Compliance Summary Report

October 2019 – September 2020

Prepared By: MSHN Compliance Officer – January 2020
Approved By: MSHN Compliance Committee – January 20, 2021
Reviewed By: Regional Compliance Committee – January 22, 2021
Operations Council – February 22, 2021
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Introduction

The Compliance Summary Report provides an overview of the activities performed during Fiscal Year 2020 as part of the Compliance Program and identified within the Compliance Plan. Those activities included 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, as well strengths, deficiencies, and recommendations for areas of quality improvement.

Recommendations

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

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

Internal Site Reviews

CMHSP Delegated Managed Care Reviews

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

Recommendation: Require use of MDHHS Self-Direction Technical Implementation Guide (October 2020) which identifies roles of the FMS and provides information specific to training oversight. MSHN has recently updated the monitoring protocol to include this technical implementation guideline. CMHSPs will have more oversight and monitoring for the training.

SUD Delegated Managed Care Reviews

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

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

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

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

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

Recommendation: MSHN has a newly developed policy on requirements for reviewing and submitting critical events for SUD Providers. This policy should increase the understanding of the requirements.

MSHN Quality Manager will work with SUD Providers in properly identifying critical incidents and in completing the required root cause analysis.

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

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

External Site Reviews- Michigan Department of Health and Human Services

Area(s) of Risk: Behavior Treatment Plans being developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees for those on the Habilitation Supports Waiver (HSW) was a repeat citation. This has been a citation during the full site reviews completed during FY2016, FY2018 and FY2020.

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

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

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

Recommendation: The Michigan Department of Health and Human Services (MDHHS) will be conducting a follow up review within 90 days following the end of the FY2020 review. Any additional findings will require a plan of correction and could result in additional action. MSHN should look at additional monitoring needs, training and education opportunities, standardization of practices where necessary, and appropriate council/committee/workgroup involvement to ensure compliance with these standards.

External Site Reviews- Health Services Advisory Group

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

Recommendation: MSHN will review the interventions quarterly to ensure improvement towards the goal is being achieved. MSHN will also ensure ongoing validation of data for this and all future projects to ensure the appropriate data is being collected and reviewed in alignment with the identified measures.

Customer Service

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

Recommendation: MSHN will work on developing standardized practices for issuing adverse benefit determination notices. MSHN will also utilize REMI to both issue adverse benefit determination notices

and track timeliness for grievance and appeal resolutions. This will be tracked as part of the quarterly customer services report.

Compliance

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

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

Monitoring and Auditing

Mid-State Health Network Internal Site Reviews

During 2020 (calendar year) twelve (12) delegated managed care interim reviews were completed. Interim reviews include a review of implementation of previous corrective action and a review of any new standards identified from contractual or regulatory changes. This year the new standards included a review of thirty (30) standards specific to BH-TEDS and Encounters, HCBS 1915(i), Severe Emotional Disturbance Waiver (SEDW), Children's Waiver Program (CWP), and Children's Intensive Crisis Stabilization Services.

The following is a summary of the site review report. For complete information, please see the Delegated Managed Care and Program Specific Site Review Summary Report 2020.

CMHSP New Standards Review Results

Includes review of thirty (30) standards. The focus of this section is to ensure compliance with new requirements.

Table 1: New Standards Regional Performance

New Standards Review	2020 Results
1915(i)	100%
CWP	82.29%
SED	85.83%
Children's Intensive Crisis Stabilization Services	82.72%
Encounters/BH-TEDS	97.56%

Note: As these are new standards, therefore is no comparison from previous years.

Results/Trends

Regionally, the CMHSP network was found to be 85.99% compliant with the New Standards Review and 97.56% compliant with the BH-TEDs/Encounters review.

All CMHSPs received 100% for the review of 1915(i) new standards.

There were no specific areas within the new standards that warranted a trend of non-compliance.

Regional Monitoring

MSHN and CMHSPs conducted regional monitoring for Fiscal Management Services and Licensed Psychiatric Hospitals.

Financial Management Services (FMS)

The FMS review team completed full reviews for all MSHN region contracted fiscal intermediary providers (3/3), which included the review of policies and procedures, sample of employee files, and sample of employer files.

