MSHN

Mid-State Health Network

Annual Compliance Summary Report

October 2022 – September 2023

Prepared By: MSHN Compliance Officer – January 2024
Approved By: MSHN Compliance Committee – February 14, 2024
Reviewed By: Regional Compliance Committee – February 16, 2024
Operations Council – February 26, 2024
MSHN Board – March 05, 2024

Table of Contents

Introduction

The Compliance Summary Report provides an overview of the activities performed during Fiscal Year 2023 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 FY2024

The 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.

Note: If there is already an established process in place for monitoring and oversight where a deficiency was noted, there was not a recommendation made to avoid any duplication of efforts.

Area of Risk: Compliance with established Customer Service standards.

> *Recommendation:* Implement quality improvement initiatives based on data from the quarterly Appeal and Grievance Regional Analysis Report.
>
> *Recommendation:* Develop a process to gather data related to limited English proficiency (LEP) from local county analysis for the prevalence of non-English languages and monitor compliance with LEP standards.
>
> *Lead Staff*: Dan Dedloff, Customer Service and Rights Manager

Area of Risk: Compliance with established Compliance and Program Integrity related standards.

> *Recommendation:* Identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards.
>
> *Recommendation:* Utilize communication means such as newsletters, emails, website, etc. to provide updates and education to providers.
>
> *Recommendation:* Research options and implement a new process for tracking compliance investigations and documentation.
>
> *Recommendation:* Update Compliance related policies and procedures and MSHN Compliance Plan to ensure compliance with new program integrity contract language.
>
> *Recommendation:* Develop processes to track new OIG data requirements such as cost avoidance, recoupments, etc.

Recommendation: Develop training opportunities to promote compliance with state and federal requirements.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Delegated Managed Care Site Reviews

Recommendation: Review standards that have ongoing lower compliance scores to determine if region wide quality improvement efforts are needed as well as provider education.

Lead Staff: Amy Dillon, Compliance Administrator

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group-Performance Measure Validation review).

Recommendation: MSHN will complete the proposed corrective action to review all abnormal disposition completed dates and times as part of its validation check.

Recommendation: MSHN will continue its efforts to meet with CMHSPs and provide further training when errors occur.

Recommendation: MSHN will employ additional enhancements to the PIHP's validation process to ensure appropriate categorization of compliant cases and capture of exceptions.

Recommendation: MSHN will perform additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting.

Lead Staff: Sandy Gettel, Quality Manager & Steve Grulke, Chief Information Officer

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group-Performance Improvement Project review).

Recommendation: MSHN should ensure that it follows the approved PIP methodology to calculate and report the remeasurement data accurately in next year's submission.

Recommendation: MSHN should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions.

Recommendation: MSHN should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

Lead Staff: Sandy Gettel, Quality Manager

The following recommendations were identified for FY2023 and are being continued for FY2024. There has been progress made, but the recommendations have not been fully implemented.

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). Staff will also receive monthly compliance related education via email. The email will also include links to the compliance webpage.

Status: The webpage has not been completed. There have been discussions during the Regional Compliance Committee regarding the information that should be included on the webpage. The webpage will be completed during this fiscal year.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

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.

Status: This task was put on hold this past year as a workgroup that included members from CMHSPs, PIIHPs, MDHHS and TBD worked on developing guidance documents for person centered planning. The Chief Compliance and Quality Officer and Chief Behavioral Health Officer participated in the workgroup. The information developed by the workgroup will be utilized and made available to the provider network.

Recommendation: MSHN will provide templates, formats and/or guidelines as identified through semi-annual review by CLC and QIC.

Status: The Clinical Leadership Committee and Quality Improvement Council have been consulted regarding MSHN providing templates, format, guidelines, etc. regarding PCP. Both groups were receptive to having options provided, but do not want any documents to be required. This will be reviewed again this year with CLC and QIC and options will be presented.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Status on FY2023 Recommendations

The following is a status update on the FY2023 areas of risk and progress made toward the recommendations. These recommendations are considered complete.

Area of Risk: Credentialing and Provider Qualifications

R*ecommendation:* Increase monitoring on compliance with state contract requirements and MSHNs policies and procedures for credentialing and provider qualifications.

Status: MSHN implemented a Credentialing and recredentialing monitoring report procedure which included increased monitoring of provider activities. In addition to continued monitoring of credentialing and qualifications during regularly scheduled Delegated Managed Care (DMC) reviews conducted throughout calendar year 2023.

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

Recommendation: Research options and determine feasibility for the completion of a compliance risk assessment region wide.

Status: An effectiveness review of the MSHN compliance program was completed using the Department of Justice guidance and template. The MSHN Compliance Committee members reviewed and provided feedback. Next steps will be developed once MDHHS has released more information related to conflict free access and planning.

Area of Risk: Delegated Managed Care Site Reviews

Recommendation: Review standards that have a decrease from the previous year compliance score with appropriate councils/committees and MSHN content experts to determine if region wide quality improvement efforts are needed.

Status: MSHN worked internally and externally to provide best practices, training, and shared information to address any region wide deficiencies identified during the Delegated Managed Care Site reviews. In addition, MSHN conducted interim DMC reviews to ensure compliance with areas that were identified as non-compliant. MSHN will continue this process ongoing as areas for improvement are identified.

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group-Performance Measure Validation review).

Recommendation: Ensure that all CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator.

Status: MSHN implemented a targeted response including primary source verification prior to submitting the performance indicator data to review the effectiveness of the validation put in place. The Health Services Advisory Group Performance Measure Validation review included a review of documentation to validate reporting. The review found that while there were not enough errors to warrant a finding, weaknesses were identified that MSHN will continue to address.

Recommendation: Mid-State Health Network and the CMHSPs should employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.

Status: MSHN and MDHHS have implemented processes, including additional validations, to ensure that there is no discrepant data. HSAG did not find any discrepant data during the FY23 review.

Recommendation: Ensure that programming codes for all delegated CMHSPs do not identify no-show appointments as a compliant record for the performance indicator.

Status: MSHN implemented a targeted response including an increase in the sample size for primary source verification for the CMHSPs that demonstrated errors during the PMV review. A sample was reviewed prior to submission to MDHHS. The programming changes effectively addressed the accuracy of the data.

Area of Risk: Compliance with established Customer Service standards.

Recommendation: Enhance quality assurance (QA) processes for Medicaid appeal and grievance notice letters to beneficiaries. MSHN will enhance QA processes through the inclusion of the

MSHN Customer Service & Rights Manager in the MSHN Delegated Managed Care reviews. The Customer Service & Rights Manager will complete the primary source verification of Appeal and Grievance notice letters to ensure the letters include the required components and meet a high standard of professionalism.

