MSHN

Mid-State Health Network

Annual Compliance Summary Report

October 2021 – September 2022

Prepared By: MSHN Compliance Officer – December 2022
Approved By: MSHN Compliance Committee – February 08, 2023
Reviewed By: Regional Compliance Committee – February 17, 2023
Operations Council – February 27, 2023
MSHN Board – March 07, 2023

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Introduction

The Compliance Summary Report provides an overview of the activities performed during Fiscal Year 2022 as part of the Compliance Program and identified within the Compliance Plan. Those activities include monitoring and oversight of the provider network completed as part of the internal site reviews, site reviews of the PIHP completed by external agencies; customer service complaints; compliance investigations and compliance related training and review.

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

Recommendations for FY2023

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

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

Area of Risk: Credentialing and Provider Qualifications

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

Area of Risk: Delegated Managed Care Site Reviews

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

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

> *Recommendation:* Ensure that all CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator.
>
> *Recommendation*: Mid-State Health Network and the CMHSPs should employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.
>
> *Recommendation:* Ensure that programming codes for all delegated CMHSPs do not identify no-show appointments as a compliant record for the performance indicator.

Area of Risk: Compliance with established Customer Service standards.

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

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

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

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

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

Area of Risk: Compliance with established Compliance related standards.

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

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

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

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

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

The following recommendations were identified for FY2022 and are being continued for FY2023. There has been progress made, but the recommendations have not been fully implemented.

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

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

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

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

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

Recommendation: PCP toolkit/training resource will be updated on a quarterly basis and made available to the provider network.

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

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

Area of Risk: Security/Privacy of Remote Work Environments

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

Area of Risk: Adherence to telehealth rules

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

Status on FY2022 Recommendations

The following is a status update on the FY2022 areas of risk and progress made toward the recommendations.

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

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

Status: The MEV site review results are trended quarterly and included within the department quarterly report. Recommendations for improvement are also included in the quarterly report for the attributes that are scoring the lowest during the reviews. Changes to the MEV review process have been approved for implementation for FY2023 that include a reduction in the amount of claim lines being reviewed and the development of guidance documents to assist the provider network in understanding the documentation required for the reviews and what findings will result in voiding of claims and what ones will result in corrective action. The changes were recommended after review of the provider network site review results with both the MSHN Compliance Committee and the Regional Compliance Committee. These changes are being made with the intent of providing additional time for the MEV Auditor to provide technical assistance and education during the site reviews. This is considered complete and will not be continued in the FY2023 recommendations.

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).

Status: The MSHN website contains the current Compliance Plan and executive summary, Annual Compliance Summary Report, compliance related resources, privacy notice, satisfaction survey results, the Quality Assessment and Performance Improvement Program (QAPIP) Plan and Annual Report, the Michigan Department of Health and Human Services (MDHHS) Waiver reviews, MDHHS Substance Use Disorder review, and the Health Services Advisory Group reviews. These documents and resources are not located on one page, but rather are located on the page (consumer, provider network and/or stakeholder) based on what would be most relevant to the individual searching the website. The recommendation will continue into FY2023 to review the creation of one page dedicated to Compliance for the ease of locating resources, etc.

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

Recommendation: Identify trends of non-compliant activities as reported on the Office of Inspector General (OIG) quarterly activity report and utilize MSHN's Compliance Committee and the Regional Compliance Committee to develop processes/education/training to promote compliance.

Status: The trends, derived from the OIG quarterly report, are included in the Compliance section of the quarterly department report. The trends are also reviewed with the MSHN Compliance Committee and the Regional Compliance Committee. During FY2022, there were no trends identified as needing additional education or training to be developed. The trends will continue to be reviewed quarterly for any needed quality improvement efforts and additional training and education to promote compliance. While this will be ongoing, it will not be continued as a recommendation into FY2023.

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

Status: Options for a risk assessment for MSHN have been researched and presented to the MSHN Compliance Committee, including the 2020 Department of Justice risk assessment recommended for compliance programs. It was recommended by the MSHN Compliance Committee to contact the Health Law Partnership (HLP) to inquire if they would be interested in completing a risk assessment for MSHN. HLP was recommended due to their experience working with CMHSPs within MSHN's region. This recommendation will be ongoing into FY2023.

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: The PCP tool kit has been updated by MSHN staff to include various trainings. It was reviewed by the Clinical Leadership Committee and the Quality Improvement Council. The toolkit has not been updated since earlier in 2022 due to the work being completed by TBD Solutions in collaboration with MDHHS related to PCP training resources. There has also been a workgroup established by MDHHS to include PIHP and CMHSP staff related to the development of PCP resources. Until further information is provided by the new workgroup and other efforts related to PCP training by MDHHS, the efforts to create additional internal training resources has been paused. It is recommended to continue this into FY2023 to ensure that MSHN is providing the most up-to-date resources to the provider network for PCP.

Recommendation: Identification of additional training(s) and resources based on findings/outcomes from annual internal (DMC) and external (MDHHS) site reviews.

Status: The DMC site review requires a plan of correction for all findings and if there are trends of non-compliance noted, the findings are referred to the SUD treatment team for additional technical assistance for the provider. When there are findings for external site reviews, those also require a plan of correction be completed by the MSHN content expert. For both internal and external site reviews, the plan of correction/action may include the development of training/educational resources. Among these trainings/educational resources include the development of a grievance and appeals training, advance benefit determination training, coordination of care training, and updates to practice guidelines. MSHN also continues to use the regional councils and committees to provide updates to the CMHSP's and the constant contact and SUD provider quarterly meetings to provide updates to the SUD Providers. This will continue to be an ongoing process but will not continue as a recommendation into FY2023.

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

Status: The use of standardized templates has been explored and based on the repeat findings from the MDHHS Waiver reviews both CLC and QIC are requesting the development of standardized tools and trainings related to Person Centered Planning (PCP), Self Determination (SD), etc. Both CLC and QIC, along with MSHN content experts, will explore the options for creating standardized templates related to PCP and SD. Any training, templates, etc. developed through MDHHS contractors or workgroups will also be reviewed for use within the region. This will continue to be a recommendation for FY2023.

Area of Risk: Security/Privacy of Remote Work Environments

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

Status: In January 2022 MSHN, under the direction of Steve Grulke (Chief Information Officer), completed the National Institute of Standards and Technology (NIST) security risk assessment, which is an overall assessment that indicated that there is some concern about the remote office security. Steve has started talking with Providence about completing a remote office assessment, but this hasn't started yet. This will continue to be a recommendation for FY2023.

