MSHN

Mid-State Health Network

Annual Compliance Summary Report

October 2023 – September 2024

Prepared By: MSHN Compliance Officer/Compliance Administrator – November 2024
Approved By: MSHN Compliance Committee – January 15, 2025
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Table of Contents

Introduction 3
Recommendations for FY2025 3
Status of FY2024 Recommendations 4
Monitoring and Auditing 8
Mid-State Health Network Provider Network Reviews 8
CMHSP Provider Delegated Managed Care Reviews 8
SUDSP Treatment Provider Delegated Function Reviews 11
Medicaid Event Verification Site Reviews 15
CMHSP 15
SUD 17
Results/Trends 18
External Reviews 19
MDHHS Waiver Review 19
MDHHS- Health Services Advisory Group (HSAG): Performance Measurement Validation Review 20
MDHHS- Health Services Advisory Group (HSAG): Network Adequacy Review 22
MDHHS- Health Services Advisory Group (HSAG): Compliance Monitoring Review 22
MDHHS- Health Services Advisory Group (HSAG): Encounter Data Validation Review 24
MDHHS- Health Services Advisory Group (HSAG): Performance Improvement Project 25
Customer Service/Compliance Reporting 26
Customer Service Contacts 26
Results/Trends 27
Activities Implemented in FY2024 29
Recommendations for FY2025 29
Compliance Reporting 28
Compliance Investigations 30
Office of Inspector General Quarterly Report for FY2024 30
Data Mining Activities 31
Subpoena(s) 31
Notification of Breach(s) 31
Overall Results/Trends 32
Activities Implemented in FY2024 32
Recommendations for FY2025 33
Compliance Training/Review 33
Internal 33
External 33
References 34

Introduction

The Compliance Summary Report provides an overview of the effectiveness of activities performed throughout Fiscal Year 2024 as part of the MSHN Compliance Program and identified within the MSHN Compliance Plan. Those activities include internal and external monitoring and oversight reviews; customer service complaints; compliance investigations and compliance related training and review.

Each section includes an overview of activity results, trends, and analysis of the data. Recommendations for areas of quality improvement for the upcoming year are identified.

Recommendations for FY2025

Recommendation focus areas are identified from the MSHN Compliance Plan tasks and activities related to the MSHN strategic plan that are supported by findings and outcomes from internal and external monitoring and oversight site reviews, and 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, recommendations were not made to avoid duplication of efforts.

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

Recommendation: Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies region wide.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Area of Risk: Delegated Managed Care Reviews

Recommendation: CMHSP standards: MSHN Behavioral Health team, and the corresponding workgroups, will address and identify ways in which the region can improve compliance in areas that are continually below the established standards or expectations.

Lead Staff: Amy Dillon, Compliance Administrator

Recommendation: SUD Standards: MSHN will incorporate training topics into the Lunch and Learn training series provided quarterly to the provider network and focus on areas that fall below 80% compliance. This will be coordinated with the MSHN SUD Treatment team as they facilitate the trainings.

Lead Staff: Amy Dillon, Compliance Administrator.

Area of Risk: Compliance with external quality review requirements (Health Services Advisory Group (HSAG – Performance Measure Validation Review and Performance Improvement Project)

Recommendation: MSHN will perform additional spot checks prior to submitting data to HSAG to ensure that the cases meet eligibility requirements.

Lead Staff: Kara Laferty, Quality Manager

Recommendation: A causal/barrier analysis will be completed annually to ensure the barriers identified are reduced or eliminated, and to identify if any new barriers exist that require the development of interventions for both subgroups. The effectiveness of each intervention will be evaluated to determine if the interventions will continue, be revised, or discontinued based on the data reviewed.

Lead Staff: Kara Laferty, Quality Manager

The following recommendations were identified for FY2024 and are being continued for FY2025. Progress has been made, but the recommendations have not been fully implemented.

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.

Status: Data mining activities have been explored with the Chief Information Officer. Activities explored included:

- Monitoring ABA services for over 21 years of age - This did not result in a data mining activity, but did result in adding an edit that is being tracked through REMI to ensure compliance.
- Monitor ABA supervision – This includes the 97156 code which includes more than just behavior technician services – would need to ensure correct use of codes prior to proceeding with this as a data mining activity
- Discussed potential for reviewing duplicate billing for health homes (such as targeted case management) – more discussion needs to happen on this before proceeding

The Chief Compliance and Quality Officer also received information from the other PIHP Compliance Officers as to what data mining activities they are completing. Due to the system requirements within MSHN's information management system, many of the activities recommended by the Office of Inspector General are not necessary. This will continue to be explored internally to identify potential data mining activities.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

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

Status: Training opportunities have been explored with the Regional Compliance Committee and the PIHP Compliance Officers workgroup. The RELIAS training is in the process of being updated and the Office of Inspector General has been consulted on potential trainings for the completion of compliance investigations. In addition, the new compliance software vendor will also offer trainings related to compliance with State and Federal requirements. This will continue to be explored during FY2025.

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Status of FY2024 Recommendations

The following is a status update on the FY2024 areas of risk and progress made toward implementing the recommendations. These recommendations are considered complete. Any recommendations that were not completed have been moved to the FY2025 Recommendations section for continuation.

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.

Status: Complete. The MSHN Customer Service Committee (CSC) has reviewed the quarterly reporting of the Appeal and Grievance Regional Analysis Report to track and trend the data. Any CMHSP that did not meet the timeliness requirements for the Appeal and/or Grievance

report is required to complete a plan of correction to evaluate the factors that led to the non-compliance and to provide a plan to mitigate future timeliness issues.

Lead Staff: Dan Dedloff, Customer Service and Rights Manager

Area of Risk: Compliance with established Customer Service standards.

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.

Status: The MSHN CSC members have worked together to clarify the expectation for each CMHSP to capture data related to limited English proficiency (LEP) for local county analysis regarding the prevalence of non-English languages and monitoring compliance with LEP standards. MCL Public Act 241 of 2023 went into effect in February 2024 and established a biennial reporting requirement to monitor compliance with LEP standards. This will continue to be monitored for compliance if this becomes part of the PIHP/MDHHS Contract. Compliance with LEP standards is also monitored as part of the Network Adequacy Assessment. This will not continue as a recommendation but will be reviewed periodically during the Regional Customer Service Committee meeting.

Lead Staff: Dan Dedloff, Customer Service and Rights Manager

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

Recommendation: Utilize communication means such as newsletters, emails, website, etc. to provide updates and education to providers.

Status: Complete. These different forms of communication, as well as council/committee meetings, have been used to provide updates and education to providers. This recommendation is considered complete but will continue to occur as new information/education is available for the provider network.

Recommendation: Research options and implement a new process for tracking compliance investigations and documentation.

Status: Complete. Three vendors completed demonstrations for compliance software to appropriate MSHN staff, CMHSP Compliance Officers and PIHP Compliance Officers. A vendor has been chosen with input from MSHN staff and the CMHSP Compliance Officers. MSHN is in process of reviewing the contract and will then establish an implementation plan.

Recommendation: Update Compliance related policies and procedures and MSHN Compliance Plan to ensure compliance with new program integrity contract language.

