MSHN

Mid-State Health Network


# Annual Compliance Report FY2025

(October 01, 2024 – September 30, 2025)

Prepared by Chief Compliance and Quality Officer & Compliance Administrator: Nov/Dec 2025
Reviewed and Approved by MSHN Compliance Committee: January 7, 2026
Reviewed by Regional Compliance Committee: January 16, 2026
Reviewed by MSHN Operations Council: February 23, 2026
Reviewed and Approved by MSHN Board: March 3, 2026

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# Purpose

The Compliance Summary Report provides an overview of the effectiveness of activities performed throughout Fiscal Year 2025 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

Recommendation focus areas are identified from the MSHN Compliance Plan tasks and activities related to the MSHN strategic plan, supported by findings and outcomes from internal and external monitoring and oversight site reviews, as well as contractual requirements and issues identified through the Customer Service and Compliance System.

## *Fiscal Year 2026*

The following are new, or continued, recommendations that have been identified as potential areas of risk for non-compliance with established standards.

Note: If an established process for monitoring and oversight already exists, and a deficiency is noted, recommendations are not made to avoid duplication of efforts.

*Area of Risk: Substance Use Disorder (SUD) providers' implementation of plans of correction resulting from MSHN oversight monitoring, related to staffing turnover and staffing shortages within the provider agencies.*

> *Recommendation: The MSHN Quality Assurance and Performance Improvement Managers, in coordination with the SUD treatment and provider staff, will provide an opportunity for one-on-one follow-up and additional training to providers, specific to findings from the previous oversight review, within six months from MSHN approval of provider plans of correction.*
>
> *Lead Staff:* Amy Dillon, Compliance Administrator

*Area of Risk*: Compliance with established Compliance and Program Integrity related standards for MSHN staff and the provider network.

> *Recommendation*: Develop training opportunities, and compliance newsletter, to promote compliance with state and federal requirements.
>
> *Lead Staff:* Kim Zimmerman, Chief Compliance and Quality Officer

*Area of Risk:* Compliance with Customer Service Standards

Recommendation: Grievance and Appeal report templates will be updated to ensure all required fields are being reported. This includes tracking of oral and written notice of extensions.

Recommendation: MSHN will implement tracking mechanisms to monitor adherence to required timeframes for completion of standards related to grievances, appeals, and adverse benefit determinations.

Lead Staff: Dan Dedloff, Customer Service and Rights Manager

*Area of Risk*: Compliance with external site review recommendations.

*Recommendation*: Develop practices/processes to ensure compliance with recommendations made during FY2025 Health Services Advisory Group reviews.

*Lead Staff:* Amy Dillon, Compliance Administrator

## *FISCAL YEAR 2025*

The following is a status update on the FY2025 areas of risk and progress made toward implementing the recommendations. Any recommendations that did not have a status of "complete" have been moved to the FY2026 Recommendations section for continuation.

*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: Complete*
Data mining activities have been explored with the Chief Information Officer and the MSHN Compliance Committee. One potential option identified was reviewing the H2016 code for any duplication of services. Prior to MSHN implementing this data mining activity, the Office of Inspector General (OIG) completed a data mining activity in August 2025 involving the H2016 code and shared the results with MSHN. The OIG identified 24 records that had potential for double billing of this code. MSHN investigated each of these records and determined that there were no cases where double billing occurred, but rather the issues were related to voids being rejected or not properly submitted. All issues were corrected. The Chief Compliance and Quality Officer has continued to have a dialog with other PIHPs as to what data mining activities they are completing. At this time, MSHN will continue to explore options for any areas determined to be at risk for new data mining for FY2026 but will not continue this as a formal recommendation.

*Lead Staff:* Kim Zimmerman, Chief Compliance and Quality Officer

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

*Status: Not Complete*
Training opportunities have continued to be explored with the Regional Compliance Committee and the PIHP Compliance Officers workgroup. The RELIAS training was not updated last year but will be reviewed by both the PIHP Compliance Officer Workgroup as well as the Regional Compliance Committee for any needed revisions. MSHN will also be utilizing a new compliance

software for FY2026 that will provide training and education options for compliance activities and a request has been made to the OIG to provide more regular training opportunities in areas such as completing and investigation. This will continue to be explored during FY2026.

*Lead Staff:* Kim Zimmerman, Chief Compliance and Quality Officer

*Area of Risk:* Compliance with established 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.

*Status: Complete*
This has been an ongoing discussion during the Regional Compliance Committee meetings. Each CMHSP has methods for looking at risk locally. MSHN completed a risk assessment utilizing the Department of Justice Evaluation of Compliance Program tool during FY2023/2024. While there were areas noted for improvement, there were not areas noted as out of compliance. MSHN will review this again during FY2026 to determine if another risk assessment should be completed. MSHN is also utilizing a new compliance software for FY2026 that will provide data region wide on compliance activities and provide an opportunity to trend and analysis data for quality improvement.

*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.

*Status: Complete*
While efforts are anticipated to continue, MSHN and CMH staff have made significant strides toward identifying areas for improvement and strengthening compliance. In addition to discussions with Waiver Workgroups, the Behavioral Health team provided newly required HCBS training and opportunities to discuss changing policies and procedures related to waivers, qualifications, and the Autism program. The MSHN QAPI team also provided training and technical assistance with CMH staff during FY25 Delegated Managed Care Reviews.

*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 training.

*Status: Complete*
The MSHN SUD Treatment team has continued to conduct monthly Lunch and Learn trainings on a variety of topics, including those suggested by the QAPI team based on compliance review results. The QAPI team has also implemented individual, optional provider training during reviews and 6 months after each review.

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.

*Status:* *Complete but ongoing.*
MSHN has implemented ongoing quarterly sampling and validation of member-level detail files to ensure accurate reporting of indicator compliance, population designation, and Medicaid eligibility across all performance indicators. Programming updates were completed in 2025 in MSHN's electronic medical record to flag non-Medicaid individuals being submitted by a provider so they can be removed prior to submission to MDHHS. Reminders were provided to the Quality Improvement Council (QIC) on appropriate documentation and coding of performance indicators and discussions are ongoing relating to interventions being implemented for indicators 2, 3, and 4a. MSHN continues to monitor these interventions and sampling validation through quarterly reviews and oversight at the QIC to ensure consistency and sustainability.

*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.

*Status:* *Complete*
MSHN undertook a comprehensive review of its Performance Improvement Projects to ensure alignment with state-defined goals and to better understand the root causes behind the lack of statistically significant improvements. As part of this effort, MSHN revisited the causal/barrier analysis with input from the Quality Improvement Council to revise/update this in 2025. In addition to this, MSHN engaged a contractor to conduct a comprehensive analysis of interventions being implemented. This analysis assessed the effectiveness of current strategies, identified gaps, and provided recommendations for adjustments. Based on these findings, MSHN refined its causal/barrier analysis and updated the intervention work plan to better address performance challenges, with ongoing monitoring incorporated into the overall project structure.

*Lead Staff:* Kara Laferty, Quality Manager

# Internal Monitoring and Auditing

MSHN conducts annual provider network monitoring. Any findings identified require the provider to submit a plan of correction. MSHN then conducts follow-up reviews to ensure that the plans of correction were implemented and that our provider network is compliant with federal and state guidelines, rules, requirements, and laws. 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*

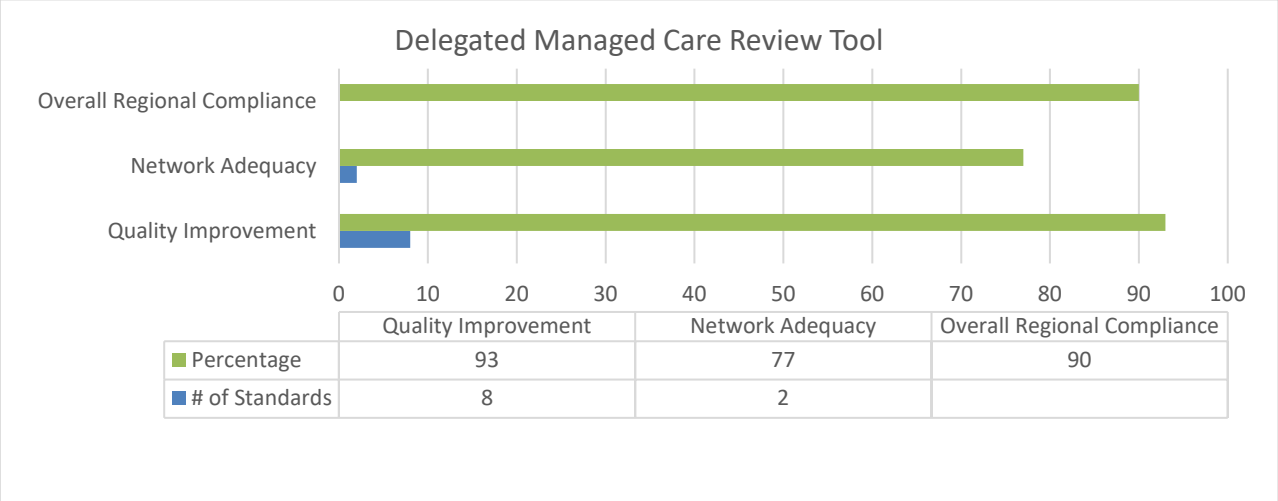
With the support and approval of the CMH Quality Improvement Council and Operations Council, MSHN modified the Delegated Managed Care Review process, effective in FY24. The new process covers all required review sections, but rather than reviewing them all in one year, the reviews are conducted on a three-year cycle. MSHN has aligned Delegated Managed Care reviews with external reviews (i.e., MDHHS, HSAG) when possible, which typically require CMHs to provide duplicate documentation for each review. These changes were implemented to enhance efficiency, minimize duplication, and streamline the review process for MSHN and CMHs. MSHN also changed the review cycle from calendar year to fiscal year.

FY25 was Year 2 of the MSHN 3-year review cycle. MSHN reviewed areas of Quality Improvement, Provider Network, BH-TEDS, and program and chart reviews for Autism, Assertive Community Treatment (ACT), Home-

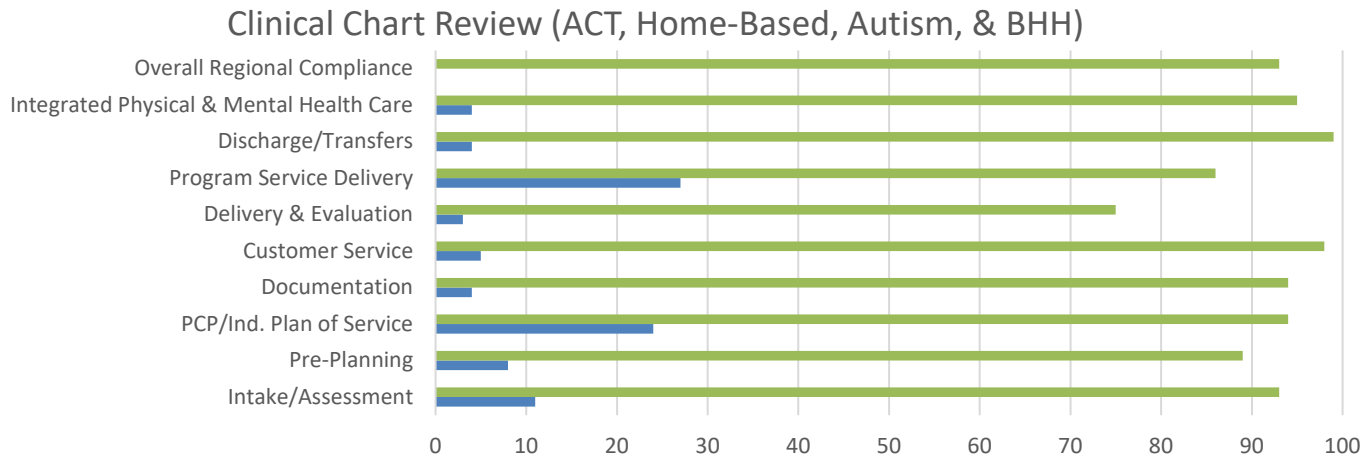
Based Services, and Behavioral Health Homes (BHH). Reviews were conducted for nine (9) of the twelve (12) CMHs in the MSHN region: Montcalm Care Network, Tuscola Behavioral Health System, The Right Door for Hope Recovery and Wellness, Gratiot Integrated Health Network, LifeWays, Shiawassee Health and Wellness, Newaygo CMH, CMH for Central Michigan, and Community Mental Health for Clinton, Eaton, and Ingham Counties.