FMS Provider	2018 Results	2020 Results
Community Alliance (CLN)	86%	87%
Guardian Trac/GT Independence	76%	98.08%
Stuart Wilson	72%	90.91%

** 2019 was a review of CAP only and all three were found to be Compliant.*

Results/Trends

All FMS providers reviewed had policies and procedures that were in full compliance with standards.

Staff training requirements continue to be an issue of compliance. MDHHS released a new Self-Direction Technical Implementation Guide October 2020 which clarifies the roles and responsibilities of the FMS and employer and provides language specific to training oversight. This is expected to lead to improvement in compliance with training requirements.

Licensed Psychiatric Hospital (LPH) Regional Monitoring

QAPI and CMHSPs conducted annual, interim reviews of the 9 regional licensed psychiatric units (LPH). Interim reviews include compliance verification of the Office of Recipient Rights (ORR) LPH Recipient Rights standards, quality oversight, and verification that 2018-2019 corrective action plans were implemented as intended. Additionally, ORR Policy Reviews, required every 3-years, were completed when applicable. The following table includes outcomes of the 2019 and 2020 reviews. The chart is reflective of ongoing process revisions throughout the past 2-years of reciprocity implementation. The following information clarifies variations that may be noted below:

LPH	2019 Chart	2019 RR	2020 Chart	2020 RR	2020 Quality Review	Policy Review
Cedar Creek	94%	96%	CAP Pending	Complete - CAP Pending	Compliant	2019
Healthsource	81%	89%	Compliant	Complete - No CAP required	Compliant	2019
Henry Ford/Allegiance Health	92%	95%	Compliant	Complete - CAP Pending	Compliant	2019
Hillsdale Hospital	97%	97%	Compliant	Complete - CAP Completed	Compliant	2019
McLaren Bay Region	100%	98%	NA - Interim Review not required due to 2019 outcomes.	Incomplete	Compliant	2017
Memorial Healthcare	98%	98%	Compliant	Complete - CAP Completed	Compliant	2018
Mid-MI Med Center Alma	92%	96%	Compliant	Complete - CAP partially complete	Compliant	2019

LPH	2019 Chart	2019 RR	2020 Chart	2020 RR	2020 Quality Review	Policy Review
Mid-MI Med Center Midland	100%	95%	Compliant	Complete – CAP Completed	Compliant	2019
Sparrow	95%	44%	NA - Compliance demonstrated within 2019 submitted CAP.	Complete - CAP in Progress	Compliant	2020 – In progress

Results/Trends

Healthsource ad Memorial Healthcare demonstrated the largest decrease in compliance with the standards from the previous review of consumer records while Henry Ford/Allegiance showed the largest increase in compliance.

Henry Ford/Allegiance and Sparrow demonstrated the largest decrease in compliance with the standards from the previous review of recipient rights while Healthsource showed the largest increase in compliance.

SUDSP Treatment Provider Delegated Function Reviews

The full review consisted of an on-site visit to the SUDSP to conduct consumer chart reviews, review and validate process requirements, review new standards added since previous audit, analyze performance and encounter data, interview staff, and monitor 2019 corrective action plans, as applicable.

MSHN completed 15 full SUDSP treatment provider agency reviews and 18 interim reviews.

Note: Full reviews are completed for half the providers one year and the other half the following year.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of one hundred and eight (108) standards.

Overall, the SUDSP provider network scored 84.47%. This was a decrease from 85.98% in 2019.

Delegated Functions Tool	# of Standards in each Section	2019 Results	# of Standards in each Section	2020 Results
Access and Eligibility	4	83.33%	4	84.17%
Information and Customer Service	19	87.93%	19	93.20%
Enrollee Rights and Protections	14	89.46%	14	91.19%
Grievance and Appeals	17	83.33%	17	78.63%
Quality and Compliance	12	90.28%	15	89.58%
Individualized Treatment & Recovery Planning & Documentation	14	85.54%	13	82.07%
Coordination of Care	5	79.17%	4	85.59%
Provider Staff Credentialing	18	82.71%	22	73.65%
Sub-Recipient Financial Review	8	49.30%	8	67.33%

* Financial review score includes all full reviews conducted for Treatment and Prevention providers.

** The number of standards increased from 102 to 108 from 2019 to 2020. The comparison from 2019 to 2020 includes 6 more standards identified in the chart above.

***The SUD providers that received a full review in 2020 were not the same as the providers who received a full review in 2019. The comparison does not include the same providers, but rather shows a comparison of how the provider network is performing from year to year.