Area of Risk: Adherence to telehealth rules

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

Status: The telehealth rules implemented during the state of emergency are reviewed during the Regional Compliance Committee to ensure regional compliance. In addition, a data mining activity comparing telehealth, face-to-face and overall encounters was completed each quarter during FY2022. This activity reviews data that compares the current month encounters with the average of all previous month's encounters with the fiscal year. The report is based on encounters that have been accepted by MDHHS. During FY2022 Q2, the comparison for January 2022 showed an increase in telehealth compared to previous months. However, overall throughout FY2022, the comparisons did not show any significant variances when compared to previous months encounters. The telehealth rules will continue to be reviewed internally at MSHN and as part of the Regional Compliance Committee meetings. This will continue as a recommendation for FY2023.

Monitoring and Auditing

Mid-State Health Network Internal Site Reviews

The following is a snapshot of the site review results for both the Community Mental Health Service Providers (CMHSP) and the Substance Use Disorder (SUD) Providers. For complete information, please see the Delegated Managed Care Quality Assurance Review Summary Report Fiscal Year 2022.

CMHSP Provider Delegated Function Reviews

During Fiscal Year 2022, three (3) of the twelve (12) CMHSPs received a full delegated managed care (DMC) review and nine (9) of the twelve (12) had an interim review completed. The full review includes a review of programs, policies, procedures, and a sample of case files and charts and the interim review consists of ensuring that the approved corrective action plans from the previous review have been implemented effectively and review of any new standards due to contractual or regulatory changes.

Delegated Managed Care Review Tool Results

Includes review of 192 standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this was 95.47%.

Note: The full reviews were all completed during FY2022 Q1

Note: All percentages are rounded to the nearest percent.

DMC Tool

DMC Standards	# Of Standards	2021 Results	2022 Results
Information Customer Service	13	100%	100%
Enrollee Rights and Protections	9	100%	100%
24/7/365 Access	17	95%	94%
Provider Network Sub-Contract Providers	14	100%	100%
Service Authorization and UM	7	97%	100%
Grievance and Appeals	20	99%	99%
Person Centered Planning	30	100%	99%
Coordination of Care/Integration	6	96%	100%
Behavior Treatment Plan Review Committee	21	78%	72%
Consumer Involvement	3	100%	100%
Provider Staff Credentialing	22	91%	97%
Quality and Compliance	7	100%	100%
Ensuring Health and Welfare	8	96%	93%
Information Technology	9	99%	100%
Trauma Informed Care	6	99%	100%

Clinical Chart Review Results

Includes review of eighty-five (85) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 93.98%.

Clinical Chart Review Tool

Clinical Chart Standards	# Of Standards	2021 Results	2022 Results
Intake/Assessment	13	96%	97%
Pre-Planning	10	88%	85%
PCP/IPOS	21	92%	96%
Documentation	3	100%	100%
Customer Service	5	96%	99%
Delivery and Evaluation	3	89%	92%
Service Delivery	23	93%	93%
Discharge/Transfers	4	100%	100%
Integrated Physical/Mental Health Care	3	98%	95%

SUDSP Treatment Provider Delegated Function Reviews

During FY2022, both full and interim reviews were completed. The interim reviews consist of any new standards and to ensure implementation of approved corrective action plans from the previous year's review. Interim reviews do not receive a score. Full reviews consist of chart reviews, validation of process requirements, staff files, policies, and procedures. Reviews by provider are inclusive of all provider sites. For providers that are outside of the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region the providers are located.

The QAPI team conducted twelve (12) full reviews and 16 (sixteen) interim reviews from October 1, 2021 – September 30, 2022.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of 118 standards. Overall compliance during this timeframe for full reviews is 93.58%.

Note: All percentages are rounded to the nearest percent.

FY22 SUD Delegated Functions Scores

Delegated Functions Standards	# Of Standards	2021 Results	2022 Results
Access and Eligibility	4	84%	90%
Information and Customer Service	17	99%	99%
Enrollee Rights and Protections	14	100%	99%
Grievance and Appeals	17	93%	94%
Compliance	11	98%	100%
Quality	4	***	88%
Individualized Treatment & Recovery Planning & Documentation	14	92%	86%
Coordination of Care	8	88%	81%
Provider Staff Credentialing	22	86%	81%
IT Compliance/IT Management	1	100%	100%
Trauma Informed Care	6	N/A	74%

*** Compliance and Quality were reviewed as a combined score in 2021. The compliance and quality standards were separated for review in 2022.

Clinical Chart Review Results

The SUDSP treatment chart review tool includes a total of fifty-four (54) standards. Overall compliance during this timeframe for full reviews is 74.81%.

Table 10: SUD Program Specific Scores

SUDSP Chart Reviews	# Of Standards	2021 Results	2022 Results
Screening, Admission, Assessment	8	84%	78%
Treatment/Recovery Planning	10	77%	75%
Progress Notes	2	81%	78%
Coordination of Care	4	56%	60%
Discharge/Continuity of Care	3	63%	81%
Residential	5	70%	86%
Medication Assisted Treatment	16	86%	65%
Women's Designated/Women's Enhanced	2	61%	81%
Recovery Housing	6	75%	74%

Medicaid Event Verification (MEV) Site Reviews

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an onsite review or a desk review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all twelve (12) of the CMHSPs and for all substance use disorder treatment providers who provide services using Medicaid funding.

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

The following is a summary of the MEV Annual report. For complete information, please see the Medicaid Services Verification Methodology Report for Fiscal Year 2022.

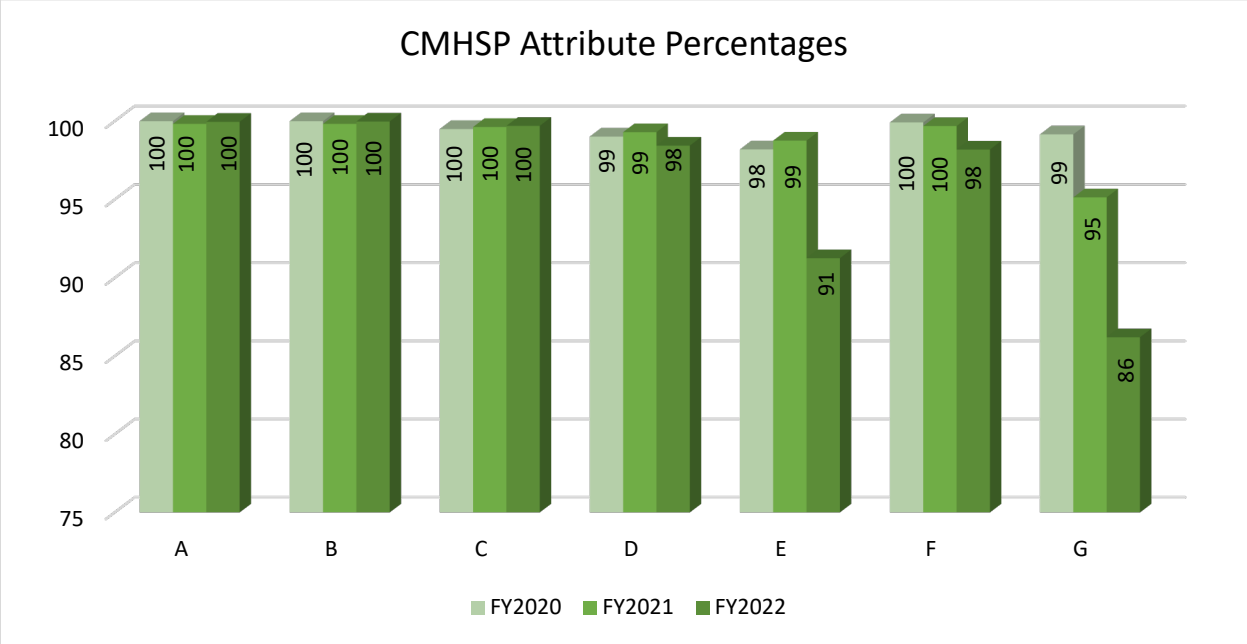
The CMHSP site reviews are completed bi-annually (twice a year) for all twelve (12) CMHSPs. The table below includes the score per CMHSP for all attributes reviewed.