Status: The MSHN Customer Service and Rights Manager completed primary source verification reviews for FY2023 as part of the delegated managed care reviews. In addition, the appeal and grievance notice letters were revised to ensure compliance with state standards.

Recommendation: The 2022 HSAG Compliance Review recommended enhance quality assurance (QA) processes for Medicaid appeal and grievance notice letters to beneficiaries. MSHN will enhance QA processes through the inclusion of the MSHN Customer Service & Rights Manager in the MSHN Delegated Managed Care reviews. The Customer Service & Rights Manager will complete the primary source verification of Appeal and Grievance notice letters to ensure the letters include the required components and meet a high standard of professionalism.

Status: The MSHN Customer Service & Rights Manager completed primary source verification reviews for FY2023 of appeal and grievance notice letters. In addition, training and technical assistance has been provided. MSHN will continue this process to ensure adherence to requirements.

Recommendation: Quality improvement initiatives will continue to be explored during the Customer Service Committee for the quarterly Appeal and Grievance Regional Analysis Report and a process for root cause analysis will be established to support the implementation of Plans of Correction (POC) for any out-of-compliance providers.

Status: The Customer Service Committee reviews the quarterly Michigan Department of Health and Human Services (MDHHS) Appeal and Grievance Analysis Report to identify any trends or areas of concern. A Plans of Correction (POC) process has been established to address any provider(s) who are found to be out-of-compliance for the Appeal and/or Grievance timeliness standards. MSHN will review the POC for root cause and determine if the steps identified within the POC address the cause for not meeting the timeliness standard.

Recommendation: Regional LEP practices will be reviewed for improvement by conducting a feasibility study to collect information from CMHSPs and SUD providers regarding cultural competency requests and through a local county analysis for non-English language prevalence to ensure compliance with LEP requirements.

Status: The MSHN Customer Service Committee explored the development of a process to add data points that capture culturally competency service requests, but it was determined that the current practices in place that ensure staff are required to be properly trained, that requests are included within the planning process/documents, and cultural competency is identified on the provider directory and provider applications was sufficient. Additionally, the MSHN Customer Service Committee has reviewed the MDHHS PIHP Contract Cultural Competence requirements to ensure current the provider LEP policies and procedures meet the process and practices to ensure compliance with LEP requirements. Ongoing analysis will be completed in the FY24 to ensure each provider has an effective methodology to assess any prevalent non-English language(s) spoken by individuals likely to be served in their county/CMHSP service area.

Recommendation: Technical support and training will be explored, in collaboration with MSHN treatment and behavioral health staff, focused on improving the quality of services for the Customer Service areas of Access to Treatment and Provider Practices within MSHN's provider network.

Status: MSHN Customer Service, in collaboration with MSHN treatment and behavioral health staff, identified the need to improve the Adverse Benefit Determination (ABD) process for MSHN's provider network. A sub workgroup was formed through the Customer Service Committee and workgroup members collaborated in the development of an ABD Regional Technical Guide. The regional technical guide was created to aid staff in understanding the Medicaid Adverse Benefit Determination process and to improve the quality of Adverse Benefit Determination Notices provided to individuals served throughout the region.

Area of Risk: Compliance with established Compliance related standards.

Recommendation: Identify region-wide data mining activities to detect possible deficiencies and/or non-compliance with established standards.

Status: MSHN completed two data mining activities during FY2023. One of the data mining activities will continue into FY2024. Additional data mining activities will be explored for FY2024 through discussion internally, regionally, as well as with other PIHPs and the Office of Inspector General.

Recommendation: Utilize the Constant Contact for compliance related updates for SUD providers.

Status: The Constant Contact has been utilized for updates related to compliance, quality, customer service and delegated managed care site reviews. This will continue to be a source of communication for the SUD provider network for these areas.

Recommendation: Work with the OIG to close all open referral cases submitted prior to FY2022 Q4.

Status: MSHN's Compliance Officer has worked with the OIG liaison to close all open referrals with the exception of one case from FY2020. This is a complex case that is being coordinated with the OIG and MDHHS.

Recommendation: Streamline compliance documentation and tracking for efficiency and ease of reporting.

Status: Revisions have been made to the compliance documentation for efficiencies and quality improvement. There are going to be additional reporting requirements added by the OIG for FY2024. Currently, there is a method of tracking all cases and documentation, but a more automated process is still being explored. This will continue to be worked on, but no longer needs to be a recommendation.

Recommendation: Create standardized templates related to confidentiality and privacy notices.

Status: MSHN has a standardized privacy notice that is reviewed annually. In addition, a new procedure for member rights requests is being developed to include access to protected health information, right to amend protected health information, accounting of disclosures and documentation of request for disclosures. With the addition of the new procedure outlining

requirements for access to protected health information, standardized templates are not needed.

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.

Status: MSHN developed a structured and detailed process including policies, procedure, and remote work agreements to ensure that home office/off site office security is prioritized and followed. In addition, MSHN has implemented regular monthly cyber training for staff and continues to provide annual Compliance training for staff. MSHN, through Providence, completed a scan of remote environments and the result of this was to update the settings on browsers to not allow stored passwords. MSHN also implemented new requirements regarding access using public internet and VPN use for out of USA access.

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: MSHN has updated policies and contract language to adhere to telehealth rules set forth by Medicaid requirements. MSHN completed monitoring of telehealth modifiers and location of services for providers in network via the Medicaid Event Verification review. MSHN will continue to monitor appropriate use of telehealth codes and documentation of consumer choice for telehealth services.

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: Implement action required as a result of the MSHN appeal of FY2022 MDHHS Waiver Site Review finding disallowing use of ranges for service provision within the person-centered plan.

Status: MSHN and MDHHS continue to have a different interpretation of the requirements around the use of ranges for service provision within the PCP. MSHN has taken the position that the use of ranges is not prohibited based on the Medicaid Provider Manual, and when used appropriately, support medical necessity and the principles of PCP. MDHHS did not approve the corrective action plan related to this site review finding and denied the appeal submitted by MSHN. MSHN continues to take the position that the use of ranges is not required and will address this again as needed.

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 Quality Assurance Review Summary Report Fiscal Year 2023.

CMHSP Provider Delegated Function Reviews

During Fiscal Year 2023, nine (9) of the twelve (12) CMHSPs received a full delegated managed care (DMC) review and three (3) of the twelve (12) had an interim review completed. The full review includes a review of programs, policies, procedures, and a sample of case files and charts and the interim review consists of ensuring that the approved corrective action plans from the previous review have been implemented effectively and review of any new standards due to contractual or regulatory changes.