Results/Trends

Access and Eligibility

- It is recommended that provider warm handoff practices be evaluated by MSHN as LOC Determinations should be accompanied by strong warm handoff practice.

Enrollee Rights and Protections

- Providers are not always offering the most current version of the Member Handbook to individuals receiving services.

Grievance and Appeal

- Adverse benefit determination letters are not being used correctly or at all.
- Providers are not always using the approved templates.

Quality and Compliance

- Providers do not have a process in place to ensure immediate reporting to the MSHN Compliance Officer regarding any suspicion of knowledge of Medicaid fraud and abuse.
- Providers did not have a process to identify, and review risk and critical events as defined.
- Providers did not have a process for documenting in the record Performance Indicators as identified in the contract.

Individualized Treatment and Recovery Planning and Documentation

- The FAS standard continues to be a general finding across the network.

Coordination of Care

- Provider policy/procedure missing language on documentation expectations when completing referrals.

Provider Staff Credentialing

- Criminal background checks and frequency are not always found in policies and procedures.
- Mid-cycle license and certification expirations monitoring is not consistently completed across the region.
- There is not an appeal process for adverse credentialing decisions.

Program Specific Results

The Program Specific tool includes a review of twenty-two (22) standards specific to various treatment program requirements.

Overall, the SUDSP provider network scored 71.62% compliance.

SUDSP Program Specific	# of Standards (2019)	2019 Results	# of Standards (2020)	2020 Results
ASAM	3	80.56%	1	86.67%
Residential	7	89.47%	1	60%
Peer Recovery Support Services	1	70.83%	1	88.89%
Women's Specialty Services	10	65.28%	3	80.95%
Medication Assisted Programs	7	75.64%	7	79.41%
Recovery Residences	9	62.50%	9	42.59%

*The SUD providers that received a full review in 2020 were not the same as the providers who received a full review in 2019. The comparison does not include the same providers, but rather shows a comparison of how the provider network is performing from year to year.

Results/Trends

- Providers increased greater compliance with ASAM – related standards.
- The network enhanced Peer Recovery Support Service scores.
- Enhancing, efficient methods of ensuring residential programs offer the required hours based on level of care designations. Recovery Residence policies and procedures do not include language required information as directed by MSHN, MDHHS, and/or the National Association of Recovery Residence (NARR).

Consumer Chart Review Results

The SUDSP treatment chart review tool includes a total of forty-six (46) standards. There was a total of 62 charts reviewed.

Overall, the SUDSP provider network was 79.44% in compliance with the standards.

SUDSP Chart Reviews	# of Standards in each Section	2019 Results	# of Standards in each Section	2020 Results
Screening, Admission, Assessment	8	85.42%	8	87.44%
Treatment/Recovery Planning	10	80.39%	8	77.46%
Progress Notes	4	89.31%	1	76.36%
Coordination of Care	4	65.42%	4	60.20%
Discharge/Continuity of Care	3	70.37%	2	86.30%
Residential	3	89.49%	3	85.14%
Medication Assisted Treatment	14	86.21%	14	81.06%
Women's Designated/Women's Enhanced	8	65.28%	2	80.00%
Recovery Housing	6	72.57%	6	37.50%

*The SUD providers that received a full review in 2020 were not the same as the providers who received a full review in 2019. The comparison does not include the same providers, but rather shows a comparison of how the provider network is performing from year to year.

Results/Trends

Recovery Housing consumer record results continue to demonstrate significant non-compliance related to coordination of care documentation.

Housing provider treatment plans do not include evidence of an independent housing goal.

SUDSP Supplemental Review

QAPI also conducts what are referred to as supplemental reviews (review of sample files and documentation for verification and validation that are not scored but still require corrective action) of Training, Credentialing, Grievance and Appeal files, Performance Indicators and Adverse Benefit Determinations.

Area of Review	# of Charts/Files Reviewed
Grievance and Appeals	6
Staff Credentialing	59
Staff Training	59
Performance Indicators	57
Adverse Benefit	89

Results/Trends

Staff training compliance has shown improvement.

The network continues to struggle with utilizing Adverse Benefit Determination letters properly.

Credentialing files did not always include all elements required.