Status: Complete. The Compliance related policies and procedures were updated to reflect changes in contract requirements and to ensure compliance with the review completed by the Office of Inspector General. The policies and procedures will continue to be updated as needed for future changes in contract requirements and the requirements of the Office of Inspector General.

Recommendation: Develop processes to track new OIG data requirements such as cost avoidance, recoupments, etc.

Status: Complete. A template has been developed to track data requirements for the provider network for FY2024. In addition, this information will be reviewed for inclusion into the

compliance software that MSHN is purchasing and implementing during FY2025.

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.

Status: Complete. The QAPI team has established a process to share the results of reviews with internal departments. This process includes bi-monthly coordination meetings, sharing results and recommendations via the quarterly report, and participating and making recommendations in Lunch and Learn trainings hosted by MSHN for the provider network. QAPI provides an annual report of scores and trends over the years to the MSHN SUD Treatment team which they use for determining their annual training plan for the provider network. QAPI continues to provide technical assistance with individual providers during the review process.

Lead Staff: Amy Dillon, Compliance Administrator

Area of Risk: Complete. 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.

Status: Complete. The corrective actions and incorporated improvement efforts as proposed by HSAG have been implemented.

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

Status: Complete. Training occurs during monthly QIC meetings and as requested by CMHSPs. MSHN also provides additional training if needed after quarterly data analysis is completed.

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

Status: Complete. Additional validations, including primary source verification, have occurred at the local level to ensure accurate data submission.

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

Status: Complete. Additional validations, including primary source verification, have occurred at the local level to ensure accurate data submission..

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.

Status: Complete. The measure data has been reported accurately, consistent with the PIP methodology.

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.

Status: Complete. A causal factor analysis is completed annually.

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.

Status: Complete. MSHN uses data to evaluate each intervention to determine if the interventions should be continued, revised or discontinued.

Lead Staff: Sandy Gettel, Quality Manager

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 continue to be discussions during the Regional Compliance Committee regarding the information that should be included on the webpage. There are numerous documents, templates and resources currently on the MSHN webpage, but will be organized into a format that is more easily accessible. This 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: A workgroup convened that included CMHSPs, PIHPs, MDHHS and TBD Solutions consulting firm and developed guidance documents for the PCP process. The MDHHS training document "IPOS Goal and Objective Writing" has been added to website and shared with the provider network. Weblink: https://midstatehealthnetwork.org/provider-network-resources/provider-resources-1/provider-trainings

In addition, the MDHHS/ARC conducted monthly trainings covering PCP which was shared with the regional training coordinators and regional waiver coordinators. Weblink: https://arcmi.org/projects/pcpqi/

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. While both groups remain receptive to having options provided, there have not been any identified. This can be reviewed with these groups as appropriate.

It is recommended that both of these recommendations be removed as an area of risk. Updates to the website will continue to be made when new trainings or resources are available,

Lead Staff: Kim Zimmerman, Chief Compliance and Quality Officer

Monitoring and Auditing

Mid-State Health Network Provider Network 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.

CMHSP Provider Delegated Managed Care Reviews

With the support and approval from the CMH Quality Improvement Council and Operation's Council, MSHN modified the Delegated Managed Care Review process beginning in FY24. The new process covers all required review sections, but rather than reviewing all in one year, the reviews are being conducted using a three-year review cycle. MSHN has aligned Delegated Managed Care reviews with external reviews (i.e. MDHHS, HSAG) when possible, which typically require CMHs provide duplicate documentation for each review. These changes were implemented to improve efficiencies, reduce duplication, and to ensure the review process is more manageable for CMHs. MSHN also changed the review cycle from calendar year to fiscal year.
FY24 was Year 1 of MSHN 3-year review cycle. The Year 1 review was conducted in alignment with the MDHHS Wavier review of MSHN Region 5. MSHN conducted waiver reviews for Bay-Arenac Behavioral Health, Community Mental Health for Central Michigan, Community Mental Health for Clinton, Eaton and Ingham Counties, Gratiot Integrated Health Network, Huron Behavioral Health, Lifeways Community Mental Health Authority, Montcalm Care Network, Newaygo County Mental Health Center, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door, and Tuscola Behavioral Health Systems. The review included Habilitation Supports Waiver (HSW), the Children's Waiver Program, the Children's Serious Emotional Disturbance Waiver (SEDW), and the 1915(i) State Plan Amendment (iSPA).

Delegated Managed Care Review Results

Five (5) different reviews tools were used which include a total of 105 standards. The focus of this section is to provide an overview of CMH compliance with programs and areas indicated below. The results for each review tool are provided below.
MSHN has also included the scores from the last full review of CMHs. Any sections FY24 results that indicated "N/A" were sections not included in the review for 2024.

2024 Administrative Standards (2023 Delegated Managed Care Tool)

Standards	# of Standards FY23	2023 Results	# Of Standards	2024 Results
Administrative (2023: Ensuring Health and Welfare)	16	97%	6	100%
Information/Customer Service	12	97%	N/A	N/A
24/7/365	18	100%	N/A	N/A
Enrollee Rights and Protections	9	100%	N/A	N/A

Provider Network Sub-Contract Providers	14	100%	N/A	N/A
Authorizations/Claims *2023: Service Authorization and Claims*	7	99%	3	100%
Grievance and Appeals	19	90%	N/A	N/A
Person Centered Planning	30	90%	N/A	N/A
Coordination of Care/Integration	6	96%	N/A	N/A
Behavior Treatment Plan Review Committee	21	94%	7	100%
Consumer Involvement	3	100%	N/A	N/A
Provider Staff Credentialing	22	93%	N/A	N/A
Compliance	7	99%	N/A	N/A
Information Technology	9	100%	N/A	N/A
Trauma Informed Care	6	99%	N/A	N/A
Environmental Modifications	N/A	N/A	1	100%
Behavior Treatment Plan Review Committee	21	94%	7	100%
Overall Regional Compliance		94.82%		100%

**The review elements for each standard change from year to year. "N/A" should not be assumed that standards related to the sections were not reviewed. The elements within each standard may be located in a different section of past review tools based on the new review tools and process.*
***2023 Results reflect reviews completed FY23 Q2-Q4 (9 of the 12 CMHs).*

Habilitation Supports Waiver (HSW) Charts

Clinical Chart Standards	**# of Standards FY23**	**2023 Results**	**# Of Standards FY24**	**2024 Results**
Freedom of Choice (2023: Pre Planning)	10	91%	2	77%
Intake and Assessment	13	97%	N/A	N/A
Pre-Planning	10	91%	N/A	N/A
Implementation of Person Centered Plan (2023: PCP/IPOS)	21	94%	7	84%
Plan of Service Documentation and Requirements (2023: Delivery and Evaluation)	3	80%	3	67%
Documentation	2	100%	N/A	N/A
Discharges/Transfers	4	80%	N/A	N/A
Integrated Physical/Mental Health Care	3	97%	N/A	N/A
Behavior Treatment Plans/Restrictions	N/A	N/A	7	52%
Waiver/iSPA Participant Health and Welfare (2023: Program Specific Services Delivery)	17	93%	2	82%
Overall Regional Compliance		*93.47%*		*74.27%*