Delegated Managed Care Review Tool Results

Includes review of 199 standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this was 94.82%.

Note: The full reviews were completed during FY2023 Q2-Q4

Note: All percentages are rounded to the nearest percent.

DMC Tool

DMC Standards	# Of Standards	2022 Results	2023Results
Information Customer Service	12	100%	97%
Enrollee Rights and Protections	9	100%	100%
24/7/365 Access	18	94%	88%
Provider Network Sub-Contract Providers	14	100%	100%
Service Authorization and UM	7	100%	99%
Grievance and Appeals	19	99%	96%
Person Centered Planning	30	99%	90%
Coordination of Care/Integration	6	100%	96%
Behavior Treatment Plan Review Committee	21	72%	94%
Consumer Involvement	3	100%	100%
Provider Staff Credentialing	22	97%	93%
Compliance	7	100%	99%
Ensuring Health and Welfare	16	93%	97%
Information Technology	9	100%	100%
Trauma Informed Care	6	100%	99%

The following identifies additional information regarding the standard(s) that fell below 90% compliance.

24/7/365 Access: 88% Compliance

This includes the review of eighteen (18) standards. Of those, nine (9) standards did not reach 90% compliance. Evidence for standards in the DMC includes policies, procedures, and other source documentation to show compliance. Findings identified could be related to any of those sources.

- Standard 3.7: Initial/provisional eligibility and level of care determination is made by conducting a professional screening. This had an 89% compliance score. Of the nine (9) CMHs reviewed, eight (8) were fully compliant and one (1) was fully non-complaint.
- Standard 3.8: Short term plan is developed; warm handoff (linking via direct connection) to services for which individuals have been screened and eligible to receive. This had an 83% compliance score. Of the nine CMHs reviewed, seven (7) were fully compliant, one (1) was identified as partially compliant and one (1) was identified as fully non-compliant.
- Standard 3.9: Access staff facilitate the admission of individuals who appear to require detox services; ensure the health and safety of all individuals. This had a 72% compliance score. Of the nine (9) CMHs reviewed, five (5) were found fully compliant, three (3) partially compliant, and one (1) fully non-compliant.
- Standard 3.10: Required demographics, and clinical/functional information is documented in PIHP Managed Care information system. This had a 61% compliance score. Of the nine (9) CMHs reviewed, four (4) were fully compliant, three (3) were partially compliant, and two (2) were fully non-compliant.
- Standard 3.11: Referrals to SUD care providers are appropriate based on screening. This had an 61% compliance score. Of the nine (9) CMHs reviewed, four (4) were fully compliant, three (3) were partially compliant, and two (2) were fully non-compliant.
- Standard 3.12: Access staff follow up with individuals who made contact within two business days to ensure services needs have been met or to reengage if referral connection have not been met. This had an 83% compliance score. Of the nine (9) CMHs reviewed in this fiscal year timeframe, seven (7) were fully compliant, one (1) was partially compliant and one (1) was fully non-compliant.
- Standard 3.14: CMHSP access system works with receiving providers to ensure service priority expectations for sub populations: pregnant injecting drug users, pregnant, other substance use disorder, injecting drug user, parents at risk of losing children, individuals under MDOC supervision. This had a 61% compliance score. Of the nine (9) CMHs reviewed, four (4) were found to be fully compliant while three (3) were partially compliant and two (2) were fully non-compliant.
- Standard 3.17: State standards are met for timely access to care and services taking into account the urgency of need. This had an 83% compliance score. Of the nine (9) CMHs reviewed, seven (7) were fully compliant, one (1) was partially compliant, and one (1) was fully non-compliant.

Clinical Chart Review Results

Includes review of seventy-eight (78) standards. The focus of this section is to ensure compliance with requirements. MSHN reviews 5-8 charts for each CMH. Overall compliance for this timeframe is 93.47%.

Clinical Chart Review Tool

Clinical Chart Standards	# Of Standards	2022 Results	2023 Results
Intake/Assessment	13	97%	97%
Pre-Planning	10	85%	91%
PCP/IPOS	21	96%	94%
Documentation	2	100%	100%
Customer Service	5	99%	97%
Delivery and Evaluation	3	92%	80%
Program Specific Service Delivery	17	93%	93%
Discharge/Transfers	4	100%	80%
Integrated Physical/Mental Health Care	3	95%	97%

The following identifies additional information regarding the standard(s) that fell below 90% compliance.

Delivery and Evaluation: 80% Compliance

This section consists of three (3) standards. Of those, two standards did not meet 90% compliance.

- Standard 6.1: Are services being delivered consistent with plan in terms of amount scope and duration? This had a 70% compliance score. Of the sixty-nine (69) charts reviewed in this fiscal year timeframe, thirty-six charts were found to be fully compliant and twenty-two (22) were found to be partially compliant. Nine (9) charts were determined to have been non-complaint. Two (2) charts were scored as not applicable.
- Standard 6.: Are periodic reviews occurring according to time frames established in plan and as warranted by clinical changes and needs? This had an 80% compliance score. Of the sixty-nine (69) charts reviewed in this fiscal year timeframe, fifty-two charts were found to be fully complaint with this standard. Eighteen (18) charts were identified as having findings which included eight (8) being fully non-compliant, and ten (10) partially complaint.

Discharge and Transfers Section: 80% Compliance

The discharge and transfers section consists of four (4) standards. None of the four (4) standards reached a score of 90% compliance. Overall, for this section, of the sixty-nine (69) charts reviewed in the fiscal year timeframe, thirteen (13) charts were identified as being applicable to at least one (1) standard in this section and fifty-six (56) charts were identified as not applicable to this section.

- Standard 8.1: For closed cases, was the discharge summary/transfer completed in a timely manner (consistent with CMHSP policy)? This had a 77% compliance score. Ten (10) of the thirteen (13) charts reviewed were fully complaint. Three (3) charts were identified as fully non-compliant with this standard.
- Standard 8.2: Does the discharge/transfer documentation include a statement of the reason for discharge and individuals' status/condition at time of discharge? This had an 88% compliance score. Eleven (11) of the thirteen (13) charts reviewed were found to be fully compliant. There were two (2) charts that had findings for this standard, one (1) that was partially compliant and one (1) that was fully non-compliant.
- Standard 8.3: Does the discharge record include a plan for re-admission to services if necessary? This had an 83% compliance score. Of the eleven (11) charts reviewed for this standard, two were identified as fully non-compliant.

- Standard 8.4: Does the documentation include recommendations, referrals, and follow-up contacts? This had a 73% compliance score. Of the eleven (11) charts reviewed for this standard, four (4) charts were identified as having findings; two (2) charts were fully non-compliant and two (2) were partially non-compliant.