Data presented in the below chart is relative to the twelve (12) CMHSP's for the full fiscal year, October1, 2021 – September 30, 2022.

CMHSP	A	B	C	D	E	F	G
BABHA	100%	100%	100%	100%	92%	100%	96%
CEI	100%	100%	100%	99%	92%	100%	51%
CMHCM	100%	100%	100%	99%	94	100%	98%
Gratiot	100%	100%	100%	99%	92%	99%	82%
Huron	100%	100%	100%	99%	92%	97%	89%
Lifeways	100%	100%	100%	97%	88%	93%	81%
Montcalm	100%	100%	99%	98%	88%	99%	92%
Newaygo	100%	100%	100%	99%	90%	100%	81%
Saginaw	100%	100%	99%	93%	83%	94%	89%
Shiawassee	100%	100%	100%	99%	92%	100%	94%
The Right Door	100%	100%	99%	99%	95%	95%	82%
Tuscola	100%	100%	100%	100%	95%	100%	98%
MSHN Average	**100%**	**100%**	**100%**	**98%**	**916%**	**98%**	**86%**

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

The following chart provides a comparison from FY2020 through FY2022 for the attributes tested:



The Substance Use Disorder site reviews are completed annually. Data presented in the below chart is relative to the thirty-seven (37) SUD treatment providers reviewed for the full fiscal year, October 1, 2021 – September 30, 2022.

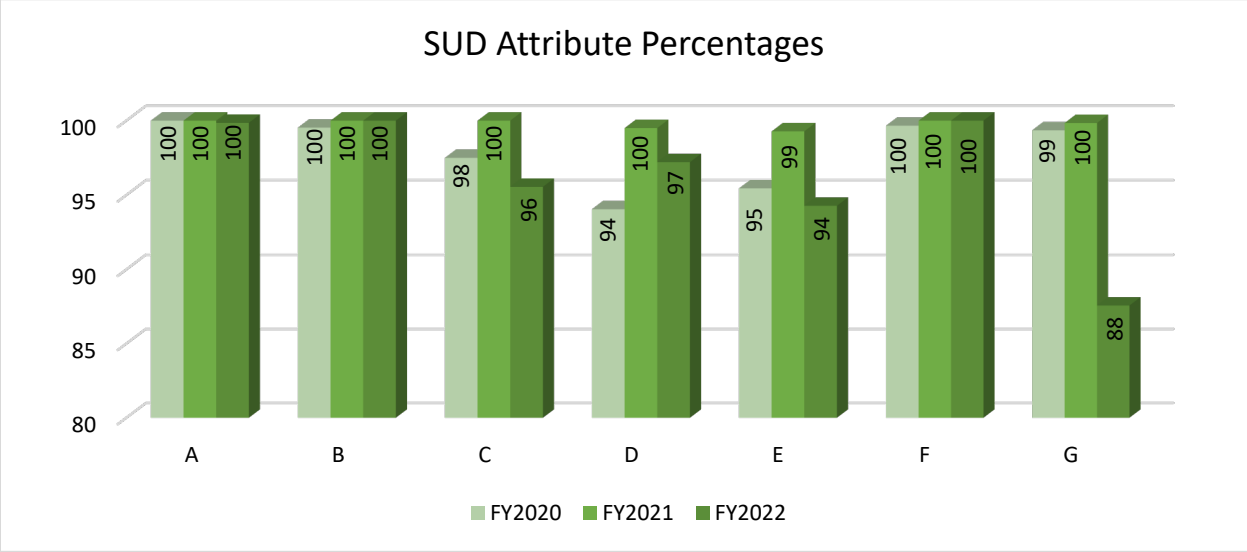
The chart below includes the score for all SUD providers combined for each attribute reviewed.

SUD

	A	B	C	D	E	F	G
SUD Providers	100%	100%	96%	97%	94%	100%	88%

*Note: This chart represents an average of the scores for all twelve (12) SUD providers who had an individual site review. **Percentages have been rounded to the nearest percent**.*

The following chart provides a comparison from FY2020 through FY2022 for the attributes tested:



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

Results/Trends

Based on the MEV review for FY2022, all 12 CMHSPs were placed on a new plan of correction and of the twelve (12) substance use disorder treatment providers reviewed, ten (10) 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 FY2021, were removed from those plans during FY2022.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and contractual services of $743,706.44 and $15,978.92 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

Regionally the CMHSPs have shown slight improvements from FY2021 to FY2022 for the following attributes:

1. A: Code is an allowable service code under the contract
2. B: Beneficiary is eligible on the date of service.

3. C: Service is included in the beneficiary's individual plan of service.

Regionally the SUD providers remained at 100% from FY2021 to FY2022 for the following attributes:

1. B: Beneficiary is eligible on the date of service.
2. F: Amount billed and paid does not exceed contractually agreed upon amount.

Monitoring and Auditing

Mid-State Health Network External Site Reviews

MDHHS Waiver Site Reviews

The Michigan Department of Health and Human Services (MDHHS) conducted a desk review for our region from June 13, 2022, through July 29, 2022. The purpose of the review was to provide monitoring on the service delivery requirements of the 1915 (c) waivers that include the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW) and the Children's Waiver Program (CWP).

The following is a summary of the MDHHS Waiver site review reports. For complete information, please see the MDHHS HSW, CWP and SEDW site review reports and corrective action plans.