## *Results*

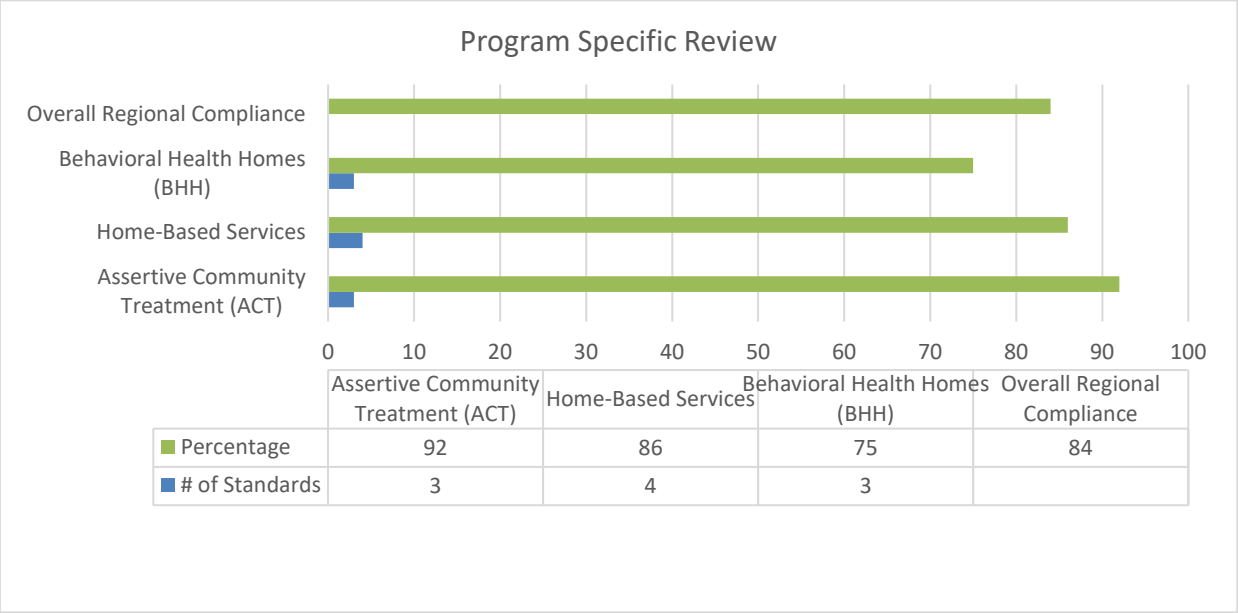
Six (6) different review tools were used to conduct the reviews. Below is a summary of scores by each review tool. The tables below show the cumulative results of each review tool.



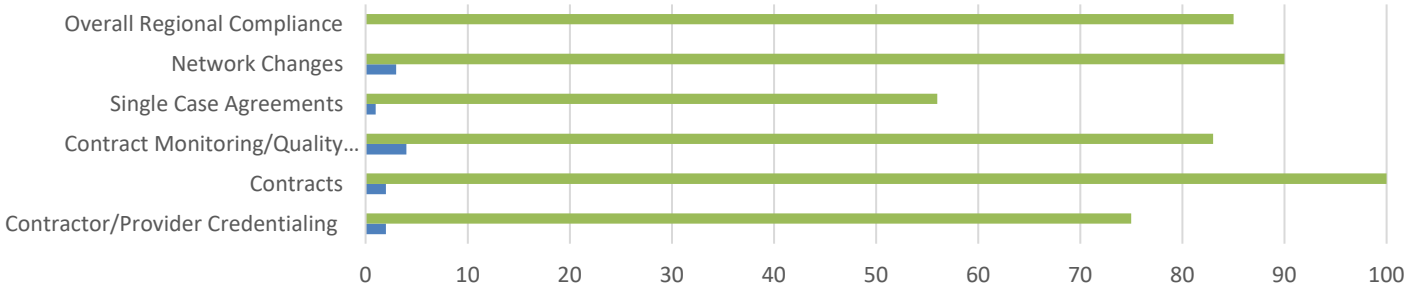

| | Quality Improvement | Network Adequacy | Overall Regional Compliance |
|---|---|---|---|
| Percentage | 93 | 77 | 90 |
| # of Standards | 8 | 2 | |



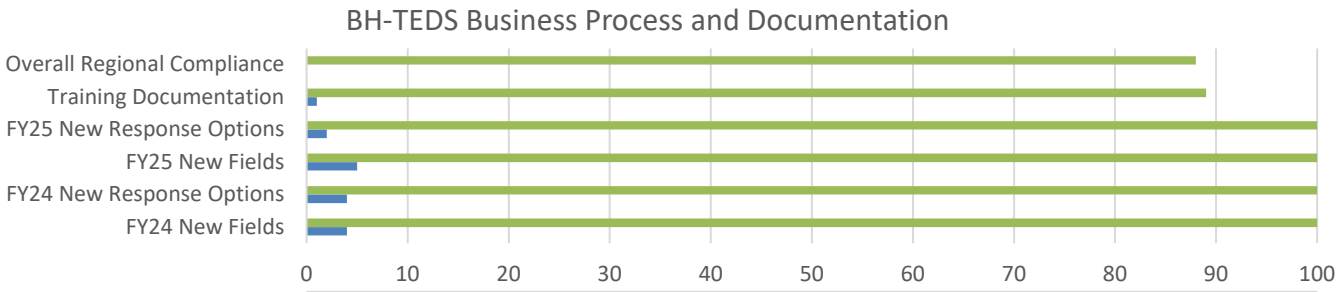

| | Intake/Assessment | Pre-Planning | PCP/Ind. Plan of Service | Documentation | Customer Service | Delivery & Evaluation | Program Service Delivery | Discharge/ Transfers | Integrated Physical & Mental Health Care | Overall Regional Compliance |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage | 93 | 89 | 94 | 94 | 98 | 75 | 86 | 99 | 95 | 93 |
| # of Standards | 11 | 8 | 24 | 4 | 5 | 3 | 27 | 4 | 4 | |



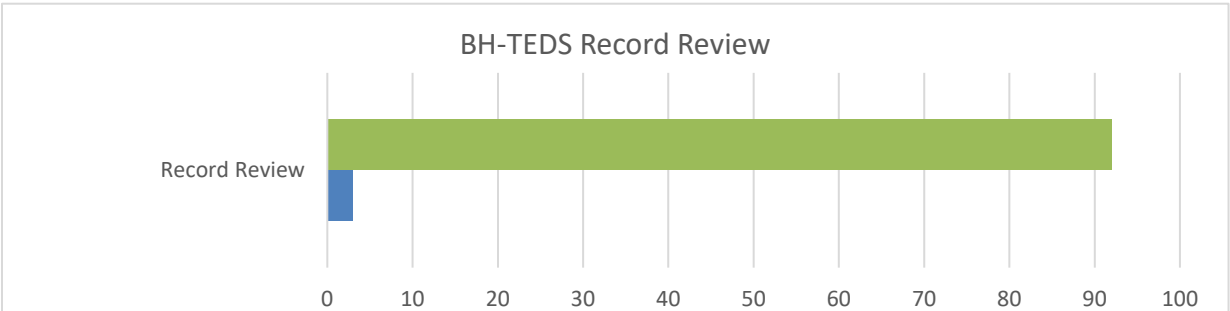

| | Assertive Community Treatment (ACT) | Home-Based Services | Behavioral Health Homes (BHH) | Overall Regional Compliance |
|---|---|---|---|---|
| Percentage | 92 | 86 | 75 | 84 |
| # of Standards | 3 | 4 | 3 | |



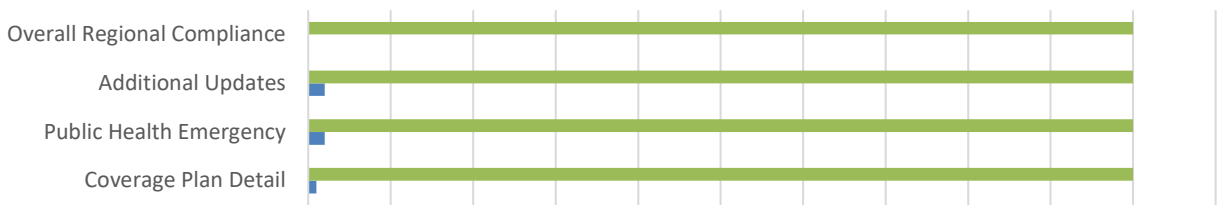

| | Contractor/Provider Credentialing | Contracts | Contract Monitoring/Quality Assessments | Single Case Agreements | Network Changes | Overall Regional Compliance |
|---|---|---|---|---|---|---|
| Percentage | 75 | 100 | 83 | 56 | 90 | 85 |
| # of Standards | 2 | 2 | 4 | 1 | 3 | |




| | FY24 New Fields | FY24 New Response Options | FY25 New Fields | FY25 New Response Options | Training Documentation | Overall Regional Compliance |
|---|---|---|---|---|---|---|
| Percentage | 100 | 100 | 100 | 100 | 89 | 88 |
| # of Standards | 4 | 4 | 5 | 2 | 1 | |




| | Record Review |
|---|---|
| Percentage | 92 |
| # of Standards | 3 |




| | Coverage Plan Detail | Public Health Emergency | Additional Updates | Overall Regional Compliance |
|---|---|---|---|---|
| Percentage | 100 | 100 | 100 | 100 |
| # of Standards | 1 | 2 | 2 | |

## *Strengths*

- CMHSPs utilize an evidence-based trauma screening tool.
- CMHSP Home-based and ACT services are consistently delivered within the consumer's home and/or community.
- CMHSPs are documenting multiple outreach attempts following missed appointments.

## *Improvement/Recommendations*

- Services are not provided as indicated in the Individual Plan of Service, and when services change, plans are not consistently updated
- Consumers in home-based services do not consistently receive 4 hours of service each month.
- Annual contract monitoring/quality assessments of the provider network are not completed annually as required.
- Single Case Agreements do not include all required elements.
- Services are not consistently offered at the amount/scope/duration noted in individual plans of service.