SUDSP Treatment Provider Delegated Function Reviews

During FY2023, both full and interim reviews were completed. The interim reviews consist of any new standards and 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.

Scores are shared quarterly and annually with MSHN departments to assist those departments in identifying training opportunities for our provider network.

The QAPI team conducted eleven (11) full reviews and 6 (six) interim reviews from October 1, 2022 – September 30, 2023.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of 116 standards. Overall compliance during this timeframe for full reviews is 93%.

Note: All percentages are rounded to the nearest percent.

FY32 SUD Delegated Functions Scores

Delegated Functions Standards	# Of Standards	2022 Results	2023 Results
Access and Eligibility	4	90%	84%
Information and Customer Service	17	99%	96%
Enrollee Rights and Protections	14	99%	95%
Grievance and Appeals	17	94%	93%
Compliance	11	100%	95%
Quality	4	88%	86%
Individualized Treatment & Recovery Planning & Documentation	14	86%	88%
Coordination of Care	8	81%	83%
Provider Staff Credentialing	22	81%	94%
IT Compliance/IT Management	1	100%	100%
Trauma Informed Care	6	74%	93%

The following identifies additional information regarding the standard(s) that fell below 90% compliance.

The Delegated Functions review is largely focused on policy and procedure language. While a provider may be able to show compliance with the standard in chart reviews or other file reviews, MSHN has placed additional requirements that providers must also have a policy and/or procedure for the standards. Based on this, it should not be assumed that if there are findings in this section that providers are not compliant with the process.

Access and Eligibility: 84% Compliance

- Eleven (11) providers were reviewed for compliance with the four (4) standards in this section. Three (3) of the four (4) standards scored under 90% compliance. Findings in this section were primarily partial findings and related to specific language from the standards not included in the provider policies.

Quality: 86% Compliance

- There are five (5) standards in this section. Three (3) of the standards scored under 90% compliance. Those were related primarily to specific language from the standards not included in the provider policies or procedures related to critical incidents and sentinel events. It should be noted that these specific standards were applicable only to seven (7) of the eleven (11) providers reviewed in this fiscal year timeframe as they are specific to residential and withdrawal management services.

Individualized Treatment and Recovery Planning and Documentation: 88% Compliance

- There are three (3) standards in this section. Two (2) of the three (3) standards scored under 80%. These findings were related to policies and procedures not including the screening of dependent children for fetal alcohol spectrum disorder (FASD) and education on FASD.

Coordination of Care: 83% Compliance

- There are four (4) standards in this section and two of those scored under 90% compliance. The standards that were under 90% were related to policies and procedures including language that included specific communicable disease language and specific language related to provider coordination with the Michigan Department of Corrections supervising agents related to client care when applicable.

Clinical Chart Review Results

The SUDSP treatment chart review tool includes a total of fifty-one (51) standards. Overall compliance during this timeframe for full reviews is 68%.

Table 10: SUD Program Specific Scores

SUDSP Chart Reviews	# Of Standards	2022 Results	2023 Results
Screening, Admission, Assessment	5	78%	73%
Treatment/Recovery Planning	10	75%	72%
Progress Notes	4	78%	69%
Coordination of Care	4	60%	59%
Discharge/Continuity of Care	3	81%	64%
Residential	4	86%	64%
Medication Assisted Treatment	15	65%	54%
Women's Designated/Women's Enhanced	2	81%	68%
Recovery Housing	4	74%	59%

The following identifies additional information regarding the standard(s) that fell below 90% compliance.

For full reviews, MSHN reviews four (4) charts, unless there is a rare occasion that the provider does not have four (4) consumers enrolled in services to review at which point, MSHN reviews at least two (2) files. For interim reviews, MSHN reviews two (2) charts specific to the findings identified in the previous full review. These scores are inclusive of both full and interim scores. There were sixty-six (66) charts reviewed in this fiscal year timeframe.

Findings are often organization specific, meaning that oftentimes the findings identified by standard are in all charts reviewed for that provider making the issue a system issue. However, there are occasions where one chart may have a finding, but the others are compliant, which may be an employee specific issue that requires additional training or sometimes could be an issue of the employee not documenting clearly that it was completed. Providers are required to submit corrective action for all findings identified in each chart.

Screening, Admission, Assessment: 73% Compliance

- There are five (5) standards in this section, four (4) of which scored under 90% compliance. It should be noted that most findings were partial findings, meaning that at least one element of the standard was not met. The findings included issues with establishing the correct ASAM level of care, screening for HIV/Aids, STD/Is, TB, Hepatitis, and trauma, and unclear or lack of detail for the individual's presenting problem.

Treatment Planning and Recovery: 72% Compliance

- There are ten (10) standards in this section and of those, only one standard reached 90% or higher compliance. Areas that scored low include the following: appropriate amount scope and duration in the treatment/recovery plan; timeliness of treatment plan development; plans addressing needs and issues identified in the assessment or clear documentation of why it is not being addressed; individualized plans being in the clients words, and clear intervention strategies identified; goals and objectives are created using SMART criteria, frequency of periodic reviews; progress reviews include all elements required; case management services

are clearly identified and documented; and an evidence-based practice is used and documented in the record for trauma.

Progress Notes: 69% Compliance

- This section includes four (4) standards, of which only one reached 90% compliance or higher. Findings in this section were related to progress notes identifying which goals and objectives were addressed in session and the progress or lack of progress toward meeting those goals; services not provided as specified in the plan, and evidence that children are screened for FASD and referral is made when applicable.

Coordination of Care: 59% Compliance

- There are four (4) standards in this section and none of those standards reached 90% compliance or higher. Regionally, coordination of care has been identified as an issue for several years. These findings include lack of evidence of coordination of care with primary care physicians, other external entities such as legal, child welfare, behavioral health, other providers when transitioning from one level of care to another, and evidence of appropriate referrals and documented follow-up.

Discharge/Continuity of Care: 64% Compliance

- There are three (3) standards in this section. Two of the standards were scored and did not meet 90% compliance, the other standard was not scored as it was not applicable to any of the charts reviewed. Findings include discharge summaries not including all continuum of care detail including next provider contact information, date/time of intake appt, etc. Additionally, consumers discharge is not always fully summarized including status at time of discharge, prognosis, stage of change, met and unmet needs and goals, summary of services received and participation.

Residential: 64% Compliance

- There were five (5) residential files for three (3) providers reviewed in the fiscal year timeframe. This section includes a total of four (4) standards, two (2) of which were not applicable. Of the two standards that were scored, one reached 100% compliance and the other, related to assuring consumers entering residential treatment are tested for TB and results are known in five (5) days, was 80% compliant.