Medicaid Event Verification (MEV) Site Reviews

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

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

The following is a summary of the MEV Annual report. For complete information, please see the Medicaid Services Verification Methodology Report for Fiscal Year 2020.

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

Data presented in the below chart is relative to the 12 CMHSP's for the full fiscal year, October1, 2019 – September 30, 2020.

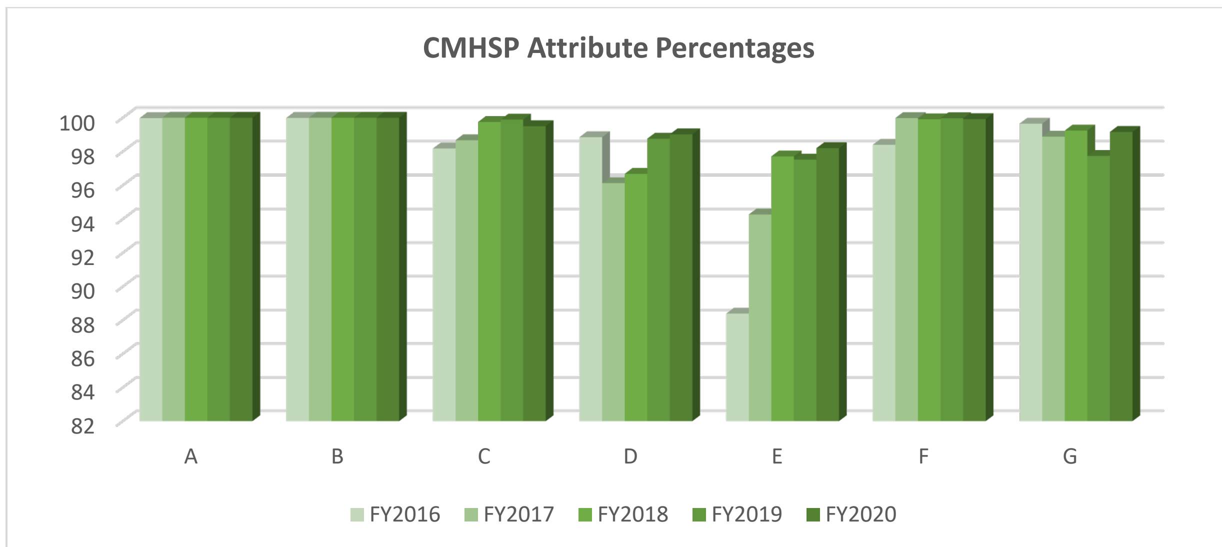
CMHSP

	A	B	C	D	E	F	G
BABHA	100%	100%	100%	99.65%	99.85%	100%	98.55%
CEI	100%	100%	100%	97.52%	96.28%	99.20%	99.28%
CMHCM*	100%	100%	99.94%	98.53%	99.06%	100%	97.89%
Gratiot	100%	100%	100%	99.87%	99.99%	100%	99.59%
Huron*	100%	100%	100%	99.83%	94.63%	100%	100%
Lifeways	100%	100%	100%	98.95%	96.07%	99.43%	100%
Montcalm*	100%	100%	100%	99.14%	99.71%	100%	100%
Newaygo*	100%	100%	97.42%	99.22%	98.71%	100%	100%
Saginaw	100%	100%	99.23%	99.60%	98.94%	100%	96.99%
Shiawassee	100%	100%	99.88%	98.53%	98.90%	100%	100%
The Right Door	100%	100%	98.02%	97.40%	96.26%	100%	100%
Tuscola	100%	100%	100%	100%	100%	100%	97.67%
MSHN Average	**100%**	**100%**	**99.50%**	**99.02%**	**98.20%**	**99.92%**	**99.16%**

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

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

The following chart provides a comparison from FY2016 through FY2020 for the attributes tested:



The Substance Use Disorder site reviews are completed annually. Data presented in the below chart is relative to the 23 SUD treatment providers reviewed for the full fiscal year, October1, 2019 – September 30, 20209.

