommendation:* MSHN will work on developing standardized practices for issuing adverse benefit determination notices. MSHN will also utilize REMI to both issue adverse benefit determination notices and track timeliness for grievance and appeal resolutions. This will be tracked as part of the quarterly customer services report.

Status: The ABDs have been developed in REMI and the SUD Providers now use REMI when issuing ABD's. The ABD forms have also been standardized as part of the grievance and appeal module in PCE for the CMHSPs to utilize. The forms were standardized through the efforts of a workgroup comprised of PCE staff and regional/statewide customer service staff. REMI will be able to be utilized to track timeliness as well as the new MDHHS report template for grievances, appeals and service authorizations.

Compliance

Area(s) of Risk: MSHN has many open, unresolved cases with the Office of Inspector General (OIG). These are based on referrals made to the OIG from MSHN. All open cases with the OIG, results in having potential inappropriate claims that have not yet been voided and federal and state funds paid for services that may require recoupment.

Recommendation: MSHN's Compliance Officer will continue to work with the OIG on all open cases to try to bring them to resolution.

Status: MSHN's Compliance Officer has continued to work with the OIG by contacting them via phone and emails to get status updates on open referrals. The OIG contacted the PIHP in September 2021 to indicate they would be setting up individual meetings with each PIHP to discuss the open referrals.

Monitoring and Auditing

Mid-State Health Network Internal Site Reviews

The following is a snapshot of the site review results for both the Community Mental Health Service Providers (CMHSP) and the Substance Use Disorder (SUD) Providers. For complete information, please see the Delegated Managed Care and Program Specific Site Review Summary Report 2021.

CMHSP Provider Delegated Function Reviews

During Fiscal Year 2021 nine (9) of the twelve (12) CMHSPs received a delegated managed care (DMC) review. The full review includes a preview of programs, policies, procedures, and a sample of case files and charts.

Delegated Managed Care Review Tool Results

Includes review of 192 standards. The focus of this section is to ensure compliance with requirements.

Table 1: DMC Tool

DMC Standards	# Of Standards	2021 Results
Information Customer Service	13	99.57%
Enrollee Rights and Protections	9	100%
24/7/365 Access	17	94.81%
Provider Network Sub-Contract Providers	14	100%
Service Authorization and UM	7	96.83%
Grievance and Appeals	20	99.06%

DMC Standards	# Of Standards	2021 Results
Person Centered Planning	30	99.81%
Coordination of Care/Integration	6	96.30%
Behavior Treatment Plan Review Committee	21	77.51%
Consumer Involvement	3	100%
Provider Staff Credentialing	22	91.08%
Quality and Compliance	7	100%
Ensuring Health and Welfare	8	96.03%
Information Technology	9	100%
Trauma Informed Care	6	99.07%
Overall		**95.45%**

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Clinical Chart Review Results

Includes review of eighty-five (85) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 93.11%.

Table 4: Clinical Chart Review Tool

Clinical Chart Standards	# Of Standards	2021 Results
Intake/Assessment	13	96.01%
Pre-Planning	10	87.91%
PCP/IPOS	21	92.37%
Documentation	3	100%
Customer Service	5	95.58%
Delivery and Evaluation	3	89.25%
Service Delivery	23	92.74%
Discharge/Transfers	4	100%
Integrated Physical/Mental Health Care	3	97.66%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year

SUDSP Treatment Provider Delegated Function Reviews

During FY2021, both full and interim reviews were completed. The interim reviews consist of any new standards and to ensure implementation of approved corrective action plans from the previous year's review. Interim reviews do not receive a score. Full reviews consist of chart reviews, validation of process requirements, staff files, policies, and procedures. Reviews by provider are inclusive of all provider sites. For providers that are outside of the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region the providers are located.

The QAPI team conducted 15 full reviews and 10 interim reviews from January 2021 – September 2021.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of 111 standards. Overall compliance during this timeframe for full reviews is 93.58%.

Table 8: SUD Delegated Functions Scores

Delegated Functions Standards	# Of Standards	2021 Results
Access and Eligibility	4	83.93%
Information and Customer Service	17	98.74%
Enrollee Rights and Protections	14	99.73%
Grievance and Appeals	17	93.07%
Quality and Compliance	15	97.54%
Individualized Treatment & Recovery Planning & Documentation	17	92.22%
Coordination of Care	4	88.18%
Provider Staff Credentialing	22	85.88%
IT Compliance/IT Management	1	100%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Clinical Chart Review Results

The SUDSP treatment chart review tool includes a total of fifty-four (54) standards. Overall compliance during this timeframe for full reviews is 76.52%.