Medication Assisted Treatment: 54% Compliance

- There were three (3) providers reviewed and a total of eleven (11) charts for this section, four of which were methadone specific. This section includes fifteen (15) standards. Of those, four (4) standards were fully compliant, ten (10) standards were under 90% compliant, and one (1) standard was not applicable to any of the charts reviewed. Findings in this section were related to documentation of full medical exams prior to initial methadone or suboxone dose; informed consent for pregnant women and all women, documented random toxicology tests, copies of prescription labels, pharmacy receipts, or printouts in chart; documented review of MAPS included in client file, coordination of care with prescribing physician, all alcohol and illicit drug use is addressed in treatment; documentation that client was informed of emergency procedures to be followed when there is an adverse reaction, overdose or withdrawal (methadone only); documentation of client signed consent to contact other OTPs within 200 miles to monitor enrollments at other methadone programs; and evidence that daily attendance at the clinic is occurring for methadone dosing including Sundays and holidays if criteria for take home medication are not met.

Women's Designated/Enhanced: 68% Compliance

- There are two (2) standards reviewed in this section. Twenty-four (24) of the sixty-six (66) charts applied to this section. One (1) standard scored over 90% compliance and the other, related to a needs assessment for each dependent child, was 48% compliant.

Recovery Housing: 59% Compliance

- There are four (4) standards included in this section. This section applied to two (2) providers and included a review of four (4) charts. Of the four (4) standards, one (1) was fully compliant and three (3) were 75% compliant. Findings included: resident charts not fully documenting emergency contacts, standard demographics, releases of information, or signed acknowledgement of rules (3 pts out of 4 pts possible); chart includes completed screen and application (6 pts out of 8 pts possible); service plan includes amount scope and duration, efforts to achieve independent living arrangements (6 pts out of 8 possible).

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 twelve (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 does not exceed contractually agreed upon amount, G.) Amount paid does not exceed contractually agreed upon amount, and H.) 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 2023.

The CMHSP reviews are completed bi-annually (twice a year) for all twelve (12) CMHSPs. The table below includes the score per CMHSP for all attributes reviewed.

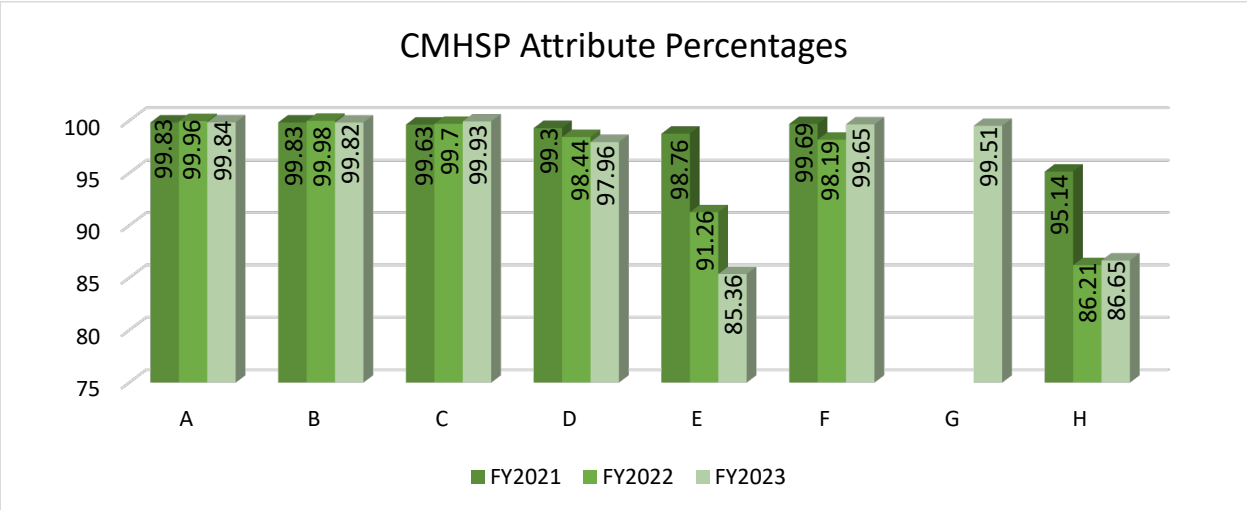
Data presented in the below chart is relative to the twelve (12) CMHSP's for the full fiscal year, October1, 2022 – September 30, 2023.

CMHSP

	A	B	C	D	E	F	G	H
BABHA	100%	100%	100%	97%	80%	100%	100%	97 %
CEI	100%	100%	100%	99%	84%	100%	100%	58%
CMHCM	100%	100%	100%	98%	91%	100%	100%	86%
Gratiot	100%	100%	100%	99%	88%	100	100%%	95%
Huron	100%	100%	100%	98%	83%	100%	100%	97%
Lifeways	100%	98%	100%	97%	81%	100%	99%	75%
Montcalm	100%	100%	100%	97%	88%	100%	100%	97%
Newaygo	99%	100%	100%	97%	86%	99%	100%	83%
Saginaw	100%	100%	100%	98%	78%	100%	97%	86%
Shiawassee	99%	100%	100%	96%	90%	100%	94%	99%
The Right Door	100%	100%	100%	99%	85%	100%	100%	89%
Tuscola	100%	100%	100%	99%	93%	100%	99%	95%
MSHN Average	**100%**	**100%**	**100%**	**98%**	**85%**	**100%**	**100%**	**97%**

Note: CMHSP reviews are completed twice during the fiscal year. The percentages displayed are an average of the scores for both reviews. ***Percentages have been rounded to the nearest percent.***

The following chart provides a comparison from FY2021 through FY2023 for the attributes tested:



Note: In FY21 and FY22, there were 7 (A-G) attributes tested compared to 8 (A-H) in FY23 (see differences listed below). For analyzation purposes, FY21/FY22 data for the former attribute G.) Modifiers are used in accordance with the HCPCS guidelines is included under attribute H.

The Substance Use Disorder site reviews are completed annually. The data presented in the below chart is relative to the twenty-six (26) SUD treatment providers reviewed for the full fiscal year, October 1, 2022 – September 30, 2023.