**FY23 Scores reflect overall compliance for all programs and all charts reviewed and are not specific to HSW.*

Children's Waiver Program (CWP) Charts

Clinical Chart Standards	# of Standards FY23	2023 Results	# Of Standards FY24	2024 Results
Eligibility (2023: Intake/Assessment)	13	97%	2	100%
Freedom of Choice (2023: Pre Planning)	10	91%	2	100%
Implementation of Person Centered Plan (2023: PCP/IPOS)	21	94%	4	63%
Plan of Service and Documentation Requirements (2023: Delivery and Evaluation)	3	80%	6	61%
Documentation	2	100%	N/A	N/A
Discharge and Transfers	4	80%	N/A	N/A
Integrated Physical/Mental Health Care	3	97%	N/A	N/A
Behavior Treatment Plan/Restrictions	N/A	N/A	7	N/A**
Waiver/iSPA Participant Health and Welfare (2023: Program Specific Services Delivery)	17	93%	2	100%
Overall Regional Compliance		*93.47%*		*78%*

**FY23 Scores reflect overall compliance for all program charts reviewed and are not specific to CWP.*
***None of the 2024 CWP chats reviewed had behavior treatment plans*

Serious Emotional Disturbance Waiver (SEDW) Charts

Clinical Chart Standards	# of Standards FY23	2023 Results	# Of Standards FY24	2024 Results
Eligibility (2023: Intake/Assessment)	13	97%	1	78%
Freedom of Choice (2023: Pre Planning)	10	91%	2	100%
Implementation of Person Centered Plan (2023: PCP/IPOS)	21	94%	4	64%
Plan of Service and Documentation Requirements (2023: Delivery and Evaluation)	3	80%	6	54%
Documentation	2	100%	N/A	N/A
Discharge and Transfers	4	80%	N/A	N/A
Integrated Physical/Mental Health Care	3	97%	N/A	N/A
Behavior Treatment Plan/Restrictions	N/A	N/A	7	100%
Waiver/iSPA Participant Health and	17	93%	2	83%

Welfare (2023: Program Specific Services Delivery)		
Overall Regional Compliance	*93.47%*	*73%*

1915i State Plan Amendment (iSPA) charts (MSHN did not review 1915i in 2023)

Clinical Chart Standards	# Of Standards	2024 Results
Eligibility	3	95%
Freedom of Choice	2	87%
Implementation of Person Centered Plan	3	95%
Plan of Service and Documentation Requirements	3	82%
Behavior Treatment Plan/Restrictions	7	11%
Waiver/iSPA Participant Health and Welfare	2	92%
Overall Regional Compliance		*88%*

SUDSP Treatment Provider Delegated Function Reviews

During FY2024, both full and interim reviews were completed. The interim reviews are conducted to ensure compliance and implementation of approved corrective action plans for findings identified in the previous review. Interim reviews do not receive a score. Full reviews consist of chart reviews, validation of process requirements, staff files, policies, and procedures. For providers that are outside of the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region where 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 eight (8) full reviews and 16 (sixteen) interim reviews from October 1, 2023 – September 30, 2024.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of 98 standards. Overall compliance is 94%.

FY24 SUD Delegated Functions Scores

Sections	# Of Standards	2023 Results	2024 Results
Access and Eligibility	4	84%	95%
Information and Customer Service	17	96%	93%
Enrollee Rights and Protections	14	95%	97%
Grievance and Appeals	16	93%	79%
Compliance	10	95%	79%
Quality	4	86%	94%
Individualized Treatment & Recovery Planning & Documentation	13	88%	97%

Coordination of Care	4	83%	80%
Provider Staff Credentialing	11	94%	73%
IT Compliance/IT Management	1	100%	86%
Trauma Informed Care	4	93%	100%

Note: All percentages are rounded to the nearest percent.

The following identifies additional information regarding the sections 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.

Grievance and Appeals: 79% Compliance

- There are sixteen (16) standards in this section. Ten (10) of the standards scored under 90% compliance. Those standards included compliance in the areas of adverse benefit determination letters being sent and including the correct language, using REMI for adverse benefit determination letters, sending letters within the required timeframes and when required, processes for expedited appeals are followed, sending appropriate acknowledgement and disposition letters as appropriate and through REMI for grievance and appeals, Maintaining logs of grievances and appeals in REMI. It should be noted that these specific standards were applicable only to five (5) of the eight (8) providers reviewed in this fiscal year timeframe.

Coordination of Care: 80% Compliance

- There are four (4) standards in this section and one (1) of those scored under 90% compliance. The standard was related to providers having processes in place to coordinate care with clients supervising agents when referred by MDOC. This was applicable to five of the eight providers reviewed.

Provider Staff Credentialing: 73% Compliance

- There are eleven (11) standards in this section and seven (7) of those scored under 90% compliance. The standards under 90% compliance were related to providers not having a staff development/training program or staff not meeting training requirements, criminal background checks not conducted as required, central registry checks not conducted as required for staff providing services to children, state and federal sex offender checks not being conducted as of 10/1/23 and assigning practitioners to provide services without all credentialing being completed.

Program Specific Review Results

The SUDSP program specific review tool includes a total of fifteen (15) standards. Overall compliance is 90.54%.

Program Specific Review

Sections	# Of Standards	2023 Results	2024 Results
Residential (2)	1	63%	100%
Peer Recovery Supports Services (3)	1	69%	100%
Women's Specialty Services (3)	2	78%	83%
Medication Assisted Treatment (1)	3	52%	100%
Recovery Residence (3)	8	76%	90%

**Not all providers offer each program/service. The number next to the section name represents the number of providers that were reviewed for these services in FY24.*

The program specific is focused on policy, procedure, process or other supporting documents to ensure the providers are meeting the requirements of the specialty program. 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.

Women's Specialty Services: 83% Compliance

- There are two (2) standards in this section. Each standard scored at total of five (5) out of six (6) possible or 83.33%. While the score was under 90%, there were only three providers that were reviewed and only one was partially non-complaint. The QAPI team has determined this would not warrant additional regional attention.

Recovery Residence: 90%

- There were three (3) providers reviewed that offer recovery residence services. Of the eight (8) standards reviewed, six (6) standards scored 100%. There were two (2) standards that scored less than 90 percent. These were related to providers having explicit written admission criteria meeting requirements (4/6 points or 67%) and evidence of weekly house meetings 3/6 points or 50%).

Clinical Chart Review Results

The SUDSP treatment chart review tool includes a total of forty-four (44) standards. Overall compliance during this timeframe for full reviews is 67%.

SUD Chart Review Scores

Sections	# Of Standards	2023 Results	2024 Results
Screening, Admission, Assessment	5	73%	63%
Treatment/Recovery Planning	9	72%	69%
Progress Notes	3	69%	78%
Coordination of Care	5	59%	52%
Discharge/Continuity of Care	3	64%	76%
Residential	5	64%	50%
Medication Assisted Treatment	8	54%	57%

Women's Designated/Women's Enhanced	2	68%	86%
Recovery Housing	4	59%	68%

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

MSHN typically reviews four (4) charts for each provider. MSHN may review more than four (4) charts if necessary to ensure review of all services/programs offered and funded by MSHN. In rare instances, a provider may not have (4) consumers enrolled in services to review at which point, MSHN reviews at least two (2) files.