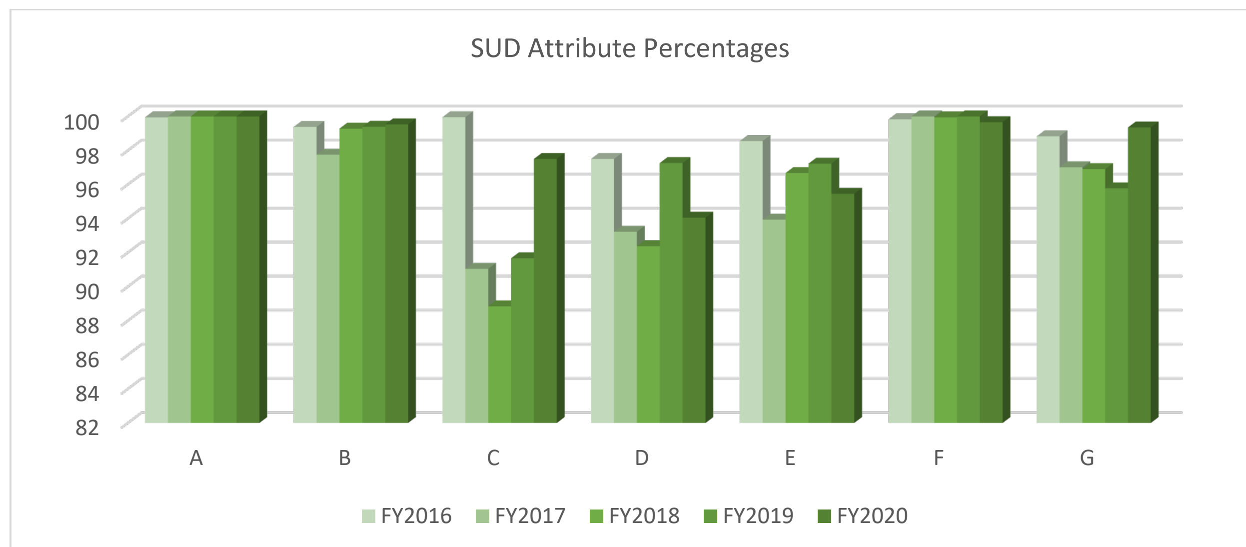
The chart below includes the score for all SUD providers combined for each attribute reviewed.

SUD Results

	A	B	C	D	E	F	G
SUD Providers*	100%	99.53%	97.50%	94.05%	95.45%	99.66%	99.35%

**Denotes that the single SUD site review results are not included in the average score due to being rescheduled because of COVID-19. Those reviews will be completed in FY21.*

The following chart provides a comparison from FY2016 through FY2020 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.

The CMHSP and SUD Providers are required to submit a plan of correction for each finding during the site review. For the FY2020 site reviews, 12 CMHSPs were placed on a new plan of correction and 18 SUD Provider locations were placed on a new plan of correction resulting from their review. In addition, 12 CMHSPs were removed from a previous plan of correction and 17 substance use disorder treatment providers were removed from a previous plan of correction.

Results/Trends

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and indirect services of $68,662.78 and $188,559.08 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

Regionally the CMHSPs have shown improvement from FY2019 to FY2020 for the following attributes:

1. D: Documentation of the service date and time matches the claim date and time of the service
2. E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed
3. G: Modifiers are used in accordance with the HCPCS guidelines

Regionally the SUD providers reviewed showed improvements from FY2019 to FY2020 for the following attributes:

1. B: Beneficiary is eligible on the date of service
2. C: Service is included in the beneficiary's individual plan of service
3. G: Modifiers are used in accordance with the HCPCS guidelines.

Monitoring and Auditing

Mid-State Health Network External Site Reviews

MDHHS Waiver Site Reviews

The Michigan Department of Health and Human Services (MDHHS) conducted an on-site review for our region from July 13, 2020 through August 21, 2020. 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 Supports Waiver (HSW) Review

The 2020 site review included the review of administrative procedures, beneficiary files, staff records and home visits.

Total Cases Reviewed (43)
Total Licensed Staff Records Reviewed (67)
Total Non-Licensed Staff Records Reviewed (462)
Total Home Visits (0)

Summary of the findings:

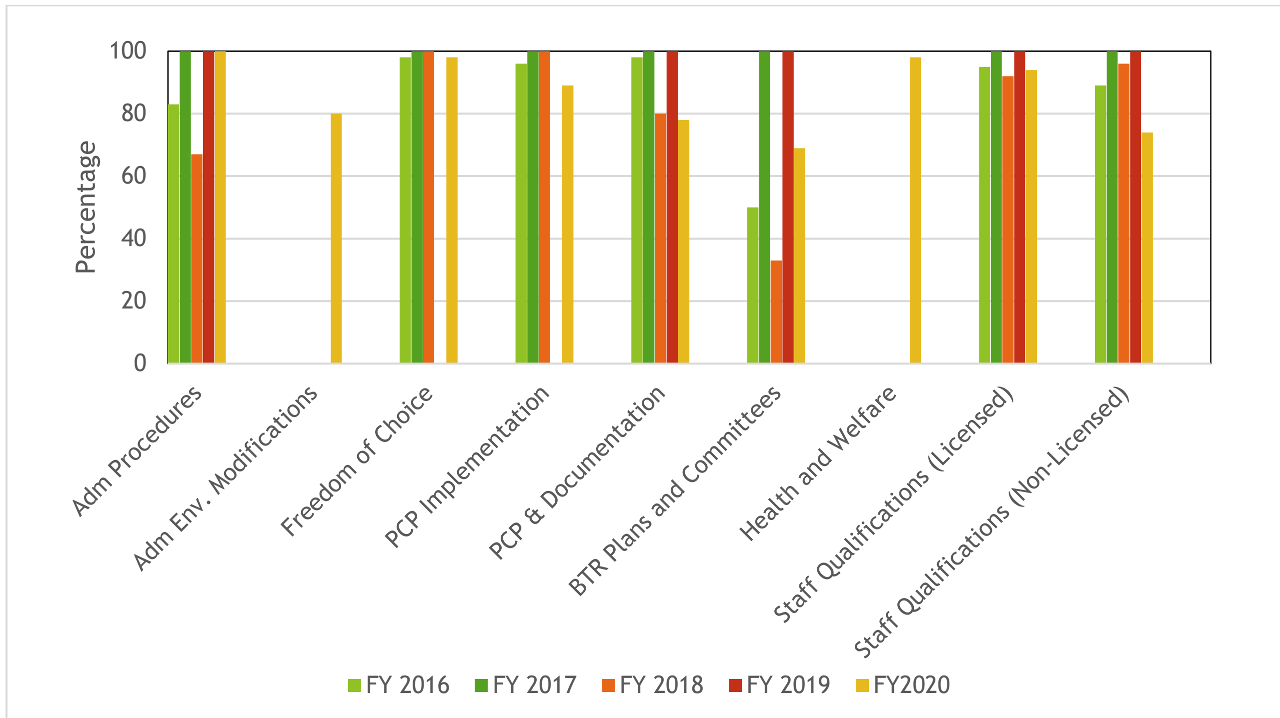
A.1.1- A.1.5	Administrative Procedures (5 elements,1 scored NA): 100%
A.3.1	Administrative: Environmental Modifications (1 Element): 80%
F.2.1 – F.2.2	Freedom of Choice (2 Elements): 98%
P.2.1 – P.2.8	Implementation of Person-Centered Planning (7 Elements): 89%
P.5.1 – P.5.3	Plan of Service and Documentation Requirements (3 Elements): 78%
B.1 – B.2	Behavior Treatment Plans and Review Committees (2 Elements): 69%
G.1 – G.2	Health and Welfare (New Section for 2020): (2 elements): 98%
Q.2.1 – Q.2.2	Staff Qualifications (Licensed) (2 Elements): 94%
Q.2.3 - Q.2.4	Staff Qualifications (Non-Licensed) (2 Elements): 74%
H.3	Health and Safety (NA – no home visits): NA
H.3	Residential Home Visits/Training/Interviews (NA- no home visits): NA
H.3	Non-Residential Home Visit (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.

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 FY2020 site review, MSHN was found to have repeat citations (from the FY2018 review) for ten elements. MSHN will be monitoring the repeat citations to ensure full compliance during the follow up review.

Comparison of Results for Full Review (FY2016), Follow Up Review (FY2017), Full Review (FY2018), Follow Up Review (FY2019) & Full Review (FY2020)



Note: FY2017 and FY 2019 were follow-up reviews only for the plans of correction from the previous year.