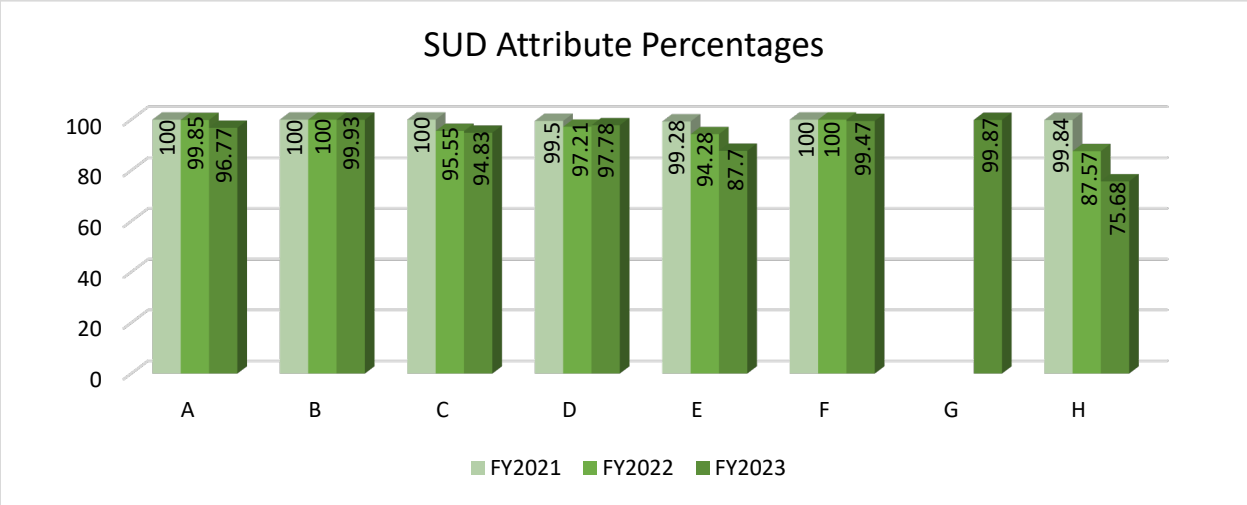
The chart below includes the score for all SUD providers combined for each attribute reviewed.

SUD

	A	B	C	D	E	F	G	H
SUD Providers	97%	100%	95%	98%	88%	100%	100%	76%

*Note: **Percentages have been rounded to the nearest percent**.*

The following chart provides a comparison from FY2021 through FY2023 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.

Note: In FY21 and FY22, there were 7 (A-G) attributes tested compared to 8 (A-H) in FY23 (see differences listed below). For analyzation purposes, FY21/FY22 data for the former attribute G.) Modifiers are used in accordance with the HCPCS guidelines is included under attribute H.

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 FY2023, all 12 CMHSPs were placed on a new plan of correction and of the twenty-six (26) substance use disorder treatment providers reviewed, twenty-three (23) 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 FY2022, were removed from those plans during FY2023.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and contractual services of $757,573,20 and $94,784.51 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

Note: Many of the invalid claims were corrected by submitting additional documentation and by resubmitting claims with correct modifiers, dates, times, etc. These claims, units and dollars are included in the summary of disallowed amounts as they were original findings that documentation did not support during the review.

Regionally the CMHSPs have shown a slight decline for the following attributes when comparing FY2022 to FY2023:

1. A. The code is allowable service code under the contract
2. B. Beneficiary is eligible on the date 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

It should be noted that 3 of the 4 attribute scores (A, B, D) remained in the high nineties and decreased less than a percentage from FY2022. The remaining score (attribute E) saw a decline of less than 6%.

Alternatively, the CMHSPs have shown slight improvements from FY2022 to FY2023 for the following attributes:

1. C: Service is included in the beneficiary's individual plan of service
2. F: Amount billed does not exceed contractually agreed upon amount
3. G: Amount paid does not exceed contractually agreed upon amount
4. H: Modifiers are used in accordance with the HCPCS guidelines

These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. In addition, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.

Regionally the SUD providers did not show significant improvements from FY2022 to FY2023. However, the SUD provider scores were already at a high level and most of the scores remained in the mid-high nineties. The attributes that had slight improvements from FY2022 to FY2023 were:

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

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their understanding of the required supporting documentation to show compliance with the attributes.

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 90-day follow up review for our region February 2023. The purpose of the review was to ensure implementation of corrective action from the 2022 review related to the service delivery requirements of the 1915 (c) waivers that

include the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW) and the Children's Waiver Program (CWP).

MDHHS accepted all follow-up documentation except for the area of amount, scope, and duration.

MDHHS will conducts reviews every other year. MSHN is scheduled for review in June 2024 which will include a review of 1915(i).

MDHHS Substance Use Disorder Site Review

In 2022, 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. Therefore, no follow-up review was necessary in 2023. MSHN anticipates a full review to be conducted by MDHHS in FY24. The dates have not yet been determined.

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 17, 2023.

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 2023.

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- Thirteen Measures Fully Validated: 100%

Recommendations

Among the recommendations from this review were the following:

- HSAG recommends that Mid-State Health Network complete the proposed corrective action to review all abnormal disposition completed dates and times as part of its validation check.
- HSAG recommends that Mid-State Health Network continue its efforts to meet with CMHSPs and provide further training when errors occur.
- HSAG recommends that Mid-State Health Network and CMHSPs employ additional enhancements to the PIHP's validation process to ensure appropriate categorization of compliant cases and capture of exceptions.
- HSAG recommends that Mid-State Health Network and the CMHSPs performance additional validation checks to ensure appropriate ongoing services are captured for compliant cases for future reporting.

MSHN has received full compliance (100%) for all elements reviewed from the first review in FY2014 through the current review in FY2023. 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 three (3) years. HSAG conducted a review of the first 6 standards for year one in FY2021. The remaining seven (7) standards were reviewed in FY2022. In FY2023, Year 3, HSAG conducted a focused review on those standards that received a "not met" the previous two years resulting in a corrective action plan.

During State Fiscal Year (SFY) 2023, HSAG completed a desk audit on August 25, 2023.

MSHN demonstrated that 23 of 24 elements had been remediated indicating that necessary policies, procedures, and initiatives were implemented to demonstrate compliance with the requirements under review. The element that was not remediated, Health Information Systems- Application Programming Interface (API), was noted as not meeting all of the requirements. However, MSHN was given the opportunity to provide a work plan to implement the API.

HSAG has indicated that a review for implementation and compliance will be conducted during FY2025.

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 2022 through 2025 is: *Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population without a decline in performance for the white population.*

The baseline data for 01/01/2021 through 12/31/2021 was 65.04% for the percentage of new persons who are Black/African- American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

The baseline data for 01/01/2021 through 12/31/2021 was 69.49% for the percentage of new persons who are White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

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%

Based on recommendations from HSAG, MSHN will address the following:

- MSHN should ensure that it follows the approved PIP methodology to calculate and report the remeasurement data accurately in next year's submission.
- Mid-State Health Network should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to identify if any new barriers exist that require the development of interventions.
- Mid-State Health Network should have an evaluation process to determine the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.
- Mid-State Health Network should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

Customer Service/Compliance Reporting

Customer Service Contacts

The total number of Customer Services contacts received in FY2023 was 155, an increase of 32.5% from FY2022. By comparison, there were 117 contacts in FY2022.