Findings are often organization specific, meaning 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 and follow-up (interim) reviews are conducted to ensure implementation of the plans of correction for each provider.

Screening, Admission, Assessment: 63% Compliance

- There are five (5) standards in this section, four (4) of which scored under 90% compliance.. The findings included accurately documenting initial contact in REMI, 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: 69% Compliance

- There are nine (9) 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: 78% Compliance

- This section includes three (3) standards, of which none 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; and consumer strengths were not identified within he record and used to drive the planning process.

Coordination of Care: 52% Compliance

- There are five (5) 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: 76% 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: 50% Compliance

- This section includes a total of five (5) standards, three (3) of which were not applicable. Of the two standards that were scored, neither reached 90% compliance. These standards were related to review of medications prior to prescribing medications in residential detoxification programs and related to assuring consumers entering residential treatment are tested for TB and results are known in five (5) days of admission.

Medication Assisted Treatment: 57% Compliance

- This section includes fifteen (8) standards. Of those, two (2) standards were fully compliant and the remaining six (6) standards did not meet 90% compliance. These standards were related to documented use of MAPS, documenting all alcohol and illicit drug use, ensuring individuals are provided informed consent on use of methadone treatment, evidence of client-signed consent to contact other OTPs within 200 miles, take-home doses occurring in accordance with regulations, and providers informing Supervision agents when MDOC referred individuals receive medication assisted treatment.

Women's Designated/Enhanced: 86% Compliance

- There are two (2) standards reviewed in this section. One standard scored under 90% related to assessment of needs completed on consumer and each independent child.

Recovery Housing: 68% Compliance

- There are four (4) standards included in this section. None of the four (4) standards reached 90% compliance. Findings were related to eligibility confirmed via outpatient treatment engagement/attendance, resident charts including all required documentation, completed screens and applications, and service plans not including all required elements.

Medicaid Event Verification 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 within the MSHN region.

The attributes tested during the Medicaid Event Verification (MEV) 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/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 reviews conducted in FY2024. For complete information, please see the Medicaid Services Verification Methodology Report for Fiscal Year 2024 which will be available in December 2024.

CMHSP

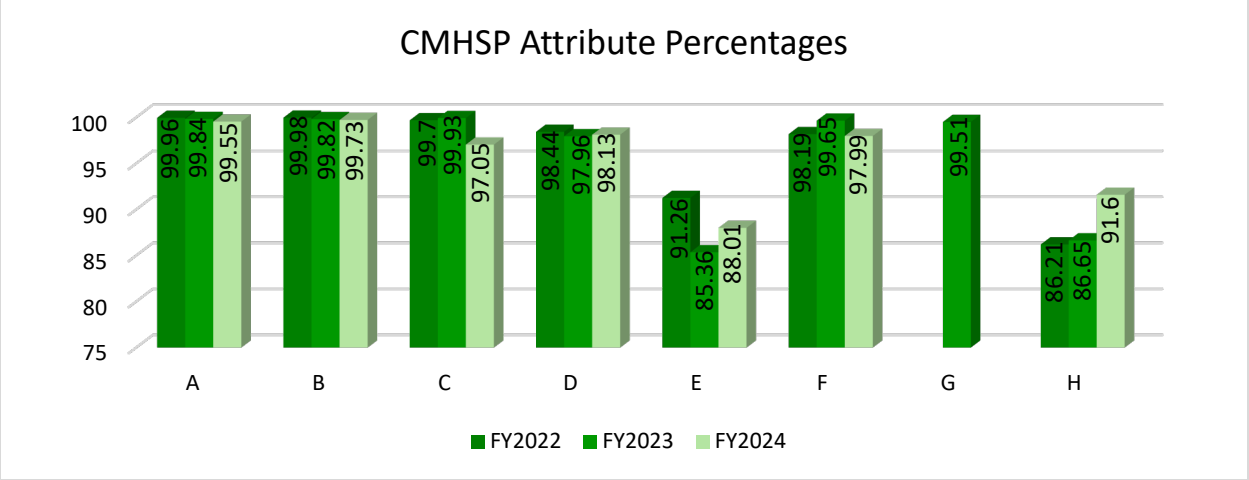
The CMHSP reviews are completed bi-annually (twice a year) for all twelve (12) CMHSPs. The table below

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, October 1, 2023 – September 30, 2024.

CMHSP	A	B	C	D	E	F	G
BABHA	100%	100%	100%	98.04%	86.75%	96.75%	88.27%
CEI	100%	100%	100%	99.52%	96.94%	100%	93.49%
CMHCM	99.63%	100%	96.42%	98.69%	91.74%	99.63%	90.53%
Gratiot	98.94%	100%	100%	99.57%	93.62%	98.94%	91.75%
Huron	100%	100%	100%	99.69%	97.20%	100%	97.95%
Lifeways	96.86%	99.69%	97.17%	96.74%	84.58%	96.59%	86.49%
Montcalm	100%	98.99%	82.59%	98.48%	80.06%	99.75%	99.60%
Newaygo	100%	98.68%	97.19%	98.18%	97.11%	100%	86.33%
Saginaw	99.35%	100%	99.10%	98.19%	89.49%	96.48%	93.11%
Shiawassee	100%	99.60%	100%	95.04%	79.16%	98.28%	92.63%
The Right Door	100%	100%	99.46%	97.83%	79.49%	100%	89.56%
Tuscola	100%	100%	94.13%	98.38%	84.59%	90.48%	92.65%
MSHN Average	**99.55%**	**99.73%**	**97.05%**	**98.13%**	**88.01%**	**97.99%**	**91.60%**

Note: CMHSP reviews are completed twice during the fiscal year. The percentages displayed are an average of the scores for both reviews (with the exception of Huron which only has data for one review as the second review had pending results at the end of the quarter and will be reported in FY2025 data).

The following chart provides a comparison from FY2022 through FY2024 for the attributes tested:



Note: In FY22 there were 7 (A-G) attributes tested compared to 8 (A-H) in FY23. In FY24, MSHN went back to 7 attributes (A-G) for the MEV review. For the purposes of this graph, FY22 and FY24 data for attribute G.) Modifiers are used in accordance with the HCPCS guidelines is included under attribute H.