Children's Waiver Program (CWP) Review

The 2020 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 (19)
Total Non-Licensed Staff Records Reviewed (24)

Summary of the findings:

A.2.2 Claims coded in accordance with MDHHS policies (1 Element): 100%
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): 84%
P.4.1 - P.4.7 Plan of Service and Documentation Requirements (6 Elements: 1 NA): 89%
B.2 Behavior Treatment Plans and Review Committees (1 Element): 100%
G.1 – G.2 Health and Welfare: (2 Elements): 100%
Q.1.1 – Q.1.2 Staff Qualifications (Licensed) (2 Elements): 97%
Q.1.3 – Q.1.4 Staff Qualifications (Non-Licensed) (2 Elements): 56%
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.

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 FY2020 site review, MSHN was found to have repeat citations (from the FY2018 review) for two elements. MSHN will be monitoring the repeat citations to ensure full compliance during the follow up review.

Since this is the first year that MSHN has oversight of the CWP there is no comparison to previous years.

Serious Emotional Disturbance Waiver (SEDW) Review

The 2020 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 (28)
Total Licensed Staff Records Reviewed (81)
Total Non-Licensed Staff Records Reviewed (18)

Summary of the findings:

E.2.1	Eligibility (1 Elements): 100%
P.3.1 – P.3.4	Implementation of Person-Centered Planning (4 Elements): 76%
P.6.1 – P.6.5	Plan of Service and Documentation Requirements (4 Elements: 1 NA): 88%
B.2	Behavior Treatment Plans and Review Committees (1 Elements): 100%
G.1 – G.2	Health and Welfare: (2 elements): 98%
Q.3.1 – Q.3.2	Staff Qualifications (Licensed) (2 Elements): 96%
Q.3.3 – Q.3.4	Staff Qualifications (Non-Licensed) (2 Elements): 38%
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.

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 FY2020 site review, MSHN was found to have repeat citations (from the FY2018 review) for four elements. MSHN will be monitoring the repeat citations to ensure full compliance during the follow up review.

Since this is the first year that MSHN has oversight of the SEDW there is no comparison to previous years.

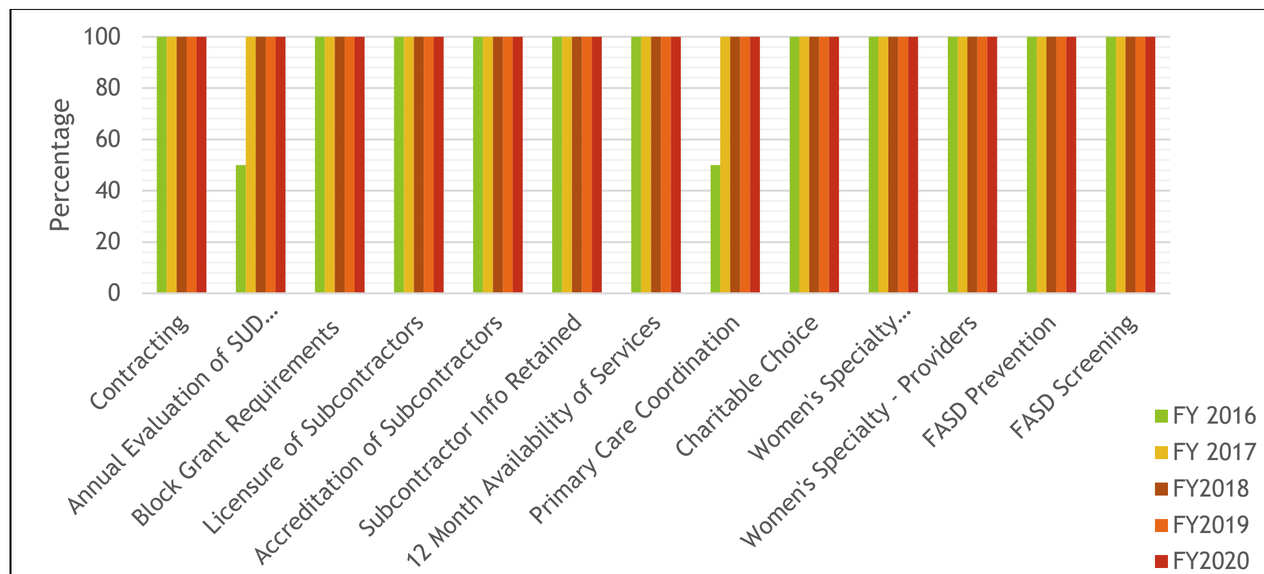
MDHHS Substance Use Disorder Site Review

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 July 14, 2020. 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 MSHN FY20 SUD Protocol Report.