Table 10: SUD Program Specific Scores

SUDSP Chart Reviews	# Of Standards	2021 Results
Screening, Admission, Assessment	8	83.62%
Treatment/Recovery Planning	10	76.83%
Progress Notes	2	81.18%
Coordination of Care	4	56.09%
Discharge/Continuity of Care	3	62.50%
Residential	5	70%
Medication Assisted Treatment	15	86%
Women's Designated/Women's Enhanced	1	60.71%
Recovery Housing	6	75%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Medicaid Event Verification (MEV) Site Reviews

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an onsite review or a desk 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.

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.) Services were provided by a qualified individual and 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.

The following is a summary of the MEV Annual report. For complete information, please see the Medicaid Services Verification Methodology Report for Fiscal Year 2021.

The CMHSP site reviews are completed bi-annually (twice a year) for all twelve CMHSPs. The table below includes the score per CMHSP for all attributes reviewed.

Data presented in the below chart is relative to the 12 CMHSP's for the full fiscal year, October1, 2020 – September 30, 2021.

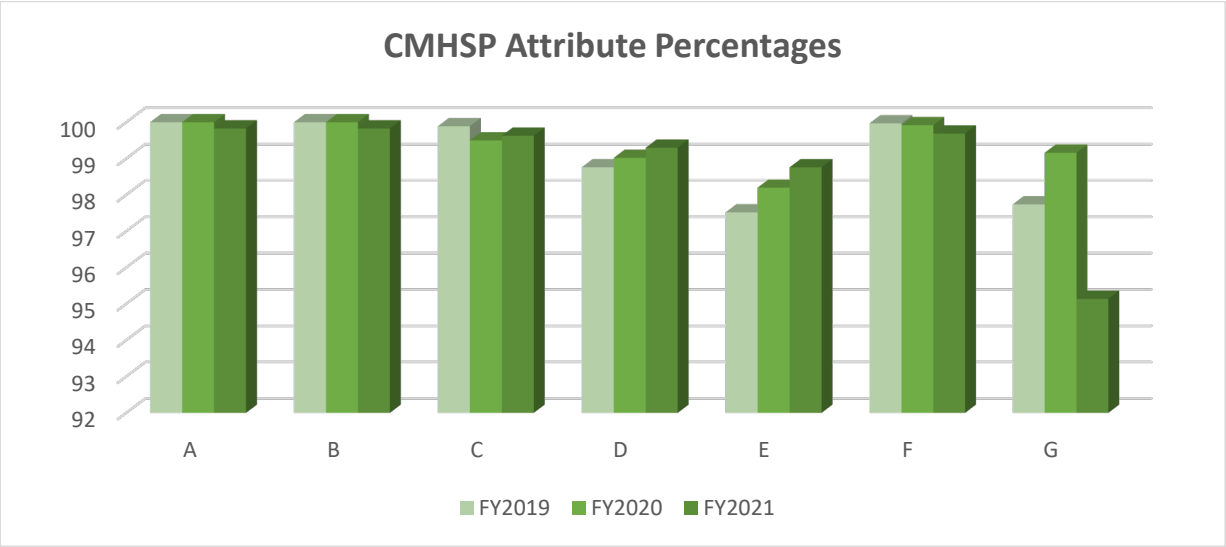
CMHSP

	A	B	C	D	E	F	G
BABHA*	100%	100%	100%	99.74%	100%	100%	100%
CEI	100%	100%	100%	100%	99.00%	100%	100%
CMHCM	100%	100%	98.78%	98.31%	97.68%	98.78%	96.41%
Gratiot*	100%	100%	100%	98.97%	98.15%	100%	99.04%
Huron	100%	100%	99.92%	99.92%	99.01%	99.52%	99.57%
Lifeways*	100%	100%	99.28%	98.79%	99.76%	100%	78.86%
Montcalm	100%	100%	100%	99.63%	99.91%	99.96%	96.67%
Newaygo	97.97%	97.97%	97.96%	97.51%	96.76%	97.96%	73.69%
Saginaw*	100%	100%	100%	99.94%	100%	100%	100%
Shiawassee*	100%	100%	100%	99.76%	100%	100%	100%
The Right Door	100%	100%	100%	99.88%	97.92%	100%	98.72%
Tuscola	100%	100%	100%	99.82%	96.94%	100%	98.71%
MSHN Average	**99.83%**	**99.83%**	**99.63%**	**99.30%**	**98.76%**	**99.69%**	**95.14%**

**Denotes the CMHSPs that only had one MEV review completed FY20 due to the need to reschedule because of COVID-19. These CMHSPs will have the second review completed in FY21.*

For the CMHSPs who had two reviews completed during the fiscal year, the percentage is an average of the scores for both reviews.