FY22 and FY24:
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 or in the treatment plan
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
G.) Modifiers are used in accordance with the HCPCS guidelines

FY23:
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 or in the treatment plan
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
H.) Modifiers are used in accordance with the HCPCS guidelines

SUD

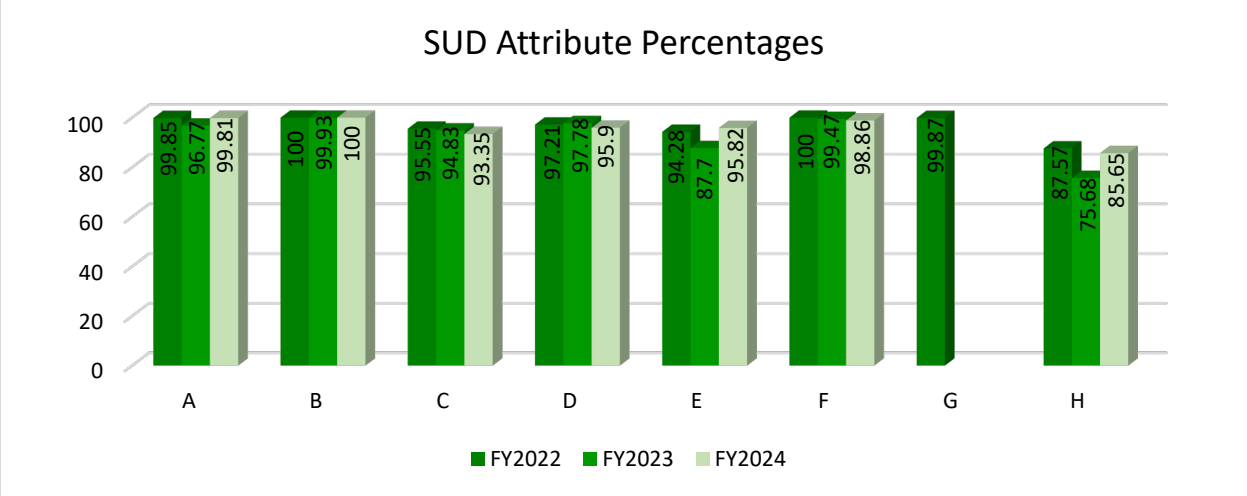
The Substance Use Disorder site reviews are completed annually. The data presented in the below chart is relative to the seventeen (17) SUD treatment providers reviewed for the full fiscal year, October 1, 2023 – September 30, 2024.

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	99.81%	100%	93.35%	95.90%	95.82%	98.86%	85.65%

The following chart provides a comparison from FY2022 through FY2024 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 FY22 there were 7 (A-G) attributes tested compared to 8 (A-H) in FY23. In FY24, MSHN went back to 7 attributes (A-G) for the MEV review. For the purposes of this graph, FY22 and FY24 data for attribute G.) Modifiers are used in accordance with the HCPCS guidelines is included under attribute H.

FY22 and FY24:
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 or in the treatment plan
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
G.) Modifiers are used in accordance with the HCPCS guidelines

FY23:
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 or in the treatment plan
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
H.) Modifiers are used in accordance with the HCPCS guidelines

Results/Trends

Based on the MEV reviews for FY2024, all twelve (12) CMHSPs were placed on a new plan of correction and of the seventeen (17) substance use disorder treatment providers reviewed, twelve (12) 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 FY2023, were removed from those plans during FY2024.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and contractual services of $663,687.94 and $20,821.42 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 slight improvements from FY2023 to FY2024 for the following attributes:
1. D. Documentation of the service date and time matches the claim date and time of the service
2. E. Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
3. G. Modifiers are used in accordance with the HCPCS guidelines
Note: Attribute G.) Modifiers are used in accordance with the HCPCS guidelines was listed as Attribute H in FY23. There is no longer an Attribute H as Attributes F and G from FY23 have been combined.

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, the telehealth modifier was discontinued near the end of FY23 which had been a particularly common finding for CMHSPs and SUDSPs in the past. Furthermore, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.

Alternatively, the SUD providers have shown considerable improvements from FY2023 to FY2024.
1. A. The code is allowable service code under the contract
2. B. Beneficiary is eligible on the date of 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
4. G. Modifiers are used in accordance with the HCPCS guidelines

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.

External Reviews

MDHHS Waiver Review

The Michigan Department of Health and Human Services (MDHHS) conducted a full review for our region May – July 2024. The purpose of the review was to ensure compliance with state and federal requirements related to the Habilitation Supports Waiver (HSW), Waiver for Children with Serious Emotional Disturbance (SEDW), Children's Waiver Program (CWP), and 1915i SPA (iSPA).
MDHHS reviewed 149 clinical records and a total of 868 staff files (236 professional staff and 632 aide-level staff). A final report was sent to MSHN on August 28, 2024, with a request for a plan of correction to be submitted. The corrective action planning process carried over into fiscal year 2025.

Results/Trends

HSW

Of the Twenty-five (25) measures reviewed related to charts the following trends were identified by MDHHS:

- Increase in compliance: 2 measures
- Maintained Compliance: 5 measures
- Decreased Compliance: 9 Measures

Of the 38 charts reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- Specific services and supports aligning with individuals assessed needs including measurable goals/objectives, with amount scope and duration and timeframe for services for implementing. Thirty three (33) of thirty eight (38) or 87% of clinical records reviewed had findings for this measure.
- Services and treatment identified in the IPOS were provided as specified in the plan. Nineteen (19) of thirty eight (38) or 58% of clinical records reviewed had findings for this measure.

CWP

Of the Twenty-seven (27) measures reviewed related to charts/files, the following trends were identified by MDHHS:

- Increase in compliance: 7 measures
- Maintained Compliance: 5 measures

- Decreased Compliance: 3 Measures

Of the twelve (12) charts reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- IPOS addresses all service needs reflected in the assessments. Six (6) of the twelve (12) files or 50% of clinical records reviewed had findings for this measure.
- Services and supports are provided as specified in the IPOS, including type, amount, scope duration and frequency. Nine (9) of the twelve (12) files or 75% of clinical records reviewed had findings for this measure.

SEDW

Of the Twenty-five (25) measures reviewed related to charts/files, the following trends were identified by MDHHS:

- Increase in compliance: 7 measures
- Maintained Compliance: 3 measures
- Decreased Compliance: 4 Measures

Of the twenty-three (23) charts reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- The IPOS is developed in accordance with MDHHS policies and procedures i.e. measurable goals/objectives and timeframes, prior authorization of services correspond to services identified in the plan, etc. Fifteen (15) of the twenty-three (23) or 65% of clinical records reviewed had findings for this measure.
- Services and supports are provided as specified in the IPOS including amount, scope, duration, and frequency. Nineteen (19) of the twenty-three (23) or 83% of clinical records reviewed had findings for this measure.

iSPA

2024 was the first year that iSPA was reviewed. There are no trends to report.

Of the seventy-six (76) clinical records reviewed, 50% or more of clinical records reviewed identified citations in the following areas:

- Specific services and support align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, duration of services and timeframes for implementing are identified in the IPOS. Sixty-five (65) of the seventy-six (76) or 87% of the clinical records reviewed had findings for this measure.
- Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objectives, the type, amount scope duration, frequency, and timeframe for implementing. Fifty-one (51) of the seventy-six (76) or 67% of the clinical records reviewed had findings for this measure.

Recommendations

The final report and a summary of trends and outcomes has been provided to the MSHN Behavioral Health Team and the MSHN Quality Improvement Council to identify and address any recommendations or areas for regional improvement.

MDHHS- Health Services Advisory Group (HSAG): Performance Measurement Validation 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 July 30, 2024.