Habilitation Support Waiver (HSW) Review

The 2022 site review included the review of administrative procedures, beneficiary files and staff records.

Total Cases Reviewed (41)
Total Licensed Staff Records Reviewed (57)
Total Non-Licensed Staff Records Reviewed (393)

Summary of the findings:

A.1.1- A.1.5	Administrative Procedures (5 elements,1 scored NA): 100%
A.3.1	Administrative: Environmental Modifications (1 Element): 100%
F.2.1 – F.2.2	Freedom of Choice (2 Elements): 100%
P.2.1 – P.2.8	Implementation of Person-Centered Planning (7 Elements): 80%
P.5.1 – P.5.3	Plan of Service and Documentation Requirements (3 Elements): 58%
B.1 – B.2	Behavior Treatment Plans and Review Committees (2 Elements): 89%
G.1 – G.2	Health and Welfare (New Section for 2020): (2 elements): 99%
Q.2.1 – Q.2.2	Staff Qualifications (Licensed) (2 Elements): 88%
Q.2.3 – Q.2.4	Staff Qualifications (Non-Licensed) (2 Elements): 88%
H.3	Health and Safety (NA – no home visits): NA

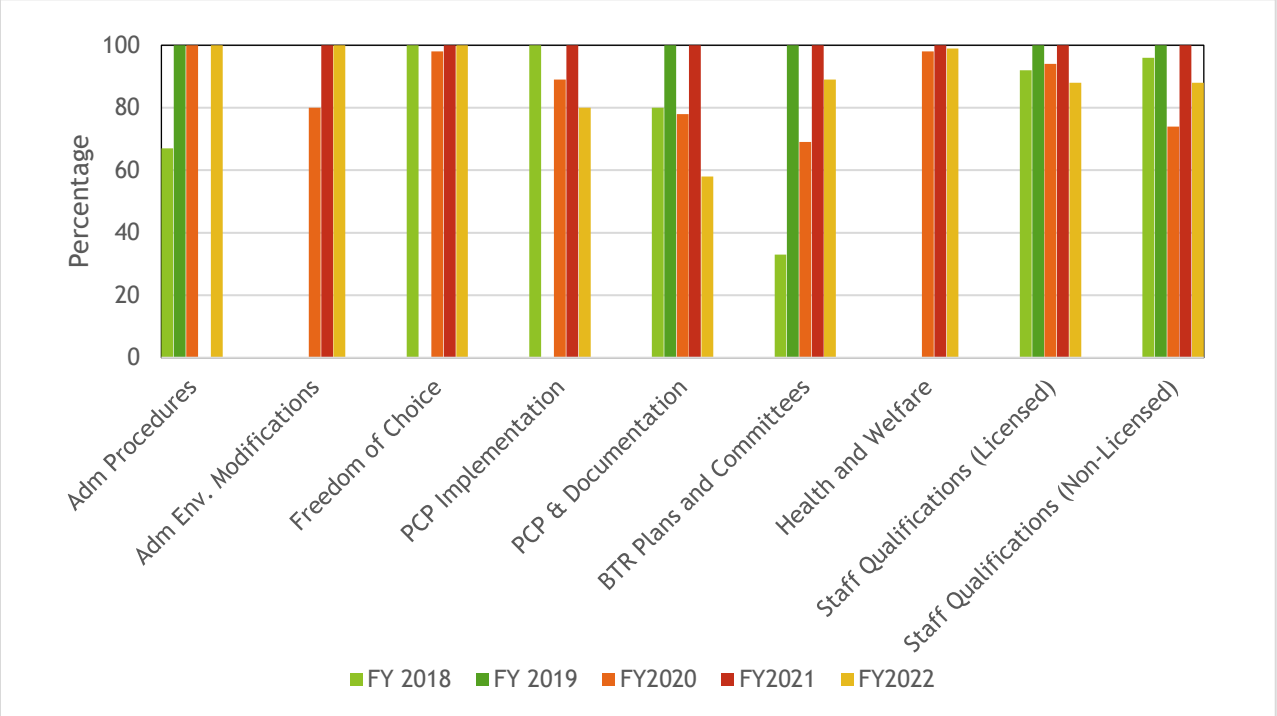
Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts reviewed for each element and then averaging the percentages for all elements with each standard. Not all charts were reviewed for all elements. All scores of NA were not included.

Results/Next Steps

MSHN was required to submit a plan of correction to MDHHS for all elements that received less than "full compliance." During the FY2022 site review, MSHN was found to have repeat citations (from the

FY2020 review) for thirteen elements. MSHN will be monitoring the repeat citations to ensure full compliance during the follow up review.

Comparison of Results for Full Review (FY2018), Follow Up Review (FY2019) & Full Review (FY2020), Follow Up Review (2021) and Full Review (2022).



Note: FY2019 and FY 2021 were follow-up reviews only for the plans of correction from the previous year.

Children's Waiver Program (CWP) Review

The 2022 site review included the review of beneficiary files and staff records. This was the first year that this review was under the oversight of the PIHP.

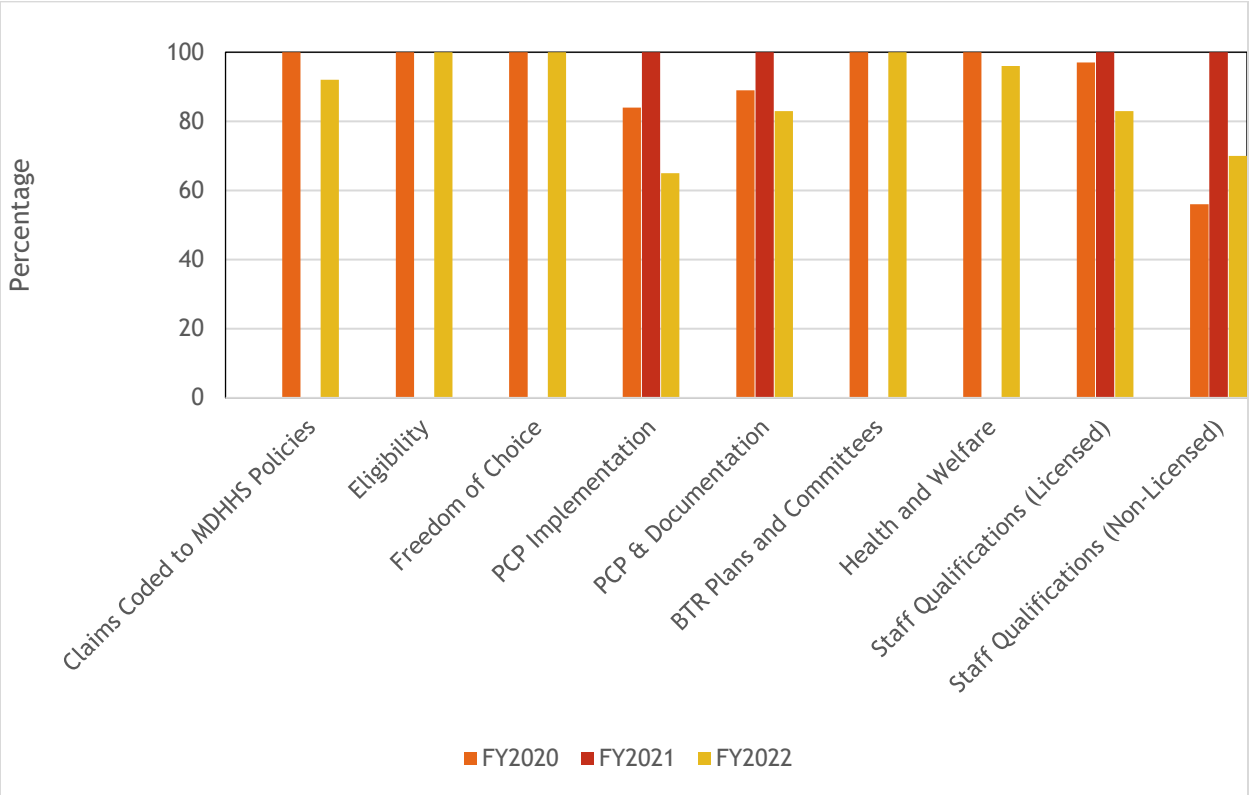
Total Cases Reviewed (13)
Total Licensed Staff Records Reviewed (23)
Total Non-Licensed Staff Records Reviewed (45)