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## *Substance Use Disorder Service Provider Delegated Function Reviews*

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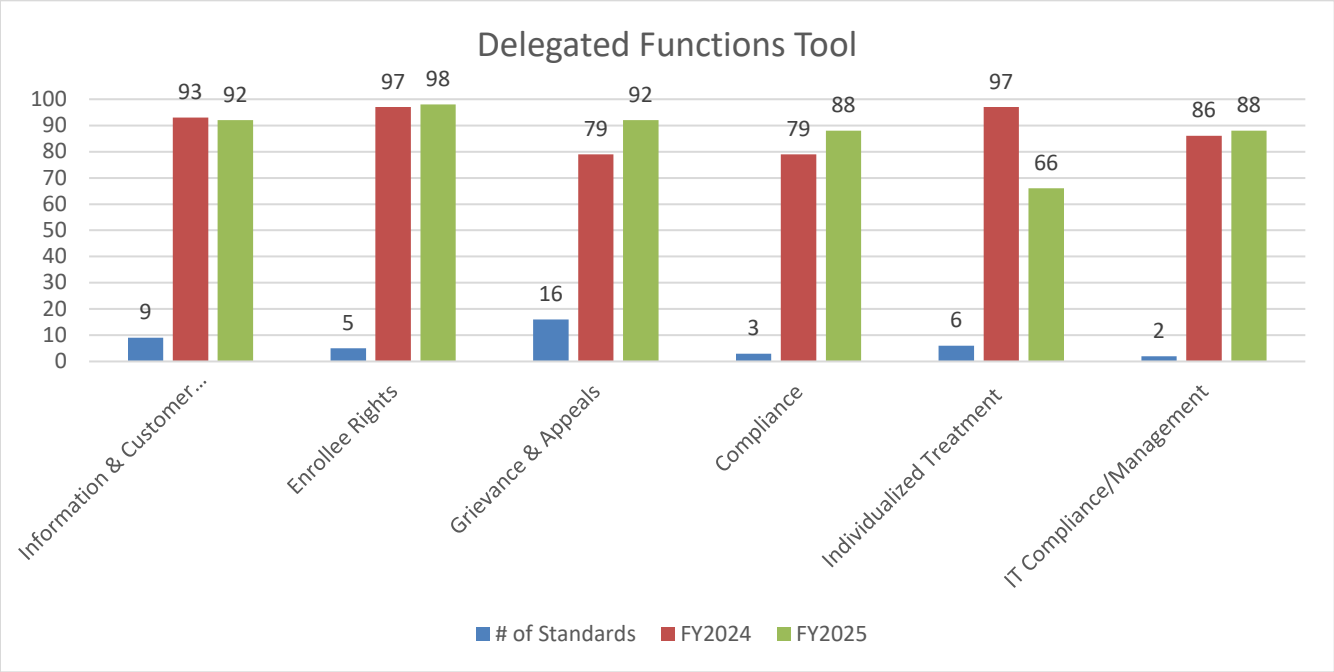
During FY2025, both full and interim reviews were completed. The interim reviews are conducted to ensure compliance and implementation of approved corrective action plans for findings identified in the previous review. Interim reviews do not receive a score; rather, they are determined to be compliant or non-compliant. Full reviews encompass chart reviews, validation of process requirements, review of staff files, and verification of policies and procedures. For providers outside the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP for the area where the providers are located. To ensure statewide reciprocity and efficiency, MSHN reviews include standards established by a statewide workgroup.

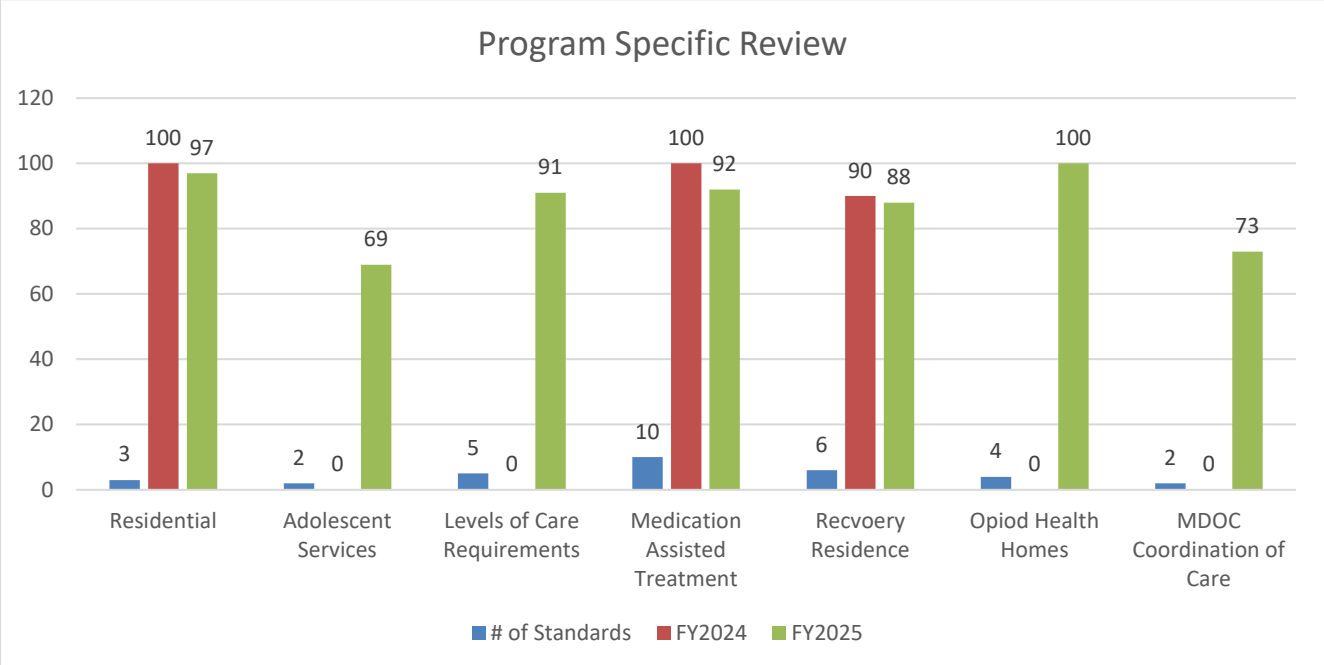
MSHN conducted thirteen (13) full reviews and 7 (seven) interim reviews throughout FY25.

### *Results*

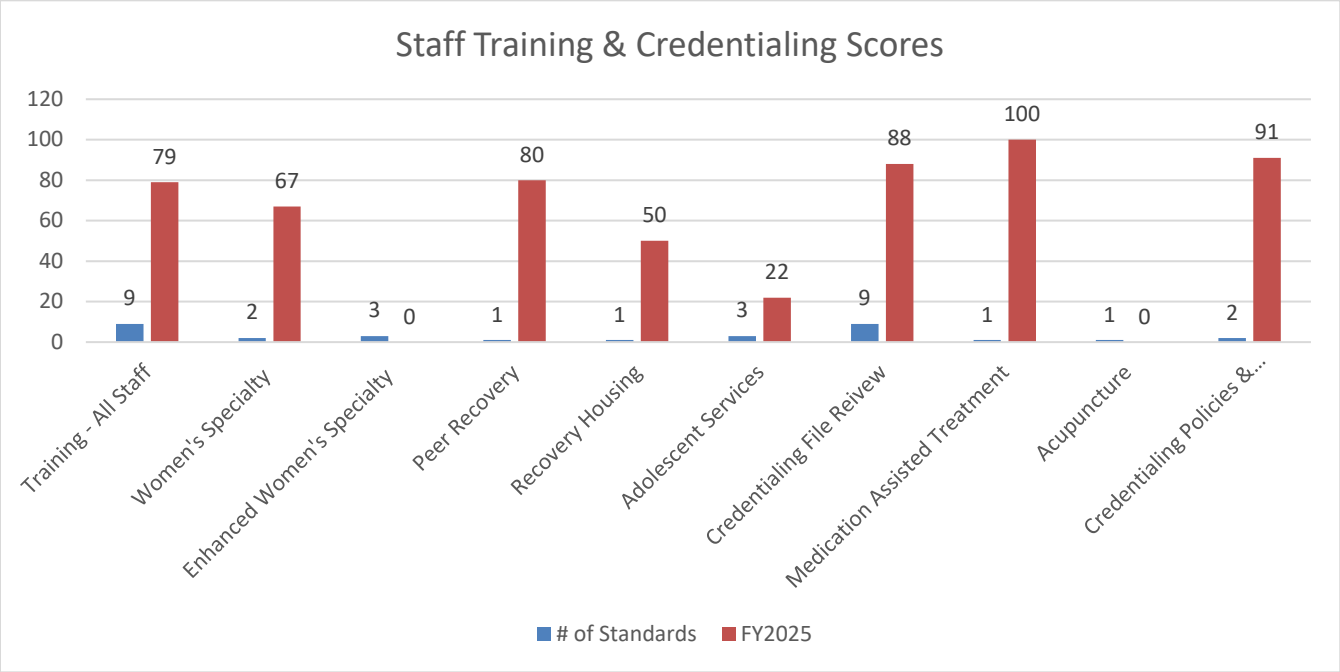
Four (4) different review tools were used to conduct the reviews. Below is a summary of scores by each review tool. The tables below show the cumulative results of each review tool.



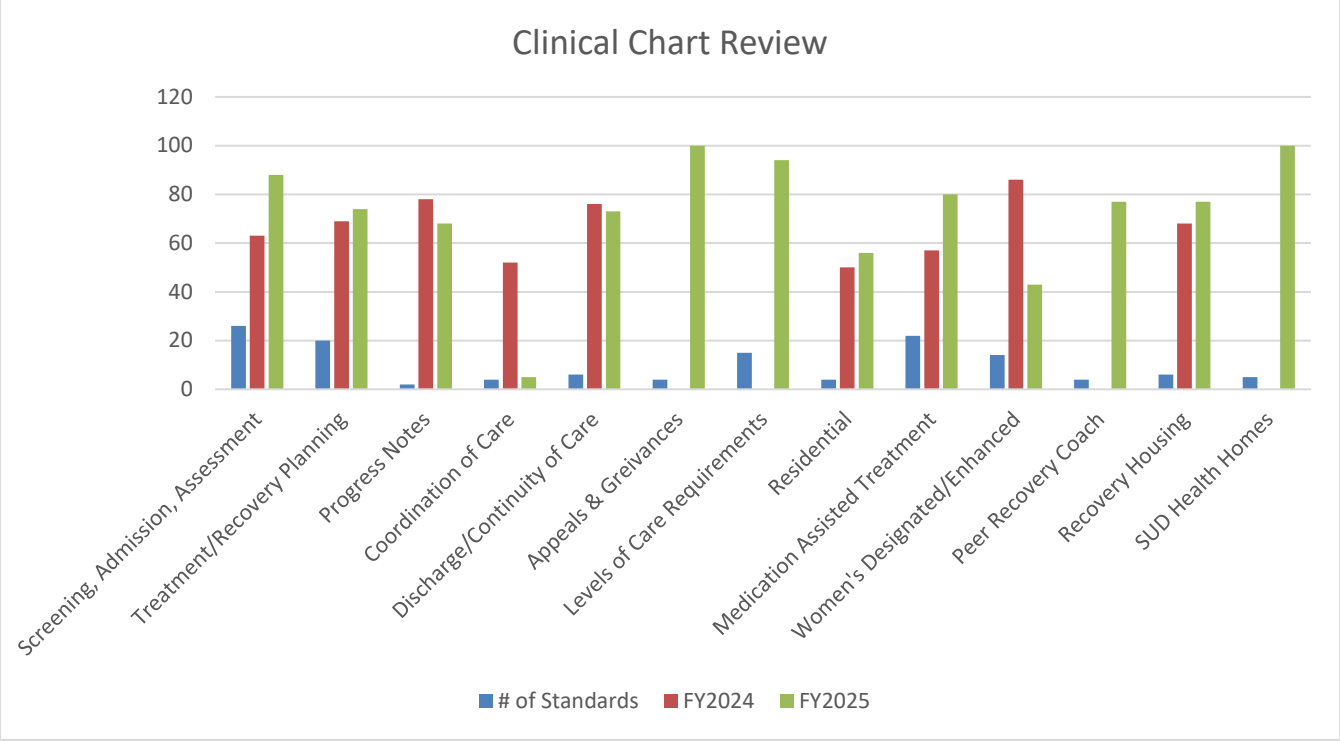

**The number of standards varies from year to year based on requirements.*




**All sections reviewed do not apply to all providers. The number of standards varies from year to year, depending on the requirements. "0" means the section was not reviewed. This does not mean that the standards in the section were not reviewed in previous years; rather, they were reviewed in other sections of the review tools and were not individually scored as their own section.*




**All sections reviewed do not apply to all providers. The number of standards varies from year to year, depending on the requirements. These sections were not reviewed during FY24 so there is no comparison in standards.*




**All sections reviewed do not apply to all providers. The number of standards varies from year to year, depending on the requirements. "0" means the section was not reviewed. This does not mean that the standards in the section were not reviewed in previous years; rather, they were reviewed in other sections of the review tools and were not individually scored as their own section in FY24.*

## *Strengths*

- SUD providers are consistently utilizing an evidence based trauma screening tool.
- Treatment plans include documentation of the intended evidence based intervention(s) such as Cognitive Behavioral Therapy.
- Outpatient providers consistently offer the required weekly hours of care.