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 2024.

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

Among the recommendations from this review were the following:

- HSAG recommends that MSHN perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet eligibility requirements. Data validation is a crucial step in ensuring an accurate submission. Incorporating additional spot checks could add value, especially when data are being integrated from multiple sources.
- HSAG recommends that MSHN proceed with its outlined remediation plan. Additionally, HSAG recommends that MSHN continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #2 and #3 data. This should include implementing another level of validation for reviewing a statistically significant sample of cases each quarter to confirm that their associated population designations are accurately reported.
- HSAG recommends that MSHN implement the programming logic updates and also perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that MSHN continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator #3 data..
- HSAG recommends that MSHN perform additional spot checks prior to submitting data to HSAG, such as performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements. Additionally, HSAG recommends that MSHN continue to work with the CMHSP to enhance existing or implement additional processes when necessary to improve the accuracy of indicator

#4a data. Retraining on how to appropriately document various scenarios in the REMI system should be provided if found necessary.

- HSAG recommends that MSHN continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.
- HSAG recommends that MSHN continue with its improvement efforts related to indicator #3 so that it meets or exceeds the 50th percentile benchmark and further ensures timely and accessible ongoing covered services following completion of a biopsychosocial assessment. The timeliness of ongoing services is critical to consumer engagement in treatment and services.

MDHHS- Health Services Advisory Group (HSAG): Network Adequacy Review

Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or a primary care case manager (PCCM) entity to have a qualified external quality review organization (EQRO) perform an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP, or PCCM entity. In accordance with 42 CFR §438.358(b)(1)(iv), the EQR must include validation of MCO, PIHP, or PAHP network adequacy to comply with requirements set forth in §438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1). As the EQRO for the Michigan Department of Health and Human Services (MDHHS), Health Services Advisory Group, Inc. (HSAG) is responsible for conducting the annual network adequacy validation (NAV) for all PIHPs contracted with MDHHS.

The focus of the review included network adequacy data collection, integration, calculation, accuracy, and reporting of indicators for each required standard. Specifically, HSAG reviewed the logic used specific to the time and distance standard.

At the time of this report, MSHN has received approval for our process of calculating time and distance. HSAG is expected to finalize the NAV audit aggregate report December 2024.

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 and includes a review of thirteen (13) different standards. FY2024 was year one of the review cycle and included review of five (5) of the thirteen (13) standards. The review took place on August 26, 2024. MSHN has received a draft copy of the final report. MSHN expects to receive the finalized report in December 2024 and to submit a plan of correction January 2025.

Results/Trends

MSHN achieved an overall compliance score of 85%.
Standard I – Member Rights and Member Information: 76%
Standard III – Availability of Services: 100%
Standard IV- Assurances of Adequate Capacity and Services: 100%
Standard V- Coordination and Continuity of Care: 93%
Standard VI – Coverage and Authorization of Services: 68%

Recommendations

HSAG made several recommendations throughout the review specific to standards. Below is an abbreviated summary of some of the recommendations that were made. Full recommendations can be viewed in the final report when added to the MSHN website.

Standard I – Member Rights and Member Information

- There were several recommendations to update language in the Member Handbook, policies, and procedures to ensure compliance with all federal and state requirements and standards reviewed in this section.
- Recommendation to update MSHN audit review tools to include more specific elements.
- MSHN should develop tracking mechanisms to confirm timely member notification when there are changes to the member handbook and provider directory.
- MSHN should develop a process for reporting and tracking members who request the information in 42 CFR §438.10 in paper format are provided with the requested information within five business days of the request.
- MSHN should develop definitions for provider types that must be in the PIHPs provider directory for clarity about the services that fall under each provider.

Standard III - Availability of Services

- To enhance the PIHP's monitoring processes of its CMHSPs, HSAG recommends that the PIHP consider developing a standardized reporting template for its CMHSPs to report data pertaining to the access standards to the PIHP.
- To enhance the PIHP's monitoring processes of its providers, HSAG recommends that the PIHP consider developing a secret shopper survey or other mechanism for monitoring provider office hours as required in contract.

Standard IV- Assurances of Adequate Capacity and Services

- HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG network adequacy validation (NAV) activity and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.

Standard V – Coordination and Continuity of Care

- As the PIHPs were not consistently applying the same screenings or assessments to this initial screening requirement, HSAG recommends that the PIHPs consult with MDHHS to confirm which screening or assessment (e.g., screening at access, assessment conducted within 14 days of a request for services) is required and update policies and procedures are updated to reference the appropriate screening or assessment.
- HSAG recommends that the PIHPs collaborate with MDHHS to develop a definition for LTSS that will be used by all PIHPs. As part of the definition, MDHHS and the PIHPs could develop a list of services and benefits under the PIHPs' scope of work (SOW) that are considered LTSS. Based on this collaboration and, with confirmation by MDHHS, the PIHP should update its policies and procedures and other utilization management (UM)-related program documents, as well as its quality assessment and performance improvement program (QAPIP) description to include the State's definition of LTSS. The PIHP should also ensure that its policies and procedures, UM-related program documents, and QAPIP description identify which members it has identified as having special health care needs (e.g., all members, a subset of members). If MDHHS declines to define LTSS and/or members having special health care needs, the PIHP should ensure that it has defined LTSS and members with special health care needs in its program documents. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.
- HSAG recommends that the PIHP reiterate to its staff members and/or its delegates the importance of ensuring that the IPOS includes documentation of the names of all IPOS meeting attendees and their roles in the meeting (e.g., member's guardian). If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a

Not Met score.

- As MDHHS' expectation is that all PIHPs will be in compliance with the requirements under 42 CFR §441.301(c)(4)(vi)(F)(1–8) by the end of calendar year 2024, and because MDHHS has added two performance measures for SFY 2025 with the waiver renewal that will assess whether completed person-centered plans with identified restrictions/modifications comply with Home and Community-Based Settings requirements and that the PIHP has effective administrative policies in place regarding Home and Community-Based Settings compliance and monitoring processes, HSAG strongly recommends that the PIHP prioritize the inclusion of all required documentation when there is a modification of the conditions that are required for Home and Community-Based Settings directly within the person-centered plan. HSAG also recommends that the PIHP consider developing a modifications section template within the person-centered plan that will be required to be used by all PIHP staff and/or its delegated entities when there is a modification to the Home and Community-Based Settings required under 42 CFR §441.301(c)(4). The template should have sections that address sub-elements (a) through (h) of this element, with detailed instructions for the documentation that must be included for each section to ensure compliance with the expectations set by MDHHS and the requirements under federal rule. Further, the PIHP must ensure that it maintains a robust and ongoing auditing process to confirm that its delegated entities are also complying with the modification requirements stipulated by federal rule and in alignment with the expectations required by MDHHS and the PIHP. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will likely receive a *Not Met* score.
- HSAG strongly recommends that the PIHP enhance its SUD chart review tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, HSAG strongly recommends that the PIHP educate its SUD treatment providers that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.