Summary of the findings:

A.2.2	Claims coded in accordance with MDHHS policies (1 Element): 92%
E.1.1 – E.1.2	Eligibility (2 Elements): 100%
F.1.1 – F.1.2	Freedom of Choice (2 Elements): 100%
P.1.1 – P.1.4	Implementation of Person-Centered Planning (4 Elements): 65%
P.4.1 – P.4.7	Plan of Service and Documentation Requirements (6 Elements: 1 NA): 83%
B.1	Behavior Treatment Plans and Review Committees (1 Element): 100%
G.1 – G.2	Health and Welfare: (2 Elements): 96%
Q.1.1 – Q.1.2	Staff Qualifications (Licensed) (2 Elements): 83%
Q.1.3 – Q.1.4	Staff Qualifications (Non-Licensed) (2 Elements): 70%
H.3	Home Visits/Training/Interviews (NA- no home visits): NA

Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts reviewed for each element and then averaging the percentages for all elements. Not all charts were reviewed for all elements. All scores of NA were not included.

Comparison of Results for Full Review (FY2020), Follow Up Review (2021) and Full Review (2022).



Results/Next Steps

MSHN was required to submit a plan of correction to MDHHS for all elements that received less than "full compliance." During the FY2022 site review, MSHN was found to have repeat citations (from the FY2020 review) for nine elements. MSHN will be monitoring the repeat citations to ensure full compliance during the follow up review.

Serious Emotional Disturbance Waiver (SEDW) Review

The 2022 site review included the review of beneficiary files and staff records. This was the first year that this review was under the oversight of the PIHP.

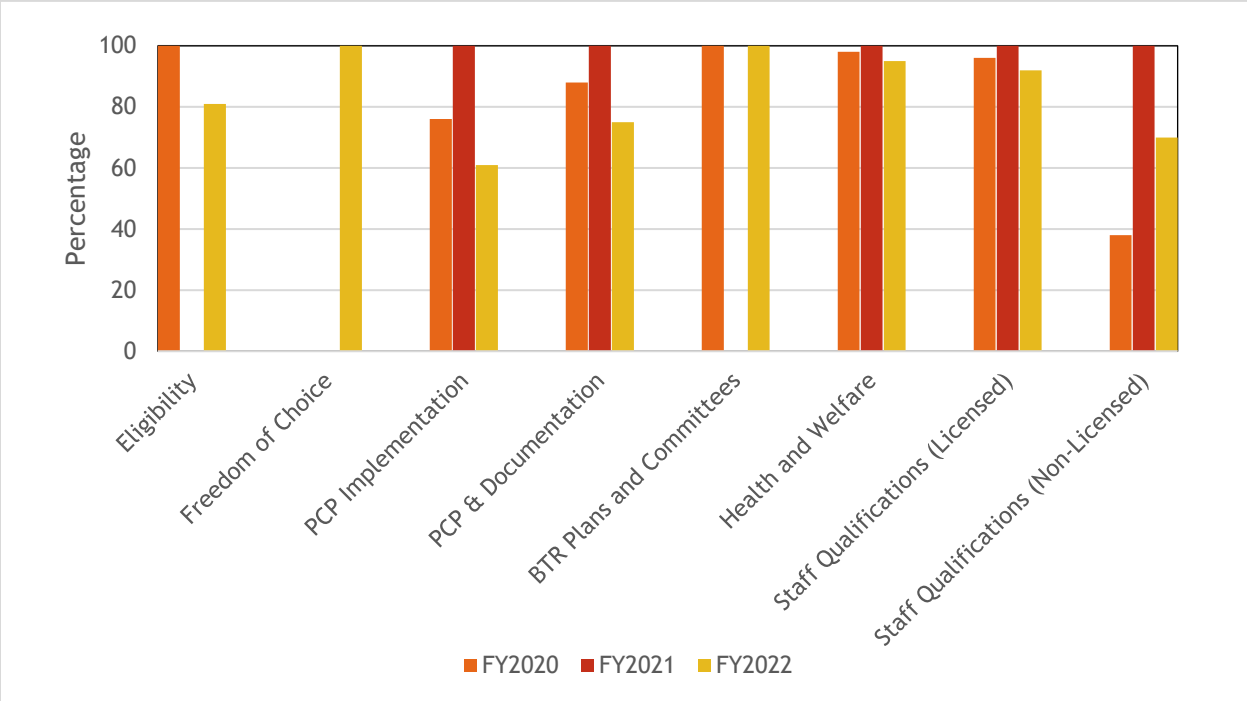
Total Cases Reviewed (30)
Total Licensed Staff Records Reviewed (72)
Total Non-Licensed Staff Records Reviewed (30)

Summary of the findings:

E.2.1	Eligibility (1 Elements): 81%
F.3.1 – F.3.2	Freedom of Choice (2 Elements): 100%
P.3.1 – P.3.4	Implementation of Person-Centered Planning (4 Elements): 61%
P.6.1 – P.6.5	Plan of Service and Documentation Requirements (4 Elements: 1 NA): 75%
B.1-B.2	Behavior Treatment Plans and Review Committees (1 Elements): 100%
G.1 – G.2	Health and Welfare: (2 elements): 95%
Q.3.1 – Q.3.2	Staff Qualifications (Licensed) (2 Elements): 92%
Q.3.3 – Q.3.4	Staff Qualifications (Non-Licensed) (2 Elements): 70%

H.3 Home Visits/Training/Interviews (NA- no home visits): NA

Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts reviewed for each element and then averaging the percentages for all elements. Not all charts were reviewed for all elements. All scores of NA were not included.