## *Improvement/Recommendations*

- Progress notes do not consistently include an individual's progress towards meeting an identified goal and/or objective.
- ASAM Continuums lack clinical summaries and justification for the recommended services/level of care.
- Charts lack evidence that the consumer was informed of, or included, any chosen natural/community/professional supports in the treatment/recovery process.
- Adolescent service providers are not completing the required training.

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## *Medicaid Event Verification Site Reviews*

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To ensure compliance with federal and state regulations, MSHN conducts oversight of the Medicaid, Healthy Michigan Plan, and Block Grant claims/encounters submitted within the Provider Network. This is accomplished by completing Medicaid Event Verification (MEV) reviews of claims/encounters submitted for services provided for all twelve (12) Community Mental Health Service Providers (CMHSPs) and substance use disorder (SUD) treatment providers who serve within the MSHN region.

The Medicaid Event Verification review involves a claims test that tests 7 (seven) attributes. The attributes tested are as follows:

A.) Code is an 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/treatment plan
D.) Documentation of the service agrees to the claim date and time of service
E.) 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
G.) Modifiers are used in accordance with the HCPCS/MDHHS guidelines

The following is a summary of MEV reviews conducted in Fiscal Year 2025. During Q4 of FY2025, twelve (12) Medicaid Event Verification (MEV) reviews were completed. Of those, six (6) were for CMHSPs and six (6) were for SUD treatment providers.

## *CMHSP Results*

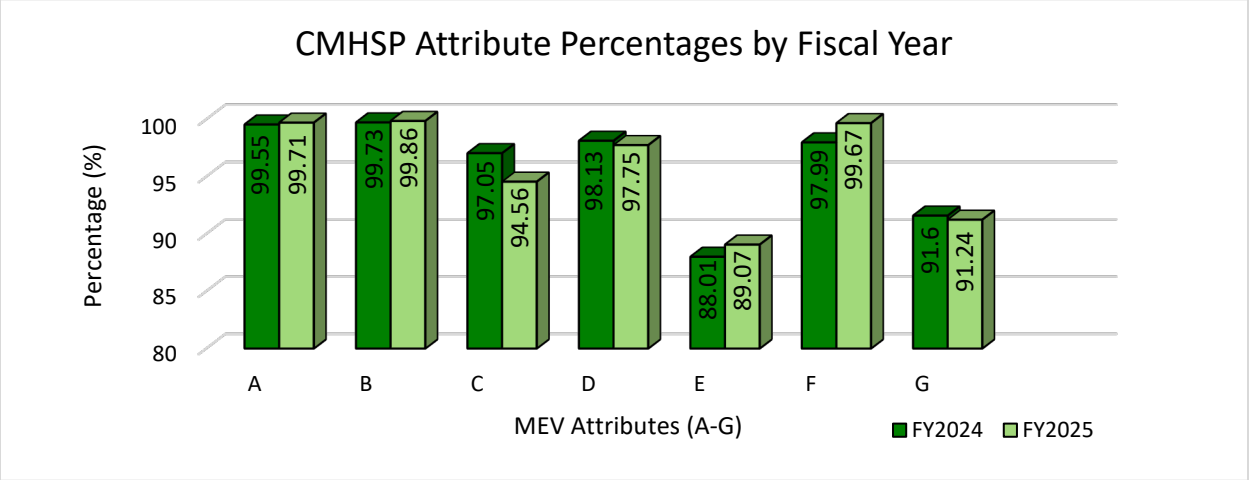
CMHSP MEV reviews are conducted bi-annually (twice a year). The table below includes the score per CMHSP for all attributes reviewed. Data presented in the table below is relative to all twelve (12) CMHSPs who had reviews completed in FY25 (Q1-Q4) and includes data for both reviews for the full fiscal year, October 1, 2024 – September 30, 2025.

The CMHSP MEV reviews completed in Q4 were for Bay-Arenac Behavioral Health Authority, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays, Saginaw County Community Mental Health Authority, and Shiawassee Health and Wellness.

| CMHSP | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| BABHA | 100% | 100% | 100% | 98.36% | 86.31% | 100% | 96.14% |
| CEI | 100% | 100% | 87.25% | 96.34% | 94.30% | 100% | 94.66% |
| CMHCM | 100% | 100% | 97.91% | 97.18% | 86.30% | 96.99% | 75.84% |
| Gratiot | 100% | 100% | 100% | 96.3% | 92.54% | 100% | 93.59% |
| Huron* | 97.74% | 99.59% | 94.43% | 99.34% | 85.55% | 100% | 93.09% |
| Lifeways | 99.82% | 98.90% | 94.99% | 99.16% | 92.11% | 99.82% | 87.77% |
| Montcalm | 100% | 100% | 96.72% | 96.72% | 87.30% | 100% | 87.31% |
| Newaygo | 100% | 100% | 97.84% | 99.41% | 86.53% | 100% | 96.13% |
| Saginaw | 100% | 100% | 88.37% | 96.07% | 89.69% | 99.85% | 90.05% |
| Shiawassee | 100% | 100% | 93.90% | 99.34% | 89.69% | 99.18% | 88.04% |
| The Right Door | 100% | 100% | 99.18% | 98.78% | 92.49% | 100% | 92.67% |
| Tuscola | 100% | 100% | 96.46% | 95.17% | 87.75% | 100% | 98.63% |
| MSHN Average* | **99.71%** | **99.86%** | **94.56%** | **97.75%** | **89.07%** | **99.67%** | **91.24%** |

**Note: Each CMHSP is typically reviewed twice during the fiscal year. The percentages in this table represent the average of those reviews for each CMHSP. An exception is Huron, which includes three reviews this time, as its FY2024 Q4 review was conducted in FY2025 Q1. Because this table displays equal-weighted averages per CMHSP (i.e., each CMHSP counts once regardless of how many reviews were completed), the "MSHN Average" row does not represent an average of the table rows above. Instead, the MSHN Average is calculated using all individual reviews conducted (25 total reviews across 12 CMHSPs) to provide a weighted average that reflects the full scope of FY2025 audit activity.*

The following chart provides a comparison from FY2024 through FY2025 for the attributes tested:




## *SUD Results*

SUD MEV reviews are conducted annually. The data presented in the table below is relative to the SUD providers who had reviews completed in FY25 (Q1-Q4) and includes review data for all twenty-three (23) SUD providers for the full fiscal year, October 1, 2024 – September 30, 2025.

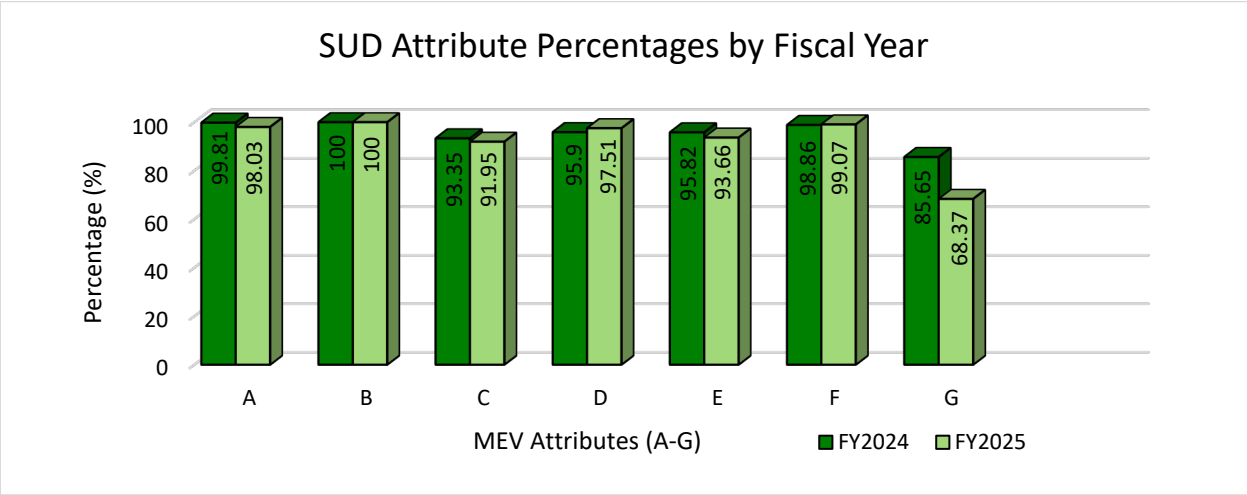
The SUD MEV reviews completed in Q4 were for Arbor Circle Counseling, Cristo Rey Community Center, Dot Caring Centers, Family Services & Children's Aid, List Psychological Services, and Saginaw Odyssey House.

| SUD | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| SUD Providers* | 98.02% | 100% | 92.29% | 98.99% | 88.80% | 98.61% | 66.80% |
| MSHN Average* | 98.03% | 100% | 91.95% | 97.51% | 93.66% | 99.07% | 68.37% |

**Note: SUD provider reviews are conducted annually, with a different set of providers reviewed each quarter. The percentages on the top line reflect scores from the current quarter, while the second line shows the year-to-date (YTD) average of all SUD reviews completed during FY2025.*

**Note: Saginaw Odyssey House appears twice in this dataset - once for a review originally scheduled for FY2024 Q4 (but completed in FY2025 Q1), and once for its regularly scheduled FY2025 Q4 review. As a result, it is included once in the current quarter's data (top row) and twice in the cumulative data (bottom row). The MSHN Average is calculated using all individual reviews conducted (24 reviews across 23 providers) and reflects a weighted average that captures the full scope of FY2025 audit activity.*

The following chart provides a comparison from FY2024 through FY2025 for the attributes tested:




## *Trends*

Overall, CMHSPs achieved an average valid claims score of 74.08% for reviews conducted in FY2025 Q4, while SUD providers averaged 56.23%. For the full fiscal year, the average scores were 77.75% for CMHSPs and 68.37% for SUD providers. Since the valid claims score is not an average of the tests (but the percentage of valid claims reviewed), it tends to trend low (even though individual attribute scores may be high). This score is calculated by taking the total number of valid claims divided by the total number of claims. (A claim is deemed "valid" if all attributes tested receive a "Y"/Yes rating.) For example, a review having 400 valid claims of 502 claims reviewed would score 79.68% for the Percentage of Valid Claims.