Standard VI – Coverage and Authorization of Services

- HSAG recommends that the PIHP include the federal Medicaid managed care definition of "medically necessary services," in its UM program description, or at minimum, cross-reference 42 CFR §438.210(a)(5) under the PIHP's internal definition of "medically necessary services.".
- HSAG recommended several updates to the MSHN monitoring tools and processes to ensure compliance with federal requirements and network delegated activities.
- HSAG recommended several policy and procedure, member handbook, and UM plan updates to ensure all federal requirements are incorporated.
- HSAG recommends that the PIHP include a list of services categorized as LTSS in its UM program description.
- HSAG recommends that the PIHP develop a procedure document that outlines the criteria for sending an ABD notice for a denial of payment as well as the coordination efforts between the UM and claims teams to ensure that an ABD notice is sent to the member on the date that the decision to deny the payment on the claim is made. HSAG also recommends that the PIHP conduct staff training to ensure their understanding of the requirements of this element and how the requirements should be implemented. Further, HSAG recommends that the PIHP conduct a review to validate that the CMHSPs have no claim payment denials for the Medicaid program, and that the CMHSPs have adequate mechanisms to ensure that ABD notices are sent when a claim payment denial occurs. HSAG recommends that the PIHP periodically (e.g., quarterly) review reports that display the number of claims received and paid for in full, and the number of claims received in which payment, in full or in part, were denied. For any payment denials, the PIHP must confirm that an ABD notice was provided to the member. If the PIHP does not provide evidence to demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.

MDHHS- Health Services Advisory Group (HSAG): Encounter Data Validation Review

MDHHS contracted with Heath services Advisory Group (HSAG) to conduct a validation of encounter data reported by PIHPs. Initially proposed to PIHPs as a study and gathering of information in FY23, MDHHS announced HSAG

would conduct documentation reviews in FY24 and every three years following. The review purpose is to ensure that encounter documentation accurately reflects the provider rendered a specific service under a managed care delivery system.

HSAG initially requested documentation for 411 encounters in addition to documentation from the encounter following, for a total of approximately 822 encounters. MDHHS and HSAG then sent communication that they would lower the 411 requested encounters by 25%, or to 308 files to include the follow up encounter, approximately 616 encounters.

Required documentation included demographic information, provider information, service date, diagnosis code, procedure code and procedure modifiers, and charts/visit notes. Files were to be uploaded in smaller numbers May 3, 3024-July 15, 2024. CMHs and MSHN met all due dates as required.

An aggregated report for Michigan is expected to be sent directly to MDHHS. The expected date has not been provided to PIHPs however, MDHHS typically sends electronic notification to PIHP CEO's informing them when the report is available.

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

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 remeasurement 1 data for 01/01/2023 through 12/31/2023 was 59.70% 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 remeasurement 1 data for 01/01/2023 through 12/31/2023 was 63.00% 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

Validation Rating: Design and Implementation

- Percentage of Evaluation Elements Met: 100%
- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *High Confidence* rating.

MSHN met 100 percent of the requirements for the data analysis and implementation of improvement strategies. MSHN used appropriate QI tools to conduct its causal/barrier analysis and to prioritize the identified barriers. Timely interventions were implemented and were reasonably linked to the corresponding barriers.

Validation Rating: Outcomes

- Percentage of Evaluation Elements Met: 33%

- Percentage of Critical Elements Met: 100%
- MSHN Validation resulted in a *No Confidence* rating.

MSHN did not demonstrate statistically significant improvement over the baseline performance for the disparate subgroup (Black/African American population). The PIHP did not achieve the state-specific goal of eliminating the existing disparity between the two subgroups without a decline in performance for the comparison subgroup (White population) with the first remeasurement period.

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

- The performance indicators have not yet achieved the goals for the PIP. MSHN should consider evidence-based intervention efforts and the risk factors in quality of care for each subgroup, independently.
- 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 required development of interventions for both subgroups.
- MSHN should continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.

Customer Service/Compliance Reporting

Customer Service Contacts

The total number of Customer Services contacts received in FY2024 was 115, a 25.8% decrease from FY2023. By comparison, there were 155 contacts in FY2023.

Customer Service Originator of Contact

Originator	Number	Percentage*
Advocate	4	3%
Authorized representative	1	1%
CMHSP	28	24%
Family Member	4	3%
Guardian	1	1%
MDHHS	18	16%
Other	13	11%
Parent of a minor	5	4%
Self/Consumer	30	26%
SUDSP	11	10%

*(*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	29	25%
Appeal	2	2%
Complaint/Dissatisfaction	18	16%
Consumer Discharge	4	3%
General Assistance	28	24%
Interaction with Provider or Plan	1	1%
LEP Assistance	4	3%
Medicaid Fair Hearing	2	2%

Notification Letter	6	5%
Provider Practices	16	14%
Provider Staff Concern	1	1%
Recipient Rights Assistance	4	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

Type of Resolution	Number	Percentage*
No follow-up required	46	40%
Resolution pending	4	3%
Resolved in favor of consumer	4	3%
Resolved in favor of provider	14	12%
Resolved through follow up actions	47	41%

*(*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 FY2024:

- Overall Customer Service contacts decreased by 26% in FY2024 (115) from FY2023 (155).
- Consumer contacts requiring follow-up action decreased by 39% from 75 in FY2023 to 46 of Consumer contacts in FY2024.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (25% / n=29) and MDHHS (9% / n=10).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (24% / n=28)
- The highest consumer complaint categories addressed Access to Treatment (23% / n=26) and Complaint/Dissatisfaction (14% / n=16). Access to Treatment was a 29% decrease in FY24 (n=29) over FY23 (41). Complaint/Dissatisfaction saw a 30% decrease in FY24 (n=16) over FY23 (n=23).
- The highest non-consumer contact category involved requests for General Assistance (23% / n=26)

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 FY24 Q1-Q4.

FY24 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	35	0.09	21	0.06	93	34	29
ACCESS AND AVAILABILITY	21	0.06	13	0.04	54	21	37
INTERACTION WITH PROVIDER OR PLAN	32	0.09	14	0.04	77	32	26
MEMBER RIGHTS	5	0.01	3	0.01	13	5	33
TRANSPORTATION	1	0.00	0	0.00	2	1	6
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	0	0.00	0	0.00	0	0	#DIV/0!
SAFETY/RISK MANAGEMENT	4	0.01	2	0.01	11	4	10
SERVICE ENVIRONMENT	7	0.02	7	0.02	18	7	9
OTHER	9	0.02	5	0.01	22	9	25
Total	114	0.31	65	0.18	290	113	28

*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 FY24 Q1-Q4.