Results/Next Steps

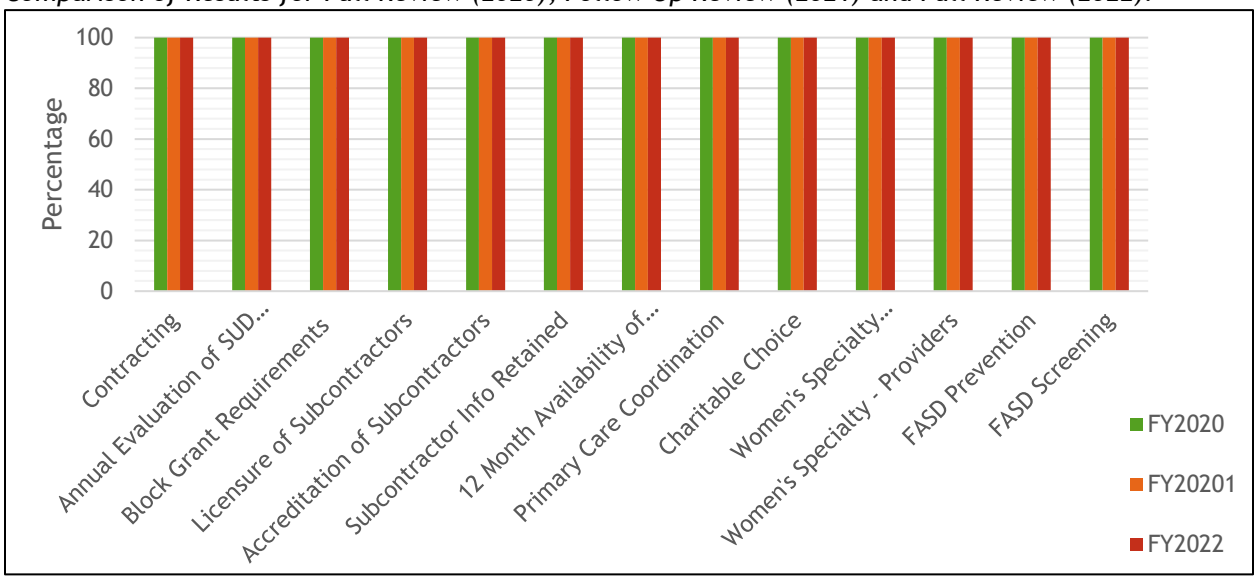
MSHN was required to submit a plan of correction to MDHHS for all elements that received less than "full compliance." During the FY2022 site review, MSHN was found to have repeat citations (from the FY2020 review) for eleven elements. MSHN will be monitoring the repeat citations to ensure full compliance during the follow up review.

MDHHS Substance Use Disorder Site Review

MSHN received full compliance on all standards reviewed by the Michigan Department of Health and Human Services (MDHHS) for compliance with the Substance Use Agreement with the Centers for Medicare and Medicaid services. The full review was completed by MDHHS on June 13, 2022, through July 29, 2022. During that time MDHHS reviewed information to confirm compliance with established standards. During the full review, MSHN was determined to be in full compliance with thirteen out of thirteen standards reviewed.

The following is a summary of the MDHHS SUD site review report. For complete information, please see the Substance Use Disorder Administrative Monitoring Protocol Report.

Comparison of Results for Full Review (2020), Follow Up Review (2021) and Full Review (2022).



Results/Trends

MSHN was in full compliance with all elements reviewed. Therefore, MSHN was not required to submit a plan of correction.

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

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

HSAG completed MSHN's review remotely on June 17, 2022.

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

Compliance was assessed through a review of the following:

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

- Evaluation of system compliance

The following is a summary of the PMV site review report. For complete information, please see the Health Services Advisory Group Validation of Performance Measures State Fiscal Year 2022.

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 Mid-State Health Network ensure that all delegated CMHSPs are identifying case exceptions using the methodology outlined in the MDHHS Codebook for each performance indicator.
- HSAG recommends that Mid-State Health Network and the CMHSPs employ additional enhancements to their BH-TEDS validation process to ensure that there are no discrepant data entered.
- HSAG recommends that Mid-State Health Network ensure that programming code for all delegated CMHSPs does not identify no-show appointments as a compliant record for the performance indicator.

MSHN has received full compliance (100%) for all elements reviewed from the first review in FY2014 through the current review in FY2022. No corrective action is required to be submitted to HSAG.

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

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

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

During State Fiscal Year (SFY) 2022, HSAG completed a desk audit on July 22, 2022.

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

Results/Trends

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

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems	12	12	11	1	0	**92%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**119**	**119**	**105**	**14**	**0**	**88%**

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

***Total Elements:** The total number of elements within each standard.*
***Total Applicable Elements:** The total number of elements within each standard minus any elements that were NA. This represents the denominator.*

MSHN demonstrated compliance in 105 out of 119 elements, with an overall compliance score of eighty-eight (88) percent. MSHN achieved full compliance in two of the seven standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of Subcontractual Relationships and Delegation and Practice Guidelines. The remaining five standards have identified opportunities for improvement. The areas with the greatest opportunity for improvement were related to Provider Selection and Grievance and Appeal Systems, as these areas received performance scores below 90 percent.

Required Actions

Among the required actions from this review were the following:

Standard VII-Provider Selection

- Elements 14-16. The PIHP must comply with, and ensure delegates performing recredentialing, credentialing, activities comply with all initial credentialing, credentialing, organizational credentialing requirements as outlined in its contract with MDHHS.

Standard IX- Grievance and Appeal System

- Elements 4, 16. The PIHP must acknowledge receipt of each appeal.
- Elements 6, 21, 27. The PIHP must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the PIHP receives the appeal. For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice.
- Element 25. For untimely appeal resolutions, the PIHP must ensure that the appeal is deemed exhausted, and members are provided immediate access to their State Fair Hearing (SFH) rights.