In FY2024, we began tracking an additional score in addition to the valid claim's percentage – the average of attributes tested. CMHSPs had an average attribute score of 95.22% in FY2025 Q4, while SUD providers averaged 91.93% during the same period. For the full fiscal year, the average attribute scores were 95.98% for CMHSPs and 94.28% for SUD providers. We will continue to trend this data in addition to the usual valid claims score.

Regionally the CMHSPs have shown slight improvements from FY2024 to FY2025 for the following attributes:

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. F. Amount billed/paid does not exceed contractually agreed upon amount

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

Alternatively, the SUD providers have shown considerable improvements from FY2024 to FY2025.

1. D. Documentation of the service agrees to the claim date and time of service
2. F. Amount billed/paid does not exceed contractually agreed upon amount

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 Monitoring and Auditing

The Michigan Department of Health and Human Services (MDHHS) requires periodic reviews to ensure compliance with state and federal regulations. The MDHHS Federal Compliance Department conducts the 1915(i) and 1915(c) waiver reviews. The MDHHS contracts with the Health Services Advisory Group, Inc. (HSAG) to serve as the External Quality Review Organization (EQRO) for Medicaid behavioral health programming.

## *MDHHS Waiver Review*

MDHHS conducted an interim review of 1915(c) waivers, which include the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW), and the Children's Waiver Program (CWP). The review also included the 1915i SPA (iSPA) waiver. The review focused on ensuring the implementation of approved plans of correction from the comprehensive evaluation conducted the previous year. The review was not scored; instead, it was determined to be compliant or non-compliant. MSHN was found to be compliant, and no further action was needed.

## *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. 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 2, 2025.

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, verification of primary sources, 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. The full report is available on the MSHN website.

## *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.

- Data Integration and Control- Thirteen Standards: 100%
- Denominator Validation - Seven Standards (2 NA): 100%
- Numerator Validation – Five Standards: 100%
- Performance Measures- Fourteen Measures (1 NA) Fully Validated: 100%

## *Recommendations*

Among the recommendations from this review were the following:

- HSAG recommends that MSHN perform increased spot checks on data before submitting data to HSAG.
- HSAG recommends that MSHN and CEI proceed with the outlined remediation plan. Additionally, HSAG recommends that CEI increase its sample size for cases reviewed each quarter for these performance indicators to improve the accuracy of the reported data and to ensure alignment with the reporting requirements. MSHN should also complete testing once the warning error is programmed in REMI to ensure that it is appropriately applied and captures non-Medicaid individuals as expected.
- Although MSHN confirmed that this was an isolated issue, HSAG recommends that MSHN perform increased spot checks on Bay-Arenac's indicator #1 reported data before submitting to HSAG. This should include performing PSV for a statistically significant sample of cases each quarter to ensure that the cases meet reporting requirements and that the appropriate times are captured. Additionally, HSAG recommends that MSHN continue to collaborate with the CMHSP to enhance existing processes or implement additional ones, as necessary, to improve the accuracy of indicator #1 data. Continued training or retraining with staff should be provided if necessary.
- HSAG recommends that MSHN and CEI proceed with the outlined remediation plan (T1020 procedure code issue). Additionally, HSAG recommends that CEI increase its sample size for cases reviewed each quarter for this performance indicator to enhance the accuracy of the reported data and ensure alignment with reporting requirements.
- 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.

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# *MDHHS – Health Services Advisory Group (HSAG): Network Adequacy Verification Review*

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HSAG began conducting Network Adequacy Verification (NAV) reviews in fiscal year 2024. The review is an annual review. The focus of the review was to validate PIHP data as it applies to network adequacy indicators set by MDHHS for fiscal year 2025.

## *Results/Next Steps*

MDHHS completed the time and distance and provider-to-enrollee ratio calculations for each region based on the submitted data provided by each PIHP. Below is a summary of the compiled results.

## Adult Services

| Service | Time/Distance Percentage Rate | | Provider to Enrollee Ratio Met or Unmet |
|---|---|---|---|
| **Assertive Community Treatment (1:30,000)** | | | Met (1:19,006) |
| **Crisis Residential Programs (16 Beds Per 500,000 Total Population)** | 96.1% | 87.9% | Met (127:1,643,130) |
| **Opioid Treatment Programs (1:35,000)** | 100% | 99.5% | Met (1:12,008) |
| **Psychosocial Rehabilitation Programs (1:45,000)** | 99.3% | 93.8% | Met (1:38,011) |
| **Inpatient Psychiatric Services** | 99.6% | 94.9% | |

*Time/Distance percentage rates above are based on the PIHP's overall percentages.

## Pediatric Services

| Service | Time/Distance Percentage Rate | | Provider to Enrollee Ratio Met or Unmet | Baseline Data Results |
|---|---|---|---|---|
| **Inpatient Psychiatric Services** | 86.1% | 66% | | |
| **Crisis Residential Programs (8-12 Beds Per 500,000 Total Population)** | 50% | 33% | Met (30:1,643,130) | |
| **Home-Based Services (1:2,000)** | | | Met (1:1,214) | |
| **Wraparound (1:5,000)** | | | Met (1:4,673) | |
| **Intensive Crisis Stabilization** | | | | 1:7,711 |
| **Respite Services** | | | | DCW Ratio 1:707<br>Beds 1:12,852 |
| **Parent Support Partner Services** | | | | 1:10,281 |
| **Youth Peer Support Services** | | | | 1:25,703 |

**MDHHS did not perform time/distance calculations on Home-Based, Wraparound, Parent Support Partner, and Youth Peer Support services due to variations in provider deployment procedures and service locations.

## Timeliness

| Service | Aggregate Average Percentage of enrollees starting services within 14 calendar days of assessment. | CMHSPs under 90% |
|---|---|---|
| Assertive Community Treatment | 81.75% | BABH (57%)<br>GIHN (not providing services)<br>LifeWays (57%)<br>MCN (not providing services)<br>NCCMH (not providing services)<br>SCCMH (50%)<br>TRD (not providing services) |
| Home-Based Services | 75% | BABH (61%)<br>CMHCM (81%)<br>CMHCEI (61%)<br>GIHN (82%)<br>HBH (70%)<br>LifeWays (54%)<br>MCN (78%)<br>NCCMH (85%)<br>SCCMH (80%)<br>SHW (75%)<br>TRD (80%) |
| Wraparound | 77.5% | BABH (75%)<br>CMHCM (77%)<br>CMHCEI (64%)<br>GIHN (67%)<br>LifeWays (21%)<br>NCCMH (75%)<br>SCCMH (87%)<br>TRD (64% |

*Average percentages in red did not meet the 90% benchmark 42 CFR 438.68(e)(2)

## Other

| Aggregated Total percentage of reported providers accepting new enrollees | Aggregated Total percentage of providers with reported physical accessibility | Aggregated Total percentage of reported providers with cultural and linguistic capabilities |
|---|---|---|
| 99.5% | 99.5% | 100% |

## American Society Addiction Medicine (ASAM) Level of Care (LOC)

| Outpatient ASAM LOC | Residential ASAM LOC | Withdrawal Management ASAM LOC |
|---|---|---|
| 2.5 (Only available outside of catchment area) | 3.3 (Only available outside of catchment area)<br>3.7 (Only available outside of catchment area) | 1.0 WM<br>2.0 WM |

MDHHS will follow up with PIHPs to address network gaps and areas of improvement needed.

## *MDHHS – Health Services Advisory Group (HSAG): Compliance Monitoring Review*

HSAG conducts the Compliance review over a period of three (3) years and includes a review of thirteen (13) different standards. FY2025 was year one of the review cycle and included a review of eight (8) of the thirteen (13) standards. The review took place on June 6, 2025.

### *Results/Trends*

The following is a summary of the Compliance Monitoring site review report. MSHN has submitted a plan of correction for findings identified. The full report is available on the MSHN website.

MSHN achieved an overall compliance score of 90%.

Standard II – Emergency and Post Stabilization Services: 100%
Standard VII – Provider Selection: 88%
Standard VIII- Confidentiality: 95%
Standard IX- Grievance and Appeal Systems: 79%
Standard X – Subcontractual Relationships and Delegation: 100%
Standard XI – Practice Guidelines: 100%
Standard XII – Health Information Systems: 78%
Standard XIII – Quality Assessment and Performance Improvement Program: 100%

HSAG made several recommendations throughout the report. Below is an abbreviated summary of some of the recommendations. In addition to implementing plans of correction, MSHN will consider recommendations when updating processes.

Standard II – Emergency and Post Stabilization Services

- Recommendation to update policy to include a list of services covered under the PIHP's scope of work (e.g., preadmission screening, crisis intervention) as the PIHP confirmed that these services do not require prior authorization and should be removed from the list of emergency services.
- Recommend policy update to add all federal provisions in elements 4-13, (recommending including verbatim to the federal rule) with an explanation of how the PIHP meets the intent of each requirement.
- HSAG recommends that the PIHP consult with MDHHS for further guidance related to the MMBPIS three-hour prescreen decision indicator in relation to the one-hour requirement for authorization of post-stabilization care services.

Standard VII – Provider Selection

- HSAG recommends that the PIHP have its credentialing committee members sign off on a nondiscrimination attestation to ensure an understanding of nondiscriminatory practices.
- HSAG strongly recommends that the PIHP consult with MDHHS on the appropriate mechanism to use to verify the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgments within the last five years. HSAG further recommends that the PIHP develop and implement a clear policy and procedure to reflect the guidance provided by MDHHS.

Standard VII- Confidentiality

- Although the PIHP explained that most Health Insurance Portability and Accountability Act of 1996 (HIPAA)-related incidents and member rights requests under the HIPAA Privacy Rule are handled through delegated entities since these are the entities primarily serving members, HSAG continues to strongly recommend that the PIHP have detailed and comprehensive HIPAA-related policies, procedures, and training materials in place to support awareness of all confidentiality-related requirements under the HIPAA Privacy Rule and Michigan Mental Health Code, and ensure that the policies, procedures, and training materials outline the responsibilities of both the PIHP and its entities delegated to manage privacy and security incidents and member rights requests. Additionally, HSAG recommends that the PIHP enhance its *Delegated Functions Tool* to incorporate the PIHP's mechanisms, ensuring that all staff and delegated entities adhere to the member's privacy rights under the HIPAA Privacy Rule. Lastly, although the PIHP discussed expectations and monitoring processes for staff training, both upon hire and annually, HSAG strongly recommends that the PIHP document and track staff training as completed (e.g., by obtaining signed attestations and storing certifications).
- Although the PIHP required the use of the MDHHS-5515 Consent to Share Behavioral Health Information form, which included a section for members to confirm whether they received or declined a copy of the form, should the PIHP (or its delegates) obtain consent for disclosing PHI for reasons outlined in 45 CFR §164.508, HSAG strongly recommends that the PIHP (or its delegates) ensure it has an appropriate HIPAA authorization form available as well as a process outlined in a policy or procedure to further demonstrate that members are provided a copy of the signed authorization form as required under 45 CFR §164.508(c)(4). Additionally, HSAG continues to strongly recommend that the PIHP ensure its oversight process of its delegates includes a component to evaluate the procedures for providing each member with a copy of any signed authorization or consent form to ensure compliance with the requirements under this element (e.g., enhance its *Delegated Functions Tool*).