The following chart provides a comparison from FY2019 through FY2021 for the attributes tested:



The Substance Use Disorder site reviews are completed annually. Data presented in the below chart is relative to the 37 SUD treatment providers reviewed for the full fiscal year, October1, 2020 – September 30, 2021.

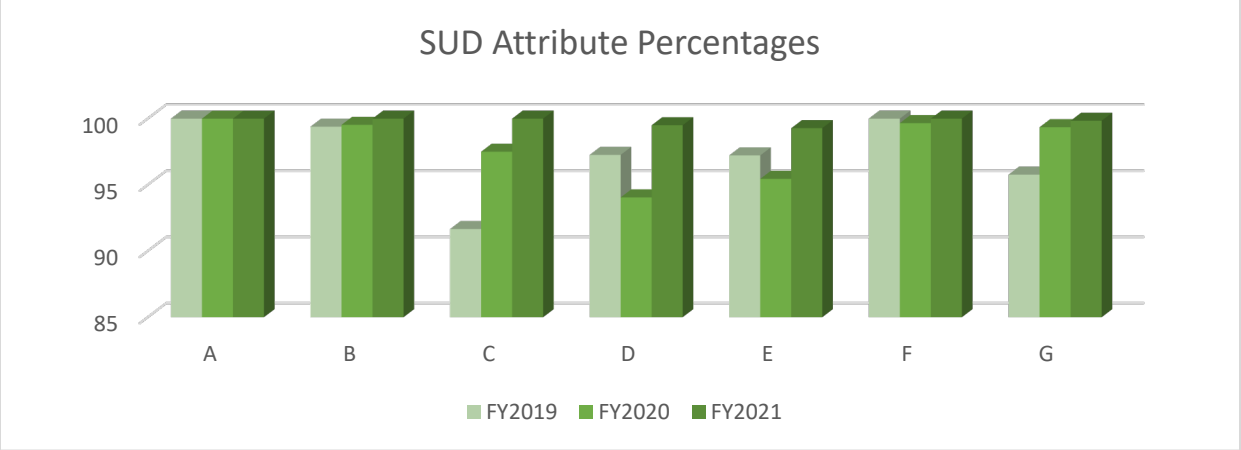
The chart below includes the score for all SUD providers combined for each attribute reviewed.

SUD

	A	B	C	D	E	F	G
SUD Providers	100%	100%	100%	99.50%	99.28%	100%	99.84%

Note: This chart represents an average of the scores for all 37 SUD providers who had an individual site review and those involved in the combined single site review.

The following chart provides a comparison from FY2019 through FY2021 for the attributes tested:



Note: The above chart does not include the same SUD providers from year to year but is representative of the region.

Results/Trends

Based on the MEV review for FY2021, 12 CMHSPs were placed on a new plan of correction and of the 37 substance use disorder treatment providers reviewed, 7 were placed on a new plan of correction. In addition, all CMHSPs and substance use disorder treatment providers who were placed on a plan of correction during FY2020, were removed from those plans during FY2021.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and indirect services of $172,561.76 and $39,892.40 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

Regionally the CMHSPs have shown slight improvements from FY2020 to FY2021 for the following attributes:

1. C: Service is included in the beneficiary's individual plan of service.
2. D: Documentation of the service date and time matches the claim date and time of the service.
3. E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed.

Regionally the SUD providers review showed improvements from FY2020 to FY2021 for the following attributes:

1. B: Beneficiary is eligible on the date of service.
2. C: Service is included in the beneficiary's individual plan of service.
3. D: Documentation of the service date and time matches the claim date and time of the service.
4. E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed.
5. F: Amount billed and paid does not exceed contractually agreed upon amount.
6. G: Modifiers are used in accordance with the HCPCS guidelines.

Monitoring and Auditing

Mid-State Health Network External Site Reviews

MDHHS Waiver Site Reviews

The Michigan Department of Health and Human Services (MDHHS) conducted a follow up desk review for our region from February 17, 2021 through April 30, 2021. The purpose was to review the implementation status and effectiveness of the corrective action plan, completed for the full review in FY2020, for the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW) and the Children's Waiver Program (CWP).