FY24 MDHHS Appeals Reporting Results (Q1-Q4)								
Reason for Adverse Decision on Appeal	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	Percent Timely-All Cases	Percent Untimely-All Cases
MEDICAL NECESSITY CRITERIA NOT MET	63	0.17	57	1	2	3	94%	6%
NOT A PIHP-COVERED BENEFIT	5	0.01	5	0	0	0	100%	0%
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
TREATMENT/SERVICE PLAN GOALS MET	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NOT ELIGIBLE FOR SERVICES	7	0.02	7	0	0	0	100%	0%

MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	24	0.06	24	0	0	0	100%	0%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
OTHER	15	0.04	15	0	0	0	100%	0%
NOT APPLICABLE	333	0.90	328	3	2	0	99%	1%
MEDICAL NECESSITY CRITERIA NOT MET	63	0.17	57	1	2	3	94%	6%
Total	63	0.17	57	1	2	3	94%	6%

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

	Count	Percentage
Appeals	447	
Appeals Upheld	95	21%
Appeals Overturned	340	76%
Appeals Partially Upheld/Overturned	12	3%

For FY2024, 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 FY2024

The following activities were implemented during FY2024.

- The quarterly Appeal and Grievance Regional Analysis Report was utilized to evaluate the quarterly MDHHS Grievance and Appeal data for regional trends and quality improvement.
- The MSHN Customer Service Committee reviewed, revised, and facilitated the publication of thirteen (13) local versions of the FY24 MSHN Guide to Services Handbook. Additionally, the thirteen (13) local versions were translated into Spanish for electronic distribution to CMHSP and SUDSP providers throughout the MSHN region.
- MSHN Customer Services continued to collaborate with MSHN staff to provide technical assistance to improve the quality of services through providers within MSHN's SUDSP network.
- MSHN provided ongoing technical support and training to the provider network in customer service, grievance and appeals, and recipient rights.

Recommendations for FY2025

Based on FY24 Customer Service data, the following is being recommended:

- The review of FY24 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.
- Based on the Meaningful Language Access to State Services Act, which became effective on February 28, 2024, was reviewed. Regional LEP practices will be evaluated to gather LEP information from local county analysis for non-English language prevalence for a biennial report of language access within the Act. CSC members will develop a process and template in preparation for the report to ensure compliance with LEP requirements.

Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2024 was 32. By comparison, there were 26 completed in FY2023. This resulted in an increase of 23.07% in FY2024 from FY2023.

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

Originator:	***Number:***	***Percent:***
SUD Provider Staff	1	3.13%
CMHSP Staff	16	50.00%
MSHN Staff	2	6.25%
Office of Inspector General (OIG)	9	28.12%
Community/Stakeholder	4	12.50%

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

Category:	***Number:***	***Percent:***
Fraud/Abuse/Waste	18	56.25%
Treatment/Services	3	9.37%
Duplicate Claims	2	6.25%
Over Payment for Services	2	6.25%
Credentialing/Qualifications	6	18.75%
Confidentiality	1	3.13%

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

Type of Resolution:	***Number:***	***Percent:***
CMHSP	15	46.87%
SUD Provider	3	9.38%
OIG	9	28.13%
Pending	5	15.62%

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	13	40.63%

Office of Inspector General Quarterly Report for FY2024

PIHPS are required to track and report program integrity activities performed within the region. The program activities must include, but are 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.

Below is a breakdown of activities reported for each quarter in FY24. Activities that are not closed out or finalized in the quarter reported carry over to the following quarterly report until resolved. Additionally, Medicaid Event Verification reviews are reported the quarter that they are considered completed/closed/finalized.
FY2024 Q1: 48 activities were reported (33 previously initiated, 15 initiated, 46 resolved)
FY2024 Q2: 46 activities were reported (23 previously initiated, 23 initiated, 32 resolved)
FY2024 Q3: 46 activities were reported (27 previously initiated, 19 initiated, 31 resolved)

FY2024 Q4: 62 activities were reported (43 previously initiated, 27 initiated, 43 resolved)

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 $552,077.76. 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 FY2024.

Data Mining Activities

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2024, 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.

Results/Trends

The following are the data mining activities and results for FY2024 Q1.

1) Death Data Report
   Results: There were 32 unique individuals that included 394 encounters. It was concluded that there were no instances where a service was provided after the date of death.

The following are the data mining activities and results for FY2024 Q2.

1) Death Data Report
   Results: There were 46 unique individuals that included 370 encounters. It was concluded that 2 (two) services, involving 2 (two) beneficiaries, reported past the identified date of death. The errors were corrected.

The following are the data mining activities and results for FY2024 Q3.

1) Death Data Report
   Results: There were 10 unique individuals that included 47 encounters. It was concluded that there were no instances where a service was provided after the date of death.

The following are the data mining activities and results for FY2024 Q4.

1) Death Data Report
   Results: There were 13 unique individuals that included 181 encounters. It was concluded that there were no instances where a service was provided after the date of death.

Subpoena(s)

MSHN received 3 (three) subpoenas during FY2024 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 FY2024, within the MSHN region, there were 4 (four) instances reported involving a breach of protected health information. Out of the instances, 2 (two) were reported from Substance Use Providers 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.

Overall 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 an increase in the total number of compliance issues reported during FY2024
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 56.25%.
- Twenty-seven (27) investigations were completed and achieved a closed status.
- Five (5) investigation is still pending closure by the OIG.

OIG quarterly report:

- FY2024 had a slight decrease in the number of reported activities from FY2023.
- 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
    - Duplicated claims/Overlapping claims
    - Services not provided as billed

Subpoenas:

- There was a slight decrease in the number of subpoenas received during FY2024, but the increase was not notable.
- No subpoenas required action as they were not for clients served by MSHN or for the identified timeframe of the request.
- The number of subpoenas received cannot be influenced by any actions by MSHN.

Breaches:

- There was a slight decrease in the number of privacy breaches from FY2023 to FY2024.
- In all instances, the cases were remediated following MSHN's breach notification policy.

Activities Implemented in FY2024

The following activities were implemented during FY2024.

- Data Mining Activities included:
    - Death Audit Compared to Encounters (Q1, Q2, Q3, and Q4)
- Reviewed updates OIG referral process and quarterly OIG report
- Provide ongoing education, and ensure compliance with, updates to state and federal policies and regulations
- Provided feedback and approval for the FY2023 Annual Compliance Summary Report
- Reviewed revisions to the Program Integrity section of the PIHP/MDHHS contract
- Clarified documentation requirements for MEV reviews
- Provided feedback on the revised Delegated Managed Care (DMC) site reviews Quality Assessment Performance Improvement Program Committee Council Annual Report Process
- Received information/trends from the DMC site reviews
- Reviewed changes to SAMHSA SUD confidentiality of patient records
- Provided feedback on data analytics platform
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Provided consultation on local compliance related matters
- 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 FY2025

The following are recommendations for improvements in FY2025.

- Continue to explore, and 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 including trends and quality improvement efforts
- Complete a workplan and implement the identified compliance software for tracking compliance investigations and documentation
- Continue to advocate with the OIG on expectations of the PIHPs when they are not identified as contractual, state, or federal requirements or value added to our system
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
- Identify compliance related educational opportunities including those aimed at training compliance officers

Compliance Training/Review

Internal

MSHN Compliance Committee
Review Compliance Plan
Review of 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. Medicaid Services Verification Methodology Report for Fiscal Year 2024
2. Health Services Advisory Group State Fiscal Year 2024 Validation of Performance Measures Report
3. Health Services Advisory Group State Fiscal Year 2024 Compliance Report
4. Health Services Advisory Group 2023-2024 PIP Validation Report