Standard IX – Grievance and Appeal Systems

- HSAG recommends that the PIHP implement mechanisms to monitor adherence to this requirement by reviewing periodic reports on acknowledgement turnaround times.
- The PIHP's system did not have a dedicated reportable field to track extensions and could only document an extension in the notes section of the module. While the PIHP had no grievance resolution time frame extensions, as it is a contractual requirement (for the PIHP to apply an extension and for members to request an extension), HSAG recommends that the PIHP enhance its system to track and report on the extension provisions.
- The PIHP's system did not have a dedicated reportable field to track oral and written notice of extensions and could only document extension notices in the notes section of the module. While the PIHP had no grievance resolution time frame extensions, as it is a contractual requirement (for the PIHP to apply an extension and for members to request an extension), HSAG recommends that the PIHP enhance its system to track and report on the extension provisions.
- While the *CS_Medicaid_Enrollee_Appeals_Grievances_Procedure* confirmed that an expedited appeal resolution would be granted when supported by the provider, a specific statement assuring that punitive action would not be taken against a provider who requests or supports a member's appeal was not located. HSAG recommends that the PIHP include this statement in its procedures and provider-facing materials, such as the provider manual.
- HSAG recommends that the PIHP enhances its mechanisms to ensure that the responsible decision-maker and the credentials of the decision-maker are clearly identified with each appeal record. Of note, the PIHP also received this recommendation during the SFY 2022 compliance review.

Standard X – Subcontractual Relationships and Delegation

- The PIHP confirmed that it had not revoked delegation for poor performance during the time period under review, but indicated that the PIHP would keep MDHHS involved in any discussions related to delegate non-compliance resulting in revocation of delegated responsibilities and would provide advanced notification to MDHHS as required. Therefore, the PIHP received a *Met* score for this element. However, as the reporting requirement was not documented within a policy or procedural document, HSAG strongly recommends that the PIHP include the 10-day advance notice to MDHHS reporting requirement in a policy and/or procedural document to ensure staff members are aware that MDHHS must be notified 10 business days in advance of issuing a notice of revocation to its delegate(s).

Standard XII – Health Information Systems

- Across all PIHPs, HSAG received conflicting information regarding whether disenrollment reasons/codes are provided to the PIHPs from MDHHS. HSAG recommends that all PIHPs consult with MDHHS regarding the disenrollment data being shared. If MDHHS provides disenrollment reasons to the PIHPs, HSAG strongly recommends that the PIHP ensure its information system has the capability to store these disenrollment reasons/codes.
- HSAG strongly recommends that the PIHP develop its own policies and procedures for its Patient Access API. Within these policies and procedures, the PIHP should include:
  - All Patient Access API federal provisions under 42 CFR §431.60 and any applicable cross-references.
  - A description of how the PIHP's API meets the intent of each federal provision.
  - A table that includes all USCDI data elements and a cross-reference to which data elements the PIHP has available within its system and the specific data fields that these data elements are being extracted from (and therefore accessible via the API).
  - A description of how the PIHP oversees PCE to ensure the Patient Access API meets all federal provisions, including timeliness requirements.
  - A description of how the PIHP incorporates a mechanism to conduct routine testing of the API.
  - All new requirements outlined under the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

Standard XIII – Quality Assessment and Performance Improvement Program

- HSAG continues to recommend the PIHP enhance its meeting minutes to capture Governing Board discussion and feedback on the QAPIP description, work plan activities, evaluation, and progress reports. HSAG made this recommendation during the 2022 compliance review, which the PIHP did not fully address.
- HSAG continues to recommend that the PIHP develop a root cause analysis (RCA) template for all CMHSPs and SUD providers to use so the PIHP can ensure that all required components are included. HSAG made this recommendation during the 2022 compliance review, which the PIHP did not fully address.

## *MDHHS – Health Services Advisory Group (HSAG) – Encounter Data Validation Review*

The FY25 EDV review was the third year of HSAG's three-year review cycle. The purpose of the review is to evaluate the extent to which encounters submitted by the PIHPs to MDHHS are complete and accurate by comparing data extracted from the PIHPs' and MDHHS's data systems. MDHHS and each PIHP extracted data from their systems in accordance with the exact specifications. For the PIHPs, the EDV study included institutional and professional encounter data. The following information was provided as part of a data discrepancy report for MSHN.

### Record Completeness and Accuracy

There are two aspects of record completeness—record omission and record surplus:

- **Record omission**: A record is present in the PIHP's submitted data files for the study but is absent from MDHHS' data files.
- **Record surplus**: A record is present in MDHHS' data files but is absent from the PIHP's submitted data files.

The MDHHS encounter data is considered relatively complete when both record omission and record surplus rates are low. The following table displays the percentage of record omission and record surplus for the MSHN and MDHHS submissions, with **lower rates indicating better performance** across the institutional and professional encounter types.

**Record Omission and Surplus**

| Encounter Type | Record Omission | Record Surplus |
|---|---|---|
| Institutional | 0.0% | 1.4% |
| Professional | 0.0% | 3.3% |

There were no notable issues identified with the record omission and surplus rates for MSHN's institutional and professional encounters.

**Institutional Encounters – Key Findings:**

- Nearly all key data elements had omission rates below 2.5 percent, indicating that, for all records with values present in MSHN's data files, the same values were also mostly present in MDHHS' submitted data files. One exception was noted for the *Secondary Diagnosis Code(s)* data element, which had an omission rate of 10.1 percent.
- All but one data element had surplus rates of 0.0 percent, indicating that, for all records with values present in MDHHS' data files, the same values were also present in MSHN's submitted data files. The only exception was the *Discharge Date* data element, which had a surplus rate of 100 percent.
- The data element missing rates for the majority of evaluated key data elements were below 1.0 percent. Notable exceptions were observed for the *Secondary Diagnosis Code(s)* (31.6 percent) and *Procedure Code* (98.0 percent) data elements.
- For records that matched between the two data sources and had data element values populated in both sources, ten of the evaluated data elements showed high accuracy rates of 100 percent. However, four data elements showed lower accuracy: *Detail Service From Date* (84.4 percent), *Detail Service To Date* (84.4 percent), *Admission Date* (86.9 percent), *Secondary Diagnosis Code(s)* (69.0 percent)

**Professional Encounters – Key Findings**

- The majority of key data elements had omission rates of 0.0 percent, indicating that for all records with values present in MSHN's data files, these key data element values were also present in MDHHS' submitted data files. Exceptions were noted for: *Billing Provider NPI* (6.1 percent), *Rendering Provider NPI* (6.1 percent), *Service Provider Address* (7.2 percent), and *Secondary Diagnosis Code(s)* (32.9 percent).
- All data elements had surplus rates of 0.0 percent, indicating that for all records with values present in MDHHS' data files, the same values were also present in MSHN's submitted data files.
- The data element missing rates for majority of evaluated key data elements were 0.5 percent or less. Notable exceptions observed across both data sources included the *Service Provider Address* (82.0 percent), *Secondary Diagnosis Code(s)* (46.2 percent), and *Procedure Code Modifier(s)* (33.8 percent) data elements.
- For records that matched between the two data sources and had data element values populated in both sources, eleven of the evaluated data elements showed high accuracy rates exceeding 95.0 percent. However, three data elements showed lower accuracy: *Rendering Provider NPI* (46.8 percent), *Secondary Diagnosis Code(s)* (84.3 percent), and *Header Paid Amount* (94.0 percent).

**Follow Up**

An aggregated report for Michigan is expected to be sent directly to MDHHS. The report is typically posted to the

MDHHS website in March or April of the following year.

## 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.* Please note that due to procurement efforts at MDHHS, they have extended the Performance Improvement Projects for another year, CY2025 will now be the third remeasurement period.

Data for the baseline and comparison remeasurement periods can be found in the table below:

| Indicator 3: The percentage of new persons who are Black/African American or White and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Time Period | Indicator Measurement | White Numerator | White Denominator | Percentage | Black Numerator | Black Denominator | Percentage | p-Value (Goal p value <0.500) |
| 01/01/2021 - 12/31/2021 | Baseline | 6050 | 8737 | 69.25% | 837 | 1294 | 64.68% | .00108 |
| 01/01/2023 - 12/31/2023 | Remeasurement 1 | 5649 | 8968 | 62.99% | 822 | 1371 | 59.96% | .03297 |
| 01/01/2024 – 12/31/2024 | Remeasurement 2 | 4874 | 7450 | 65.42% | 777 | 1273 | 61.04% | .00274 |
| 01/01/2025 – 06/30/2025 | Remeasurement 3 | 2234 | 3432 | 65.09% | 390 | 600 | 65% | 1 |

### 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% of the requirements for data analysis and the 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 second remeasurement period.

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

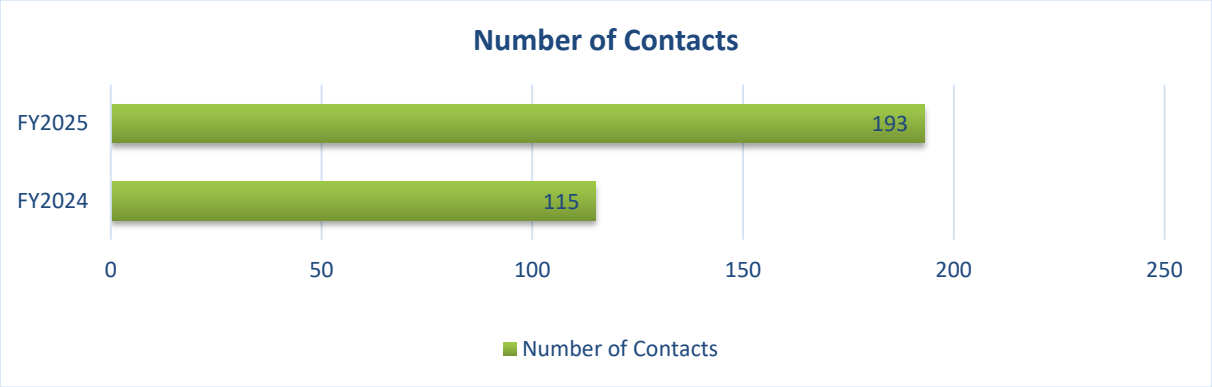
- The performance indicators have not yet achieved the goals for the PIP. MSHN included intervention efforts occurring at the community mental health services program (CMHSP) level, but the PIHP will also include efforts that have occurred at the plan level in the final report for CY2025 (remeasurement 3).
- MSHN will 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 will 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 involves processing agency customer inquiries, facilitating communication, and taking action in response to inquiries, complaints, grievances and appeals.

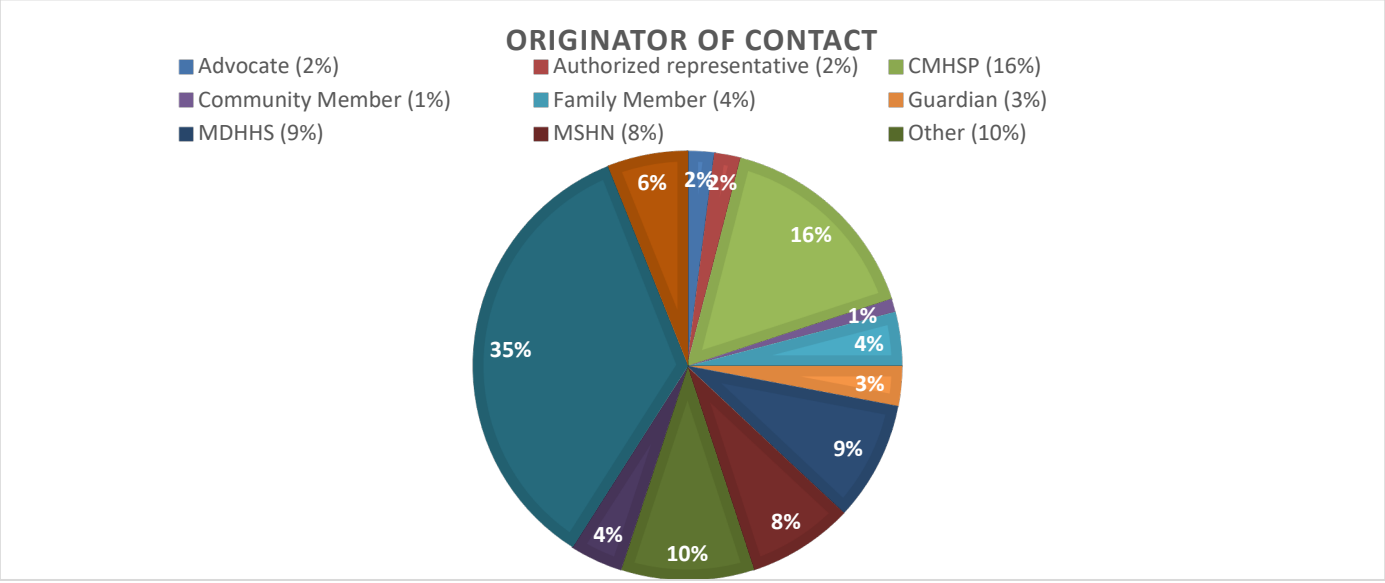
## *Customer Service Contacts*

The total number of Customer Services contacts received in FY2025 was 193, a 67.8% increase from FY2024. By comparison, there were 115 contacts in FY2024.