The MDHHS site review staff assessed whether the actions taken by the PIHP were effective in correcting the findings noted during the initial site review. The review staff found the actions taken by the PIHP were effective in correcting the findings noted during the initial site review.

MDHHS Substance Use Disorder Site Review

There was no follow up review required during FY2021. MSHN received full compliance on all standards reviewed by the Michigan Department of Health and Human Services (MDHHS) for compliance with the Substance Use Agreement with the Centers for Medicare and Medicaid services during FY2020.

MDHHS- Health Services Advisory Group (HSAG): Performance Measurement Validation (PMV) Site Review

Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration, conducted the validation activities for the prepaid inpatient health plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients. The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements.

HSAG completed MSHN's review remotely on June 22, 2021.

For this review, HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). The review consisted of interviews, system demonstrations, review of data output files, primary source verification, observation of data processing and review of data reports.

Compliance was assessed through a review of the following:

- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports
- Supporting documentation
- Evaluation of system compliance

The following is a summary of the PMV site review report. For complete information, please see the Health Services Advisory Group Validation of Performance Measures State Fiscal Year 2021.

Results/Trends

MSHN received a status of "Reportable" indicating the performance indicators were compliant with the State's specifications and the rate can be reported.

- The Data Integration and Control- Thirteen Standards: 100%
- Denominator Validation - Seven Standards (2 NA): 100%
- Numerator Validation – Five Standards: 100%
- Performance Measures- Fourteen Measures Fully Validated: 100%

Recommendations

Most of the recommendations from this review included completing additional validations on MSHN's quarterly submissions against its own encounter data prior to submission to MDHHS.

MSHN has received full compliance (100%) for all elements reviewed from the first review in FY2014 through the current review in FY2021. No corrective action is required to be submitted to HSAG.

MDHHS- Health Services Advisory Group (HSAG): Compliance Monitoring Review

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, its agent that is not a Medicaid prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO) must conduct a review to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance monitoring reviews of the PIHPs.

The Compliance Site Review is conducted over a period of 3 years. HSAG conducted a review of the first 6 standards for year one in FY2021. The remaining 7 standards will be reviewed in FY2022. The third year is used for a focused review on those standards that received a "not met" the previous two years resulting in a corrective action plan. The third year (2023) score is the score of all standards after the CAP has been completed.

During State Fiscal Year (SFY) 2021, HSAG completed a desk audit on July 19, 2021.

Note: Changes were made to this review for FY2021 that included aligning the review tools with Federal Managed Care Final Rule. The compliance review standards in Michigan were reduced from 17 standards to 13 standards. The standards for Staff Qualifications and Training; and Disclosure of Ownership, Control and Criminal Convictions were removed. Standards related to the validation of the Network Adequacy were included.

Results/Trends

The table below represents an overview of the results for FY2021. Due to the changes made to the site review standards beginning this year, it is not possible to complete an accurate comparisons on these standards to previous years.

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	13	1	0	**93%**
VI	Coverage and Authorization of Services	11	11	10	1	0	**91%**
	Total	**65**	**65**	**55**	**10**	**0**	**85%**

***M** = Met; **NM** = Not Met; **NA** = Not Applicable*

***Total Elements:** The total number of elements within each standard.*
***Total Applicable Elements:** The total number of elements within each standard minus any elements that were NA. This represents the denominator.*
***Total Compliance Score:** The overall percentages were obtained by adding the number of elements that received a score of Met (1 point), then dividing this total by the total number of applicable elements.*
**Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.*

MSHN demonstrated compliance in 55 out of 65 elements, with an overall compliance score of 85 percent. This indicated that MSHN had necessary policies, procedures and initiatives in place to carry out many of the required functions of the contract, while other areas demonstrated opportunities for improvement.

MSHN was required to submit a corrective action plan for all elements that scored below 100%

MDHHS- Health Services Advisory Group (HSAG): Performance Improvement Project (PIP)

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid consumers in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

MSHN's Performance Improvement Project for 2018 through 2021 was: *The percentage of Patient with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the measurement period.*

Remeasurement period 2 had a goal of a 7% increase over the remeasurement period 1 rate of 36.1%. This equates to a remeasurement period 2 goal of 38.6%.

Results/Trends

MSHN received a status of "Met" indicating High confidence in reported PIP results.