Customer Service Originator of Contact

Originator	Number	Percentage*
Advocate	3	2%
Authorized representative	1	1%
CMHSP	31	21%
Family Member	1	1%
Guardian	4	3%
MDHHS	35	23%
Other	13	8%
Parent of a minor	8	5%
Self/Consumer	41	26%
SUDSP	17	11%

*(*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	41	26%
Appeal	7	5%
Authorization	1	1%
Complaint/Dissatisfaction	22	14%
Consumer Discharge	5	3%
General Assistance	41	26%
Interaction with Provider or Plan	1	1%
LEP Assistance	4	3%
Member Handbook	1	1%
Notification Letter	2	1%
Provider Practices	23	15%
Provider Staff Concern	2	1%
Recipient Rights Assistance	2	1%

*(*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

Type of Resolution	Number	Percentage*
No follow-up required	63	41%
Resolution pending	2	1%
Resolved	1	1%
Resolved in favor of consumer	6	4%
Resolved in favor of provider	25	16%
Resolved through follow up actions	58	37%

*(*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 FY2023:

- Overall Customer Service contacts increased by 32.5% in FY2023 (155) from FY2022 (117)
- Consumer contacts requiring follow-up action decreased from 77% (n=90) in FY2022 to 48% (n=75) of overall contacts in FY2023.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (26%/n=41) and MDHHS (23%/n=35).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (21%/n=31)
- The highest consumer complaint categories involved complaints addressing Access to Treatment (26%/n=41) and Provider Practices (15%/n=23). Access to Treatment was a 16% increase in FY23 (41) over FY22 (35). Provider practices saw a 39% decrease in FY23 (23) over FY22 (34).
- The highest non-consumer contact category involved requests for General Assistance (26%/n=41)

As part of MDHHS' State monitoring activities, PIHPs are required to submit Grievance reporting information using the state developed reporting template. Report data submissions are on a quarterly basis, and the final report covers FY23 Q1-Q4.

FY23 MDHHS Grievance Reporting Results (Q1-Q4)

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	46	0.12	30	0.08	77	44	42
ACCESS AND AVAILABILITY	34	0.09	27	0.07	70	30	33
INTERACTION WITH PROVIDER OR PLAN	49	0.13	33	0.09	102	46	32
MEMBER RIGHTS	2	0.01	1	0.00	3	2	12
TRANSPORTATION	0	0.00	0	0.00	0	0	#DIV/0!
ABUSE, NEGLECT, OR EXPLOITATION	1	0.00	1	0.00	1	1	78
FINANCIAL OR BILLING MATTERS	3	0.01	2	0.01	4	3	18
SAFETY/RISK MANAGEMENT	1	0.00	0	0.00	1	1	0
SERVICE ENVIRONMENT	11	0.03	8	0.02	22	11	44
OTHER	11	0.03	9	0.02	14	11	12
Total	238	0.42	111	0.29	294	149	N/A

*Field will display "#DIV/0!" if there are no reported cases per category.

As part of MDHHS' State monitoring activities, PIHPs are required to submit Appeals reporting information using the state developed reporting template. Report data submissions are on a quarterly basis and the report covers FY23 Q1-Q4.

FY23 MDHHS Appeals Reporting Results (Q1-Q4)							
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	35	0.09	33	0	2	0	100%
ACCESS AND AVAILABILITY	0	0.00	0	0	0	0	#DIV/0!
INTERACTION WITH PROVIDER OR PLAN	2	0.01	2	0	0	0	100%
MEMBER RIGHTS	1	0.00	1	0	0	0	100%
TRANSPORTATION	5	0.01	5	0	0	0	100%
ABUSE, NEGLECT, OR EXPLOITATION	30	0.08	28	1	1	0	97%
FINANCIAL OR BILLING MATTERS	0	0.00	0	0	0	0	#DIV/0!
SAFETY/RISK MANAGEMENT	16	0.04	16	0	0	0	100%
SERVICE ENVIRONMENT	268	0.70	260	7	1	0	97%
OTHER							
Total	357	0.93	325	8	4	0	N/A

*Field will display "#DIV/0!" if there are no reported cases per category.

	Count	Percentage
Appeals	357	
Appeals Upheld	76	21%
Appeals Overturned	270	76%
Appeals Partially Upheld/Overturned	11	3%

For FY2023, the grievance and appeal data were reviewed through the Regional Customer Service Committee (CSC) to identify trends and potential quality improvement efforts. The quarterly MDHHS grievance and appeal data will continue to be reviewed through the CSC.

Activities Implemented in FY2023

The following activities were implemented during FY2023.

- Information was collected from providers regarding cultural competency requests (CCR). A CCR reporting process was developed and an initial FY23 Q1-2 report received. Providers reported that cultural competency requests are honored through existing processes and requested reconsideration on adding CCR reporting. MSHN suspended the CCR reporting while a review is completed to determine if the current practices were sufficient to meet access standard requirements.
- Regional guidance was developed to assist providers in analyzing their counties to determine non-English language prevalence to ensure compliance with LEP requirements.

- The quarterly Appeal and Grievance Regional Analysis Report was utilized to evaluate the quarterly MDHHS Grievance and Appeal data for trends and quality improvement across the region.
- The MSHN Customer Service Committee formed a sub-workgroup to develop an Adverse Benefit Determination (ABD) focused Frequently Asked Questions (FAQ) document to provide technical support to the CMHSP and SUDSP provider network within the region on ABD best practices.
- The MSHN Customer Service Committee reviewed, revised, and facilitated the publication of 13 local versions of the FY23 MSHN Guide to Services Handbook. Additionally, the 13 local versions were translated into Spanish for electronic distribution to CMHSP and SUDSP providers throughout the MSHN region.
- MSHN Customer Services continued to work in collaboration with the MSHN staff to provide technical assistance to improve the quality of services through 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 FY2024

Based upon FY23 Customer Service data, the following is being recommended:

- The review of FY23 Customer Service data did not identify systemic issues but identified issues at the individual provider level requiring technical assistance. Quality improvement initiatives will occur during the Customer Service Committee utilizing the quarterly Appeal and Grievance Regional Analysis Report to support provider compliance.
- Regional LEP practices will be enhanced to gather LEP information from local county analysis for non-English language prevalence to ensure compliance with LEP requirements.

Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2023 was 26. By comparison, there were 28 completed in FY2022. This resulted in a decrease of 7.14% in FY2023 from FY2022.

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

Originator:	***Number:***	***Percent:***
SUD Provider Staff	3	11.54%
CMHSP Staff	4	15.38%
MSHN Staff	8	30.77%
Office of Inspector General (OIG)	9	32.62%
Advocate	1	3.85%
Community/Stakeholder	1	3.85%

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

Category:	***Number:***	***Percent:***
Fraud/Abuse/Waste	10	38.46%
Treatment/Services	4	15.38%
Duplicate Claims	2	7.69%
Over Payment for Services	3	11.54%
Credentialing/Qualifications	4	15.38%
Licensure	2	7.69%
Violation of ADA requirements	1	3.85%

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

Type of Resolution:	***Number:***	***Percent:***
CMHSP	5	19.23%
SUD Provider	11	42.31%
OIG	8	30.77%
Advocate	1	3.85%
Pending	1	3.85%

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

Agency:	***Number:***	***Percent:***
OIG	8	30.77%

Office of Inspector General Quarterly Report for FY2023

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.

FY2023 Q1: 46 activities were reported
FY2023 Q2: 47 activities were reported
FY2023 Q3: 65 activities were reported
FY2023 Q4: 62 activities were reported

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

The total amount of overpayments that were adjusted as a result of the QIG quarter report activities was $840,144.31. While this was identified as an overpayment, many of the encounters could be corrected and resubmitted after the claims were voided which may have resulted in a lower recoupment/cost settled amount for FY2023.

Data Mining Activities

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2023, MSHN completed the following data mining activities.

1) Death Data Report (Q1, Q2, Q3, and Q4)
   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 (Q1 and Q2)
   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 FY2023 Q1.

1) Death Data Report
   Results: It was concluded that there were no instances where a service was provided after the date of death.
2) Comparison for telehealth, face-to-face and overall encounters
   Results: The comparison did not show any significant variance when compared to the average of previous months' encounters.

The following are the data mining activities and results for FY2023 Q2.

1) Death Data Report
   Results: There were 2 (two) services, involving 2 (two) beneficiaries, reported past the identified date of death. The errors were corrected.
2) Comparison for telehealth, face-to-face and overall encounters
   Results: The comparison did not show any significant variance when compared to the average of previous months' encounters.

The following are the data mining activities and results for FY2023 Q3.

1) Death Data Report
   Results: There were 2 (two) instances, involving 2 (two) beneficiaries, that had a service provided after the identified date of death. After investigation, it was determined that both of these instances were for payments made to the Fiscal Intermediary and were acceptable. No corrections were needed.

The following are the data mining activities and results for FY2023 Q4.

1) Death Data Report
   Results: There were 3 (three) instances, involving 3 (three) beneficiaries, that had a service provided after the identified date of death. These errors were corrected.

Subpoena(s)

MSHN received 4 (four) subpoenas during FY2023 requesting records. No action was needed regarding these requests as MSHN was not in possession of any requested records. MSHN was not named as a defendant in any of the subpoenas.

Notification of Breach(s):

During FY2023, within the MSHN region, there were 6 (six) instances reported to MSHN involving a breach of protected health information. Out of the instances, 4 (four) were reported from CMHSPs and 2 (two) were reported from MSHN staff. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future reoccurrence.

Results/Trends

While there were fluctuations in numbers and percentages from the previous year, there were no discernible trends identified that warrant systemic changes. However potential quality improvement efforts will be discussed with the MSHN Compliance Committee and the Regional Compliance Committee.

Compliance investigations:

- There was a slight decrease in the total number of compliance issues reported during FY2023
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 38.46%.
- Twenty-five (25) investigations were completed and achieved a closed status.
- One (1) investigation is still pending closure by the OIG.

OIG quarterly report:

- FY2023 had a slight decrease in the number of reported activities from FY2022.
- The largest number of findings reported include the following:
    - Lack of documentation to support the claims submitted
    - Use of incorrect modifiers or lack of modifiers

Subpoenas:

- There was a slight increase in the number of subpoenas received during Fy2023, but the increase was not notable.
- Only one subpoena involved a consumer that was served within the region, but no records were provided based on the timeframe requested.
- The number of subpoenas received cannot be influenced by any actions by MSHN.

Breaches:

- There was a slight increase in the number of privacy breaches from FY2022 to FY2023.
- In all instances, the cases were remediated following MSHN's breach notification policy.

Activities Implemented in FY2023

The following activities were implemented during FY2023.

- Data Mining Activities included:
    - Death Audit Compared to Encounters (Q1, Q2, Q3, and Q4)
    - Comparison for telehealth, face-to-face and overall encounters (Q1 and Q2)
- Revised processes, and provided education, related to revised OIG referral process, quarterly OIG report, adverse action forms and annual provider list
- Reviewed region wide compliance training for updates
- Completed an effectiveness review of the MSHN compliance program
- Provide ongoing education, and ensure compliance with, updates to state and federal policies and regulations
- Recommended changes to the Delegated Managed Care site review standards and process
- Revised compliance investigation process and documentation to align with new requirements from the OIG
- Revised compliance policies and procedures to align with new contract program integrity requirements and HSAG Compliance site review findings

- Coordinated with the PIHP Compliance Officers and representatives from MDHHS related to need to streamline and revise HSAG standards related to the Compliance site review
- Revised region wide privacy notice and standardized processes for providing protected health information

Recommendations for FY2024

The following are recommendations for improvements in FY2024.

- Identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Utilize the Constant Contact, emails, and other communication means for compliance related updates for providers
- Research options, and implement a new process for tracking compliance investigations and documentation
- Update Compliance related policies and procedures and MSHN Compliance Plan to ensure compliance with new program integrity contract language
- Develop processes to track new OIG data requirements such as cost avoidance, recoupments, etc.

Compliance Training/Review

Internal

MSHN Compliance Committee
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Regional Compliance Committee
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

MSHN Operations Council
Review Compliance Plan
Review Compliance Policies and Procedures
Review Annual Compliance Summary Report

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

Board of Directors
Review and approve Compliance Plan
Review and approve Compliance Policies
Review and approve Annual Compliance Summary Report

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 2023
2. Medicaid Services Verification Methodology Report for Fiscal Year 2023
3. Health Services Advisory Group State Fiscal Year 2023 Validation of Performance Measures Report
4. Health Services Advisory Group State Fiscal Year 2023 Compliance Report
5. Health Services Advisory Group 2022-2023 PIP Validation Report