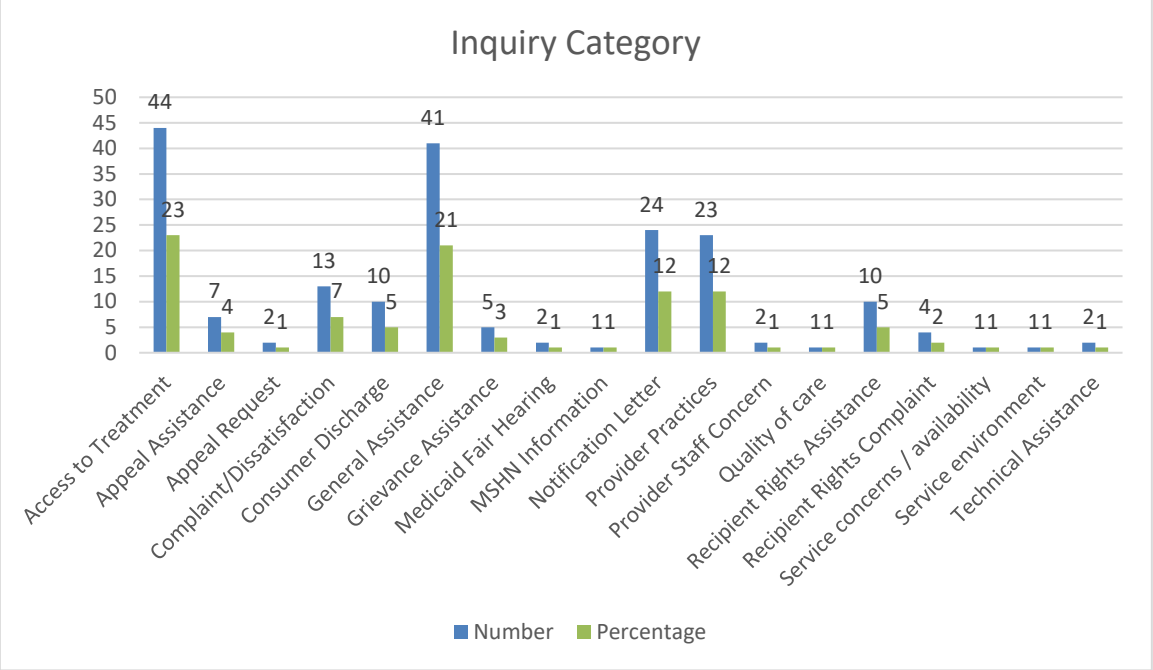


## Originator of Contacts

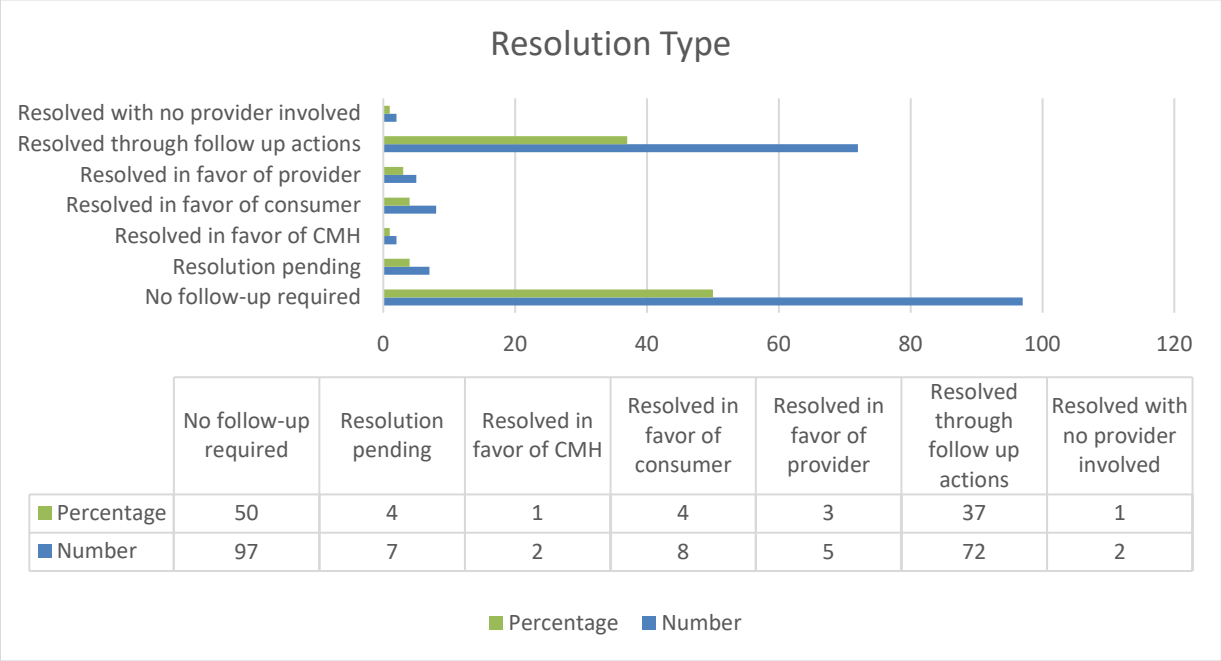
The following graph shows the percentages for each type of originator contact.




## Customer Service Inquiry Category



## *Conclusion/Resolution Type*




| | No follow-up required | Resolution pending | Resolved in favor of CMH | Resolved in favor of consumer | Resolved in favor of provider | Resolved through follow up actions | Resolved with no provider involved |
|---|---|---|---|---|---|---|---|
| Percentage | 50 | 4 | 1 | 4 | 3 | 37 | 1 |
| Number | 97 | 7 | 2 | 8 | 5 | 72 | 2 |



## *Results/Trends*

The following trends/changes were noted during FY2025:

- Overall Customer Service contacts increased by 67.8% in FY2025 (193) from FY2024 (115).
- Consumer contacts requiring follow-up action increased by 50% from 46 in FY2024 to 69 in FY2025.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (52% / n=54) and MSHN (12% / n=12).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (30% / n=27)
- The highest consumer complaint categories addressed Access to Treatment (15% / n=29), Provider Practices (9% / n=18), and Complaint/Dissatisfaction (6% / n=11). The highest non-consumer contact category involved requests for General Assistance (18% / n=34)

As part of MDHHS's 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 FY25 Q1-Q4.

| FY25 MDHHS Grievance Reporting Results (Q1-Q4) | | | | | | |
|---|---|---|---|---|---|---|
| Grievance Category | Number of Cases Closed | Number of Cases Substantiated | Percent Substantiated | Number of Cases Resolved within 90 Calendar Days | Average Number of Days for Resolution* | Percent Resolved within 90 Days |
| QUALITY OF CARE | 30 | 22 | 73% | 30 | 39 | 100% |
| ACCESS AND AVAILABILITY | 29 | 21 | 72% | 29 | 42 | 100% |
| INTERACTION WITH PROVIDER OR PLAN | 11 | 7 | 64% | 11 | 63 | 100% |
| MEMBER RIGHTS | 3 | 1 | 33% | 2 | 67 | 67% |
| TRANSPORTATION | 0 | 0 | #DIV/0! | 0 | #DIV/0! | #DIV/0! |
| ABUSE, NEGLECT, OR EXPLOITATION | 0 | 0 | #DIV/0! | 0 | #DIV/0! | #DIV/0! |
| FINANCIAL OR BILLING MATTERS | 2 | 2 | 100% | 2 | #DIV/0! | 100% |
| SAFETY/RISK MANAGEMENT | 2 | 2 | 100% | 2 | #DIV/0! | 100% |
| SERVICE ENVIRONMENT | 4 | 4 | 100% | 4 | 10 | 100% |
| OTHER | 14 | 6 | 43% | 12 | 95 | 86% |
| **Total** | **95** | **65** | **68%** | **92** | **25** | **97%** |

*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 FY25 Q1-Q4.

| FY25 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** | 70 | 0.19 | 64 | 2 | 4 | 0 | 97% | 3% |
| **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** | 3 | 0.01 | 3 | 0 | 0 | 0 | 100% | 0% |
| **MEMBER NOT ELIGIBLE FOR SERVICES** | 5 | 0.01 | 5 | 0 | 0 | 0 | 100% | 0% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN** | 18 | 0.05 | 18 | 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** | 35 | 0.09 | 31 | 3 | 1 | 0 | 91% | 9% |
| **NOT APPLICABLE** | 194 | 0.52 | 180 | 4 | 10 | 0 | 98% | 2% |
| **Total** | 330 | 0.88 | 306 | 9 | 15 | 0 | 97% | 3% |

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

| | Count | Percentage |
|---|---|---|
| Appeals | 330 | |
| Appeals Upheld | 121 | 37% |
| Appeals Overturned | 202 | 61% |
| Appeals Partially Upheld/Overturned | 9 | 3% |

For FY2025, 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 FY2025*

The following activities were implemented during FY2025.

- 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.
- 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.
- The MSHN Adverse Benefit Determination (ABD) Technical Guide was updated with expanded information to assist provider staff in meeting the ABD requirements.

## *Recommendations for FY2026*

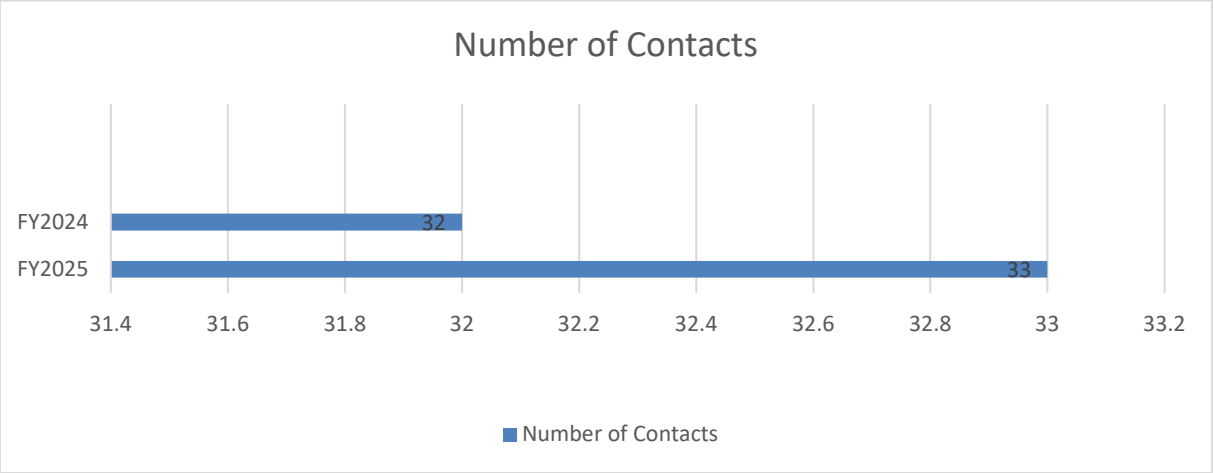
Based on FY25 Customer Service data, the following are recommended:

- The review of FY25 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.