HSAG reviewed the PIP for 9 evaluation elements. MSHN received 100% for all elements.
- Percentage Score of Evaluation Elements Met: 100%
- Percentage Score of Critical Elements Met: 100%

The following figure shows the results for the diabetes monitoring for baseline year through remeasurement year 2.

Study Indicator Results				
Study Indicator	**Baseline (1/1/2018–12/1/2018)**	**Remeasurement 1 (1/1/2019–12/31/2019)**	**Remeasurement 2 (1/1/2020–12/31/2020)**	**Sustained Improvement**
Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period	33.6%	36.1% ⇔	49.2% ↑*	

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↑* The remeasurement rate demonstrated statistically significant improvement ($p < 0.05$) over the baseline rate.

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.
- Seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.
- Reference the PIP Completion Instructions annually to ensure that all requirements for

each completed step have been addressed.

Customer Service/Compliance Reporting

Customer Service Contacts

The total number of Customer Services contacts received in FY2021 were 104, a decrease of 21.8% from FY2020. By comparison, there were 133 contacts in FY2020, and the decrease continues a downward trend of overall contacts from previous years. The decrease is largely associated with a 27.9% decrease in CMHSP and SUDSP technical assistance requests credited to the ongoing commitment of MSHN's Customer Service department to assist providers in improving their quality of services. Additionally, there was a 71.4% decrease in FY21 for general community (other) requests for assistance.

Customer Service Originator of Contact

Originator	Number	Percentage*
Advocate	1	1%
Authorized representative	1	1%
CMHSP	27	26%
Guardian	1	1%
MDHHS	12	12%
Other	4	4%
Parent of a minor	8	8%
Self/Consumer	33	32%
SUDSP	17	16%

*(*the percentage indicates the originator category number compared to the total number of contacts*
Note: Numbers are rounded up, so the sum of the percentages equals slightly more than 100%)

Customer Service Inquiry Category

Category	Number	Percentage*
Access to Treatment	10	10%
Appeal	3	3%
Authorization	1	1%
Complaint/Dissatisfaction	14	13%
Consumer Discharge	2	2%
Denial of Services	2	2%
General Assistance	33	32%
Grievance	2	2%
LEP Assistance	1	1%
Medicaid Fair Hearing	1	1%
Notification Letter	3	3%
Provider Practices	23	22%
Provider Staff Concern	3	3%
Recipient Rights Assistance	3	3%
Recipient Rights Complaint	3	3%

*(*the percentage indicates the originator category number compared to the total number of contacts*
Note: Numbers are rounded up, so the sum of the percentages equals slightly more than 100%)
Conclusion/Resolution:

Type of Resolution	Number	Percentage*
No follow-up required	38	37%
Resolution pending	9	9%
Resolved in favor of consumer	3	3%
Resolved through follow up actions	54	52%

*(*the percentage indicates the originator category number compared to the total number of contacts*
Note: Numbers are rounded up, so the sum of the percentages equals slightly more than 100%)

Results/Trends

The following trends/changes were noted during FY2021:

- Overall Customer Service contacts decreased by 21.8% in FY2021 (104) from FY2020 (133)
- Consumer contacts requiring follow-up action increased from 49% (n=65) in FY2020 to 63% (n=66) in FY2021.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (32% / n=33)
- The highest number of non-consumer customer service contacts originated from CMHSP staff (26% / n=27)
- The highest consumer complaint category involved complaints addressing Provider Practices (22% / n=23)
- The highest non-consumer contact category involved requests for General Assistance (32% / n=33)

FY21 MDHHS Grievance Reporting

As part of MDHHS' State monitoring activities, PIHPs were required to submit Grievance reporting information using the state developed reporting template. The initial MDHHS Grievance reporting submission covered FY21 Q1-Q2 and was submitted to MDHHS on May 15, 2021. Report data submissions are on a quarterly basis and the final report covering FY21 Q1-Q4 was submitted to MDHHS on November 15, 2021.

FY21 MDHHS Grievance Reporting Results							
Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	88	0.29	50	0.16	100	86	24
ACCESS AND AVAILABILITY	33	0.11	21	0.07	34	33	25
INTERACTION WITH PROVIDER OR PLAN	24	0.08	17	0.06	30	24	19
MEMBER RIGHTS	1	0.00	1	0.00	1	1	5
TRANSPORTATION	1	0.00	1	0.00	1	1	6
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	1	0.00	1	0.00	1	1	0
SAFETY/RISK MANAGEMENT	3	0.01	3	0.01	3	3	13
SERVICE ENVIRONMENT	2	0.01	2	0.01	2	2	33
OTHER	3	0.01	2	0.01	3	3	10
Total	156	0.51	98	0.32	175	154	23
*Field will display "#DIV/0!" if there are no reported cases per category.							