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

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

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

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

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

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

Results/Trends

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

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

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

- Complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 period may not have the time to impact the performance indicator rate or achieve significant improvement.
- Implement active, innovative improvement strategies that have the potential to impact the performance indicator outcomes or achieve significant improvement.
- Have an evaluation process to determine 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 FY2022 were 117, an increase of 12.5% from FY2021. By comparison, there were 104 contacts in FY2021, and the increase reverses the previous downward trend of overall contacts from previous years. Additionally, there was a 150% (30) increase in FY22 for requests from MDHHS over FY21 (12).

Customer Service Originator of Contact

Originator	Number	Percentage*
Advocate	2	2%
Authorized representative	2	2%
CMHSP	13	11%
Family Member	4	3%
Guardian	1	1%
MDHHS	30	26%
Other	10	9%
Parent of a minor	12	10%
Self/Consumer	30	26%
SUDSP	13	11%

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

Customer Service Inquiry Category

Category	Number	Percentage*
Access to Treatment	35	30%
Appeal	3	3%
Complaint/Dissatisfaction	10	9%
Consumer Discharge	6	5%
General Assistance	16	14%
LEP Assistance	2	2%
Notification Letter	6	5%
Provider Practices	34	29%
Provider Staff Concern	2	2%
Recipient Rights Assistance	2	2%
Service Concerns/Availability	1	1%

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

Conclusion/Resolution Type

Type of Resolution	Number	Percentage*
No follow-up required	27	23%
Resolution pending	10	9%
Resolved in favor of consumer	3	3%
Resolved in favor of provider	3	3%
Resolved through follow up actions	73	62%
Resolved with no provider involved	1	1%

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

Results/Trends

The following trends/changes were noted during FY2022:

- Overall Customer Service contacts increased by 12.5% in FY2022 (117) from FY2021 (104)
- Consumer contacts requiring follow-up action increased from 63% (n=66) in FY2021 to 77% (n=90) in FY2022.
- The highest number of consumer-based customer service complaints originated from Consumers themselves (35%/n=26) and MDHHS (35%/n=26).
- The highest number of non-consumer customer service contacts originated from CMHSP staff (11%/n=13)
- The highest consumer complaint categories involved complaints addressing Access to Treatment (30%/n=35) and Provider Practices (29%/n=34). Access to Treatment was a 250% increase in FY22 (35) over FY21 (10). Provider practices saw a 42% increase in FY22 (34) over FY21 (24).
- The highest non-consumer contact category involved requests for General Assistance (12% / n=14)

FY22 MDHHS Grievance Reporting

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 covering FY22 Q1-Q4.

FY22 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	58	0.16	32	0.09	103	54	35
ACCESS AND AVAILABILITY	21	0.06	9	0.02	35	20	43
INTERACTION WITH PROVIDER OR PLAN	19	0.05	15	0.04	25	18	39
MEMBER RIGHTS	1	0.00	0	0.00	1	1	12
TRANSPORTATION	0	0.00	0	0.00	0	0	#DIV/0!
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	3	0.01	3	0.01	4	3	33
SAFETY/RISK MANAGEMENT	0	0.00	0	0.00	0	0	#DIV/0!
SERVICE ENVIRONMENT	13	0.04	6	0.02	21	13	18
OTHER	8	0.02	2	0.01	10	8	23
Total	123	0.34	67	0.19	199	117	37

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

FY22 MDHHS Member Appeals Reporting

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 covering FY22 Q1-Q4.

FY22 MDHHS Appeals Reporting Results (Q1-Q4)

Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	51	0.14	28	0.08	91	48	34
ACCESS AND AVAILABILITY	14	0.04	6	0.02	22	13	41
INTERACTION WITH PROVIDER OR PLAN	17	0.05	14	0.04	22	16	40
MEMBER RIGHTS	0	0.00	0	0.00	0	0	#DIV/0!
TRANSPORTATION	0	0.00	0	0.00	0	0	#DIV/0!
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	3	0.01	3	0.01	4	3	33
SAFETY/RISK MANAGEMENT	0	0.00	0	0.00	0	0	#DIV/0!
SERVICE ENVIRONMENT	11	0.03	6	0.02	18	11	9
OTHER	6	0.02	2	0.01	8	6	21
Total	102	0.29	59	0.17	165	97	32

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

	Count	Percentage
Appeals	400	
Appeals Upheld	98	25%
Appeals Overturned	299	75%
Appeals Partially Upheld/Overturned	3	1%

For FY2022, 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 FY2022

The following activities were implemented during FY2022.

- An Adverse Benefit Determination (ABD) training was developed by the MSHN Customer Service Committee to assist provider staff in understanding and meeting the required standards for ABDs.

- A quarterly Appeal and Grievance Regional Analysis Report was developed to evaluate the quarterly MDHHS Grievance and Appeal data for trends and quality improvement across the region.
- The MSHN Customer Service Committee reviewed, revised, and facilitated the publication of 13 local versions of the FY22 MSHN Guide to Services Handbook. Additionally, the 13 local versions were translated into Spanish for electronic distribution to CMHSP and SUDSP providers throughout the MSHN region.
- MSHN Customer Services continued to work in collaboration with the MSHN staff to provide technical assistance to improve quality of services through providers within MSHN's SUDSP network.
- Ongoing technical support and training to the provider network in areas of customer service, grievance and appeals and recipient rights.

Recommendations for FY2023

Based upon FY22 Customer Service data, the following is being recommended:

- The 2022 HSAG Compliance Review recommended enhance quality assurance (QA) processes for Medicaid appeal and grievance notice letters to beneficiaries. MSHN will enhance QA processes through the inclusion of the MSHN Customer Service & Rights Manager in the MSHN Delegated Managed Care reviews. The Customer Service & Rights Manager will complete the primary source verification of Appeal and Grievance notice letters to ensure the letters include the required components and meet a high standard of professionalism.
- Initial review of FY22 Customer Service data did not identify systemic issues but did identify errors at the individual provider level. Quality improvement initiatives will continue to be explored during the Customer Service Committee for the quarterly Appeal and Grievance Regional Analysis Report and a process for root cause analysis will be established to support the implementation of Plans of Correction (POC) for any out-of-compliance providers.
- Regional LEP practices will be reviewed for improvement by conducting a feasibility study to collect information from CMHSPs and SUD providers regarding cultural competency requests and through a local county analysis for non-English language prevalence to ensure compliance with LEP requirements.
- Technical support and training will be explored, in collaboration with MSHN treatment and behavioral health staff, focused on improving the quality of services for the Customer Service areas of Access to Treatment and Provider Practices within MSHN's provider network.

Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed by the MSHN Compliance Officer in FY2022 was 28. By comparison, there were 16 completed in FY2021. This resulted in an increase of 75% in FY2022 from FY2021.