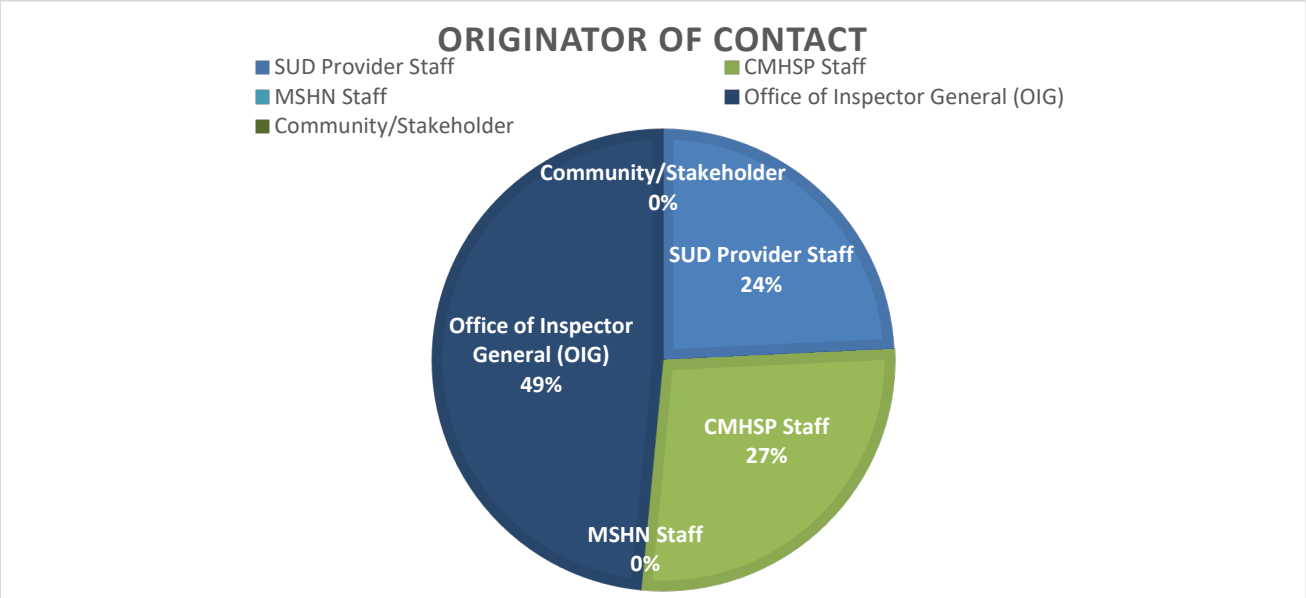
# Compliance Reporting

## Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2025 was 33. By comparison, there were 32 completed in FY2024. This resulted in an increase of 3.13% in FY2025 from FY2024.

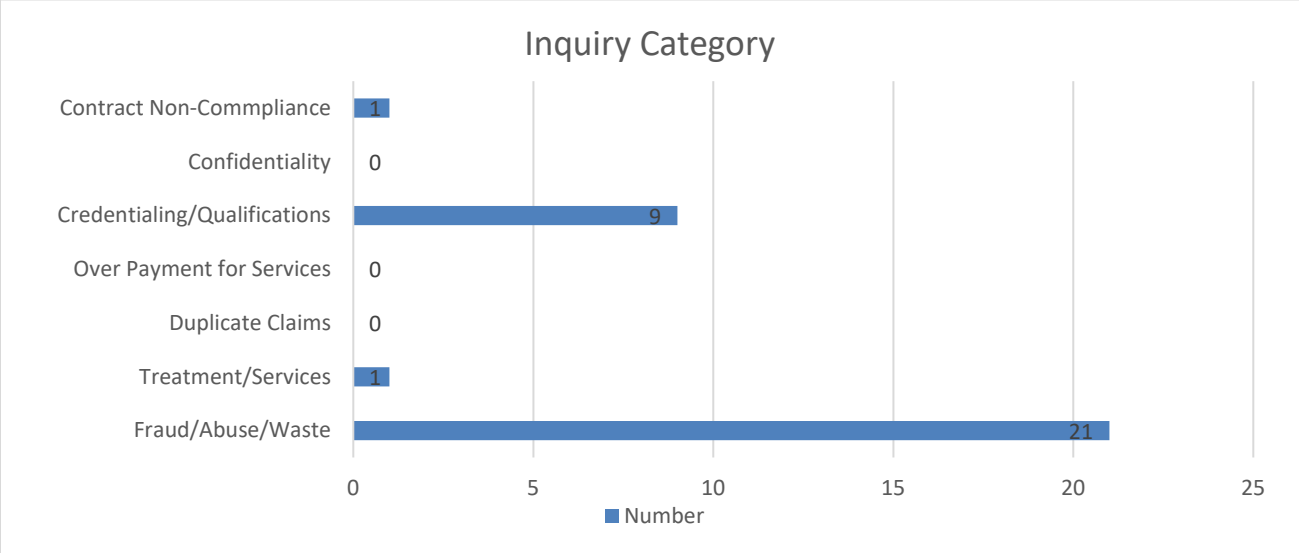



## Originator of Contact




*The percentage indicates the percent the originator represents of the total complaints.*

## Type of Compliance Investigation

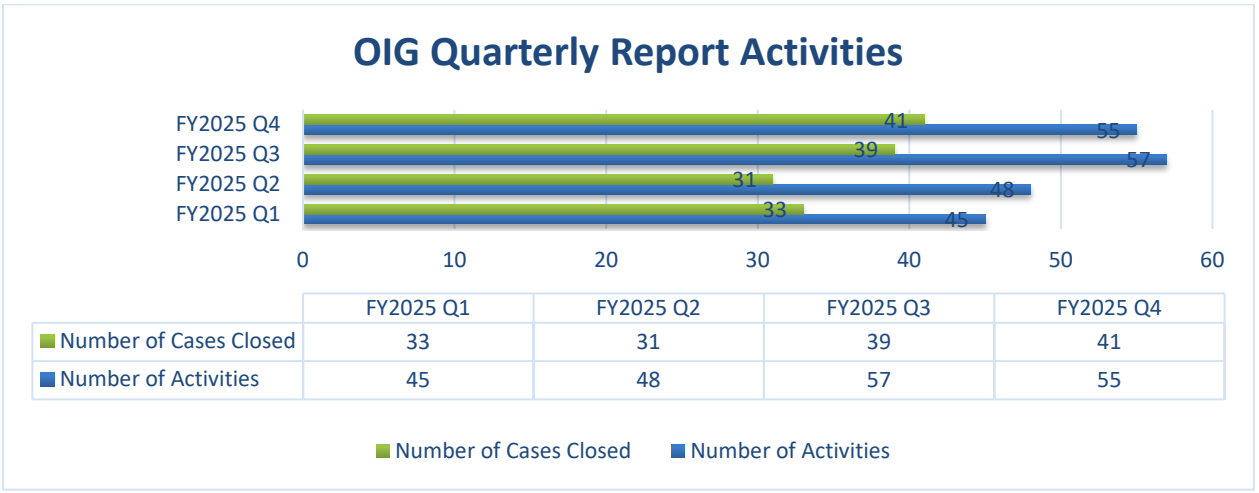



*The percentage indicates the percentage the type represents of the total complaints.*

## Office of Inspector General Quarterly Report for FY2025

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 FY25. 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.




| | FY2025 Q1 | FY2025 Q2 | FY2025 Q3 | FY2025 Q4 |
|---|---|---|---|---|
| Number of Cases Closed | 33 | 31 | 39 | 41 |
| Number of Activities | 45 | 48 | 57 | 55 |

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 $638,990.33. 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 FY2025.

## *DATA MINING ACTIVITIES*

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2025, 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) 90853 code: Group Psychotherapy
   a. This was a joint effort between the OIG and MSHN. The OIG pulled a report including this coder to see if there were any duplicate claims within the region.
3) H2016 code:
   a. This was a joint effort between the OIG and MSHN. The OIG pulled a report including this coder to see if there were any duplicate claims within the region.

### *Results/Trends*

- The following are the data mining activities and results for FY2025 Q1 through Q4.
  - Death Data Report
    Results: FY25 results included 71 unique individuals, accounting for 704 encounters. There were no instances where a date of service was reported after the date of death.
  - 90853 code
    Results: There were 2 instances identified by the OIG as potential duplicate billing. Upon investigation by MSHN, it was determined that the services occurred on the same day, but at different times. Therefore, there was no duplicate billing.
  - H2016 code
    Results: The OIG identified 24 records where there was a potential for double billing of this code. MSHN investigated each of these records and determined that there were no cases where double billing occurred, but rather the issues were related to voids being rejected or not properly submitted. All issues were corrected.
- The number of referrals from the OIG for allegations of fraud, waste and abuse continue to increase each year, showing a potential for increasing oversight by the OIG for the behavioral health system.

## SUBPOENA(S)

MSHN received 3 (three) subpoenas during FY2025 requesting records. MHSN did have records for 2 (two) of the cases and those records were provided as signed releases were provided. MSHN was not named as a defendant in any of the subpoenas.

## NOTIFICATION OF BREACH(S)

During FY2025 within the MSHN region, there were 6 (six) instances reported involving a breach of protected health information. Out of the instances, 1 (one) was reported from a Substance Use Provider, 4 (four) were reported from CMHSPs and 1 (one) was reported by MSHN staff. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future recurrence.

## ACTIVITIES IMPLEMENTED IN FY2025

The following activities were implemented during FY2025.

- Data Mining Activities included:
    - Death Audit Compared to Encounters (Q1, Q2, Q3, and Q4)
    - Joint activity with the OIG:
        - H2016 code for duplication of billing
        - 90853 code for duplication of billing
- Research and selection of a vendor for Compliance Software to be used region wide
- Tested compliance software and made recommendations for revisions/updates to forms and process
- Trained CMHSP staff in the use of the compliance software
- Revised and approved the 2025 MSHN Compliance Plan
- Reviewed and approved the FY2024 Annual Compliance Summary Report inclusive of recommendations
- Operationalized updates/revisions to Office of Inspector General (OIG) quarterly report and fraud referral process
- Development of process for reporting OIG monthly overpayment report
- Revised Privacy Notice to include changes in federal requirements

## RECOMMENDATIONS FOR FY2026

The following are recommendations for improvements in FY2026.

- Continue to explore, and identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Expand communication to MSHN staff and provider network by utilizing Constant Contact, emails, webpage and other communication means for compliance related updates for providers including trends and quality improvement efforts
- Develop reports that can be used to extract data from the compliance software to identify

trends and quality improvement efforts
- 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/stakeholders-resources/quality-compliance/external-site-reviews


1. Health Services Advisory Group State Fiscal Year 2025 Validation of Performance Measures Report
2. Health Services Advisory Group State Fiscal Year 2025 Compliance Report
3. Health Services Advisory Group State Fiscal Yeat 2025 PIP Validation Report