FY21 MDHHS Member Appeals Reporting

As part of MDHHS' State monitoring activities, PIHPs were required to submit Appeals reporting information using the state developed reporting template. The initial MDHHS Appeals reporting submission covered FY21 Q1-Q3 and was submitted on August 15, 2021. Report data submissions are on a quarterly basis and the final report covering FY21 Q1-Q4 was submitted to MDHHS on November 15, 2021.

FY21 MDHHS Member Appeals Reporting Results						
Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
MEDICAL NECESSITY CRITERIA NOT MET	20	0.07	20	0	0	0
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0
CLINICAL DOCUMENTATION NOT RECEIVED	1	0.00	1	0	0	0
TREATMENT/SERVICE PLAN GOALS MET	1	0.00	1	0	0	0
MEMBER NOT ELIGIBLE FOR SERVICES	13	0.04	13	0	0	0
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	19	0.06	18	1	0	0
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0
OTHER	13	0.04	12	0	1	0
NOT APPLICABLE	188	0.61	184	1	2	1
Total	255	0.83	249	2	3	1

	Count	Percentage
Appeals	255	N/A
Appeals Upheld	56	22%
Appeals Overturned	191	75%
Appeals Partially Upheld/Overturned	8	3%

Due to this reporting process being new, the data has not yet been reviewed and analyzed. For FY2022, the grievance and appeal data will be reviewed through the Regional Customer Service Committee to identify trends and potential quality improvement efforts.

Activities Implemented in FY2022

The following activities were implemented during FY2021.

- The Utilization of MSHN's Information Management System (REMI) to issue Adverse Benefit Determination (ABD) notices for MSHN's SUDSP provider network began April 1, 2021. This enhancement will assist SUDSP provider staff in completing ABD notices with all the required elements for ABDs. The 2021 HSAG Compliance review identified the need to provide greater oversight of the ABD process. Secondarily, MSHN staff will have greater access to ABD notices which will improve the quality and compliance of notices during DMC reviews and periodic reviews by Customer Service staff.
- The Utilization of MSHN's Information Management System (REMI) access for MSHN's SUDSP provider network to complete the Grievance and Appeals resolution processes within the REMI system. This enhancement will assist SUDSP provider staff in following the prescribed format and requirements of the Grievance and Appeals resolution processes. Additionally, MSHN staff will be able to directly draw Grievance and Appeals data for SUDSP providers for the quarterly MDHHS Grievance and Appeals reporting.

- Process finalization for the inclusion of Consumer Representatives on MSHN's Customer Service Committee (CSC). Consumer Representatives will assist CSC members through providing a consumer-focused perspective on the CSC.
- MSHN Customer Services continued to work in coordination with the MSHN treatment team to provide technical assistance to improve quality of services for providers within MSHN's SUDSP network.
- Ongoing technical support and training to the provider network in areas of customer service, grievance and appeals and recipient rights.

Recommendations for FY2022

Based upon FY21 Customer Service data, the following is being recommended:

- The 2021 HSAG Compliance review identified that Adverse Benefit Determinations (ABD) did not contain all the required element necessary. The MSHN Customer Service Committee (CSC) reviewed the findings and will be developing a targeted ABD training to assist provider staff in completing ABD notices according to the requirement standards.
- A resolution standard for Grievances and Appeals reporting will be established and providers who do not meet the standard may be required to provide a quality improvement plan.
- Ongoing review of applications and selection of consumer representatives by the Customer Service Committee as needed.
- Continue to provide technical support and training to providers in the areas of customer service, grievance, appeals and recipient rights.

Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2021 was 16. By comparison, there were 18 completed in FY2020. This resulted in a decrease of 11.1% in FY2021 from FY2020.

Compliance Investigations:
(The percentage indicates the percent the originator represents of the total complaints.)

Originator:	***Number:***	***Percent:***
SUD Provider Staff	2	12.50%
CMHSP Staff	1	6.25%
MDHHS Staff	1	6.25%
MSHN Staff	10	62.50%
Former CMHSP/SUD Staff)	2	12.50%

Type of Compliance Investigation:
(The percentage indicates the percent the type represents of the total complaints.)