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

Originator:	***Number:***	***Percent:***
SUD Provider Staff	6	21.43%
CMHSP Staff	6	21.43%
MSHN Staff	8	28.57%
Office of Inspector General (OIG)	7	25.00%
Office of Civil Rights (OCR)	1	3.57%

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

Category:	***Number:***	***Percent:***
Fraud/Abuse/Waste	11	39.29%
Treatment/Services	1	3.57%
Unequal Service	1	3.57%
Duplicate Claims	2	7.14%
Over Payment for Services	2	7.14%
Credentialing/Qualifications	8	28.57%
Licensure	2	7.14%
Eligibility	1	3.57%

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

Type of Resolution:	***Number:***	***Percent:***
CMHSP	4	14.29%
SUD Provider	12	42.86%
MSHN Staff	1	3.57%
OIG	9	32.14%
OCR	1	3.57%
Pending	1	3.57%

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	9	32.14%
OCR	1	3.57%

During this time period, MHSN closed 11 cases with the OIG and were notified that an additional 5 cases were closed by the OIG in previous fiscal years, but the OIG failed to notify MSHN of the closures. There continues to be 15 cases that are still active with the OIG and are being reviewed. MSHN's Compliance Officer will continue to follow up with the OIG on these open cases.

Office of Inspector General Quarterly Report for FY2022

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

FY2022 Q1: 69 new activities were reported
FY2022 Q2: 45 new activities were reported
FY2022 Q3: 54 new activities were reported
FY2022 Q4: 70 new activities were reported

Most of the activities reported were a result of local and region wide Medicaid Event Verification activities, clinical record reviews and internal audits. The activities reported included inappropriate

credentials/training, lack of supporting documentation, wrong use of modifiers, billing for incorrect dates and times, incorrect service codes and overpayment.

The total amount of overpayments identified as a result of the QIG quarter report activities was $437,893.72. 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 FY2022.

Data Mining Activities

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2022, MSHN completed the following data mining activities.

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

Results/Trends

The following are the data mining activities and results for FY2022 Q1.

1) Death Data Report
   Results: It was concluded that there was one instance where a service was provided after the date of death. This instance was corrected.
2) Comparison for telehealth, face-to-face and overall encounters
   Results: The comparison did not have any significant variance when compared to the average of previous months encounters within fiscal year 2021.

The following are the data mining activities and results for FY2022 Q2.

1) Death Data Report
   Results: There were no instances that had a service provided after the identified date of death.
2) Comparison for telehealth, face-to-face and overall encounters
   Results: The comparison showed an increase for telehealth in January 2022 compared to previous months, but overall encounters were still only at 93% of the previous months average.

The following are the data mining activities and results for FY2022 Q3.

1) Death Data Report
   Results: There were 5 (five) instances, involving 2 (two) beneficiaries, that had a service provided after the identified date of death. These were errors and there is no suspicion of fraud. Corrections will be made to include voiding of claims and no further analysis is necessary.
2) Comparison for telehealth, face-to-face and overall encounters
   Results: Comparison showed a slight decrease in the average total numbers of face-to-face and telehealth contacts for April and May 2022 compared to previous months. This decrease was within an expected range and no further analysis was necessary.

The following are the data mining activities and results for FY2022 Q4.

1) Death Data Report
   Results: There were no instances that had a service provided after the identified date of death.
2) Telehealth and Face-to-Face Comparison
   Results: The comparison did not have any significant variance when compared to the average of previous months encounters.

Subpoena(s)

MSHN received 3 (three) subpoenas during FY2022 requesting records. No action was needed regarding 2 (two) of the subpoenas and records were provided for the other. MSHN was not named as a defendant in the subpoena.

Notification of Breach(s):

During FY2022, within the MSHN region, there were three (3) instances reported to MSHN involving a breach of protected health information. Two of the instances were reported from CMHSPs and one from a contracted vendor. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future reoccurrence.

Results/Trends

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

Compliance investigations:

- There was an increase in the total number of compliance issues reported during FY2022
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 39.29%.
- Twenty-seven (27) investigations were completed and achieved a closed status.
- One (1) investigation is still pending closure by the OIG.

OIG quarterly report:

- FY2022 had a slight increase in the number of reported activities from FY2021.
- The largest number of findings reported include the following:
    - Lack of documentation to support the claims submitted
    - Use of incorrect modifiers or lack of modifiers

Subpoenas:

- There was not a notable increase or decrease in the number of subpoenas received during FY2022.
- Only one subpoena involved a consumer that was served within the region.
- The number of subpoenas received cannot be influenced by any actions by MSHN.

Breaches:

- There were a similar number of breach notifications in FY2022 as in FY2021
- In all instances, the cases were remediated following MSHN's breach notification policy

Activities Implemented in FY2022

The following activities were implemented during FY2022.

- Data Mining Activities included:
    - Death Audit Compared to Encounters

    - Comparison for telehealth, face-to-face and overall encounters
- Review and revision of the MSHN Compliance Plan
- Revised/updated the standardized compliance training, and post-test, through the PIHP Compliance Officers Workgroup and the Regional Compliance Committee
- Provide ongoing education, and ensure compliance with, updates to state and federal policies and regulations, including but not limited to:
    - Department of Justice Compliance Program Guidelines
    - COVID-19 requirements
    - 21st Century Cures Act
    - CMS Patient Access Rule
- Revised the MEV site review process to gain efficiencies and to allow for the provision of technical assistance to the provider network
- Provided education and training on the use of the revised OIG quarterly report template for use for FY22 Q4

Recommendations for FY2023

The following are recommendations for improvements in FY2023.

- Identify additional region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Utilize the Constant Contact for compliance related updates for SUD providers
- Work with the OIG to close all open referral cases submitted prior to FY2022 Q4
- Streamline compliance documentation and tracking for efficiency and ease of reporting
- Create standardized templates related to confidentiality and privacy notices

Compliance Training/Review

Internal

MSHN Compliance Committee
Reviewed and Approved MSHN Compliance Plan on August 10, 2022

MSHN Regional Compliance Committee
Reviewed and Approved MSHN Compliance Plan on August 19, 2022

MSHN Operations Council
Reviewed and Approved MSHN Compliance Plan on September 19, 2022
Compliance Policies and Procedures

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

Board of Directors
Received and approved MSHN Compliance Plan on November 01, 2022

External

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

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

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

References

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

1. Delegated Managed Care and Program Specific Site Review Summary Report 2022
2. Medicaid Services Verification Methodology Report for Fiscal Year 2022
3. MDHHS R5 FY22 HSW, CWP and SEDW Reports
4. MDHHS R5 2022 Substance Use Disorder Protocol Report
5. Health Services Advisory Group State Fiscal Year 2022 Validation of Performance Measures Report
6. Health Services Advisory Group State Fiscal Year 2022 Compliance Report
7. 2021-2022 PIP Validation Report: 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.