Category:	***Number:***	***Percent:***
Fraud/Abuse/Waste	5	31.25%
Treatment/Services	1	6.25%
Ethical Violations	4	25.00%
Duplicate Claims	2	12.50%
Over Payment for Services	2	12.50%
MEV Review Correction	1	6.25%
Retaliation	1	6.25%

Conclusion/Resolution:
(The percentage indicates the percent the resolution represents of the total complaints.)

Type of Resolution:	***Number:***	***Percent:***
CMHSP	2	12.50%
SUD Provider	9	56.25%
MSHN Staff	3	18.75%
MDHHS Staff	1	6.25%
Pending OIG Resolution	1	6.25%%

Referrals to Outside Regulatory Bodies: (based on contractual requirements)
(The percentage indicates the percent the referral represents of the total complaints.)

Agency:	***Number:***	***Percent:***
Office of Inspector General	1	6.25%

MSHN continues to have 17 open, active cases with the Office of Inspector General (OIG). This includes 5 cases that were referred by the OIG to MSHN and 12 referrals from MSHN to the OIG for suspected fraudulent activities. Many cases date back to FY2019, with one dating back to FY2017. The approximate recoupment amount for all 17 cases equals $534,063.86. MSHN's Compliance Officer will continue to follow up with the OIG on these open cases.

Office of Inspector General Quarterly Report for FY2021

Beginning Fiscal Year 2019, the PIHPs were required to track and report program integrity activities performed within the region. The program activities must include, but not limited to, the following activities: data mining, analysis of paid claims, audits performed, overpayments collected, identification of fraud, waste and abuse, provider dis-enrollments and contract terminations.

FY2021 Q1: 40 activities were reported
FY2021 Q2: 86 activities were reported
FY2021 Q3: 37 activities were reported
FY2021 Q4: 59 activities were reported

Most of the activities reported were a result of local and region wide Medicaid Event Verification activities and clinical record reviews. The activities reported included lack of supporting documentation, wrong use of modifiers, billing for incorrect dates and times, overlapping claims, incorrect service codes and overpayment.

Data Mining Activities

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2021, MSHN completed the following data mining activities.

1. Death Data Report
    a. This report compares the death list from Care Connect 360 to service data from MSHN's information management system. There should be no instance where a service is provided to a recipient after the date of death.
2. Comparison for telehealth, face-to-face and overall encounters
    a. The report reviews data that compares the current month encounters with the average of all previous month's encounters with the fiscal year. The report is based on encounters that have been accepted by MDHHS.

Results/Trends

The following are the data mining activities and results for FY2021 Q1.

1) Death Data Report
    a. There were 64 unique recipients identified on the death list.
    b. This included 702 encounters for individuals whose date of death, and service range, occurred between October 1, 2020 through December 28, 2020.
    c. Results: It was concluded that there were six instances, involving 3 clients, where a service was identified as provided after the date of death.
    d. All issues were corrected

The following are the data mining activities and results for FY2021 Q2.

1. Death Data Report
    a. There were 75 unique recipients identified on the death list.
    b. This included 681 encounters, for individuals whose date of death, and service range, occurred between January 1, 2021 through March 11, 2021.
    c. Results: There were no instances where a service was provided after the date of death. No further analysis necessary.

The following are the data mining activities and results for FY2021 Q3.

1. Death Data Report
    a. There were 59 unique recipients identified on the death list.
    b. This included 588 encounters, for individuals whose date of death, and service range, occurred between April 1, 2021 through June 30, 2021.
    c. Results: There were six instances, involving 4 beneficiaries, where a service was provided after the date of death.
    d. All issues were corrected.

The following are the data mining activities and results for FY2021 Q4.

1. Death Data Report
    a. There were 54 unique recipients identified on the death list.
    b. This included 318 encounters, for individuals whose date of death, and service range, occurred between July 1, 2021 through September 30, 2021.
    c. Results: There were seven instances, involving two beneficiaries, where a service was identified as provided after the date of death.
    d. All issues are in process of being corrected.
2. Telehealth and Face-to-Face Comparison
    a. The comparison of telehealth, face-to-face and overall encounters did not have any significant variance when compared to the average of previous months encounters within fiscal year 2021.

Subpoena(s)

MSHN received eight subpoenas during FY2021 requesting client specific information regarding treatment and services to be utilized in civil lawsuits. Through a thorough search of all available data bases and records, it was determined that MSHN only possessed records for one, out of the eight, request for information.

In addition, MSHN also received a subpoena requiring MSHN to provide documentation pertaining to Self Determination arrangements at the CMHSP level. MSHN complied with the request by providing non-consumer identifying documentation.

MSHN was not the plaintiff nor the defendant in any of the cases.

Notification of Breach(s):

During FY2021, within the MSHN region, there were four instances reported to MSHN from the provider network involving a breach of protected health information. All four instances were reported from CMHSPs. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future reoccurrence. All instances were able to be remediated at the local level and did not require reporting to MDHHS.

Results/Trends

While there were fluctuations in numbers and percentages from the previous year, there were no discernible trends identified that warrant any action.

Compliance investigations:

- There was an increase in the total number of compliance issues reported from MSHN staff and a decrease in reports from CMHSP staff.
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 31.25%.
- Fourteen investigations were completed and achieved a closed status.
- Two investigations continue to be ongoing.

OIG quarterly report:

- FY2021 had a decrease in the number of reported activities from FY2020.
- The largest number of findings reported include the following:
    - Lack of documentation to support the claims submitted
    - Service times on documentation not matching times on billing record
    - Use of modifiers

Subpoenas:

- There was a notable increase in the number of subpoenas received during FY2021.
- Only one subpoena involved a consumer that was served within the region.
- The number of subpoenas received cannot be influenced by any actions by MSHN.

Breaches:

- There were a similar number of breach notifications in FY2021 as in FY2020
- In all instances, the cases were remediated locally and did not require state level reporting

Activities Implemented in FY2021

The following activities were implemented during FY2021.

- Data Mining Activities included:
    - Death Audit Compared to Encounters
    - Comparison for telehealth, face-to-face and overall encounters
- Review and revision of the MSHN Compliance Plan
- Review and revision of MSHN's compliance policies and procedures
- Developed and finalized a standardized compliance training, and post-test, through the PIHP Compliance Officers Workgroup and the Regional Compliance Committee
- Ensured compliance with updates to state and federal policies and regulations, including but not limited to:
    - Department of Justice Compliance Program Guidelines
    - Office Guidance of Civil Rights Protections

- Summary of 42 CFR Part 2 Final Rule
- COVID-19 requirements
- 21st Century Cures Act
- CMS Patient Access Rule

Recommendations for FY2022

The following are recommendations for improvements in FY2022.

- Work with PCE to implement the changes to the OIG quarterly activities report being required for FY2022
- Include the standardized compliance training and post-test within Relias for MSHN staff
- Identify region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Utilize the Constant Contact for compliance related updates for SUD providers
- Work with the OIG to close all open referral cases

Compliance Training/Review

Internal

MSHN Compliance Committee

Reviewed and Approved MSHN Compliance Plan on August 11, 2021
Compliance Policies and Procedures

MSHN Regional Compliance Committee

Reviewed and Approved MSHN Compliance Plan on August 20, 2021
Compliance Policies and Procedures

MSHN Operations Council

Reviewed and Approved MSHN Compliance Plan on September 20, 2021
Compliance Policies and Procedures

MSHN Staff

Receive Compliance Training as part of new hire orientation
Compliance Training for ongoing staff training through Relias
Compliance Plan
Compliance Policies and Procedures

Board of Directors

Received and approved MSHN Compliance Plan on November 02, 2021

External

MSHN Compliance Plan and Compliance Line Available on Website- Compliance calls are received through the Compliance Line, the main line of MSHN or through the direct line to the Chief Compliance and Quality Officer.

MSHN Customer Service Line Available on Website - Customer Service calls are received through the Customer Services Line, the main line of MSHN or through the direct line to the Customer Services and Rights Specialist.

MSHN Contact information and reporting process located in Consumer Member Handbook “Guide to Services.”

References

The following documents were used in the completion of the Compliance Summary Report and can be found in their entirety on Mid-State Health Networks website at: https://midstatehealthnetwork.org/

1. Delegated Managed Care and Program Specific Site Review Summary Report 2021
2. Medicaid Services Verification Methodology Report for Fiscal Year 2021
3. MDHHS HSW, CWP and SEDW site review follow up letter
4. Health Services Advisory Group State Fiscal Year 2021 Validation of Performance Measures for Region 5 – Mid-State Health Network
5. Health Services Advisory Group State Fiscal Year 2021 Compliance Review for Pre-Paid Inpatient Health Plans
6. 2020-2021 PIP Validation Report: Patient With Schizophrenia and Diabetes Who Had an HbA1c and LCL-C Test