Results/Trends

Comparison of Results for Full Review (FY2016), Follow Up Review (FY2017), Full Review (FY2018, Follow Up Review (FY2019) & Full Review (2020)



MDHHS Autism Site Review

The Michigan Department of Health and Human Services did not complete a review for Autism Services during 2020.

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 by webex on June 12, 2020.

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.

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 2020.

Results/Trends

Performance Indicators (10 Elements): **100%**

The following were new measures SFY 2020 (Effective April 1, 2020). These indicators were not reviewed during this review period.

- Indicator #2a
  - The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-Adults, MI-Children, IDD-Adults, IDD-Children).
- Indicator #2b
  - The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.
- Indicator #3
  - Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-Adults, MI-Children, IDD-Adults, and IDD-Children).

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

Data Integration, Data Control and Performance Indicator Documentation (13 Elements): **100%**
Denominator Validation Findings (7 Elements): **100%**
Numerator Validation of Findings (5 Elements): **100%**

MSHN has received full compliance (100%) for all elements reviewed from the first review in FY2014 through the current review in FY2020. For FY20 Q1, MSHN was above the 90% standard for the completion of specific data elements within the BH-TEDS data file that included age, disability designation, employment status and minimum wage. MSHN achieved the set standards for the Performance Indicators reviewed during FY20 Q1. 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.

During State Fiscal Year (SFY) 2020, HSAG completed a desk audit for SFY 2017-2018 and SFY 2018-2019 corrective action plans that consisted of the following primary activities:

- Reviewing each plan of action
- Providing preliminary feedback to each plan of action, as needed
- Monitoring the progress of each plan of action through two progress reports submitted by the PIHPs
- Reviewing supporting documentation submitted by the PIHPs for each plan of action
- Evaluating the degree to which each plan of action resulted in compliance with federal Medicaid managed care regulations and the associated MDHHS contract requirements

The intent of this review was to ensure that the PIHPs achieved full compliance with all federal and state requirements reviewed as part of the previous two years' compliance review activities.

The following is a summary of the Compliance status review report. For complete information, please see the Health Services Advisory Group 2019-2020 Compliance Monitoring Report for Pre-Paid Inpatient Health Plans Corrective Action Plan Implementation Review.

Results/Trends

The table below represents an overview of the combined results of the three-year cycle of compliance reviews for MSHN. Only those elements that required a CAP were evaluated during this year's CAP review. All elements that received scores of *Met* and/or standards with scores of 100 percent compliance in the SFY 2017–2018 and SFY 2018–2019 reviews remained unchanged and were included as scores of *Met* in this year's combined total compliance scores for each standard and the total combined compliance score across all standards.

Prior Years (SFY 2017-2018, SFY 2018-2019) and Current Year (SFY 2019-2020) Scores							
Compliance Monitoring Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Years		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	QAPIP Plan and Structure	8	7	1	1	0	**100%**
II	Quality Measurement and Improvement	8	6	2	2	0	**100%**
III	Practice Guidelines	4	4	0	NA	NA	**100%**
IV	Staff Qualifications and Training	3	3	0	NA	NA	**100%**
V	Utilization Management	16	12	4	2	2	**88%**
VI	Customer Service	39	34	5	5	0	**100%**
VII	Grievance Process	26	24	2	2	0	**100%**
VIII	Members' Rights and Protections	13	13	0	NA	NA	**100%**
IX	Subcontracts and Delegation	11	10	1	1	0	**100%**
X	Provider Network	12	12	0	NA	NA	**100%**
XI	Credentialing	9	5	4	4	0	**100%**
XII	Access and Availability	19	18	1	1	0	**100%**
XIII	Coordination of Care	11	11	0	NA	NA	**100%**

Prior Years (SFY 2017-2018, SFY 2018-2019) and Current Year (SFY 2019-2020) Scores							
Compliance Monitoring Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Years		Current Year		
			M	*# CAPs*	*M*	*NM*	
XIV	Appeals	54	50	4	3	1	**98%**
XV	Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	NA	NA	**100%**
XVI	Confidentiality of Health Information	10	10	0	NA	NA	**100%**
XVII	Management Information Systems	14	14	0	NA	NA	**100%**
	Total	**271**	**247**	**24**	**21**	**3**	**99%**

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

Total Compliance Score: Elements that received a score of *Met* during the SFY 2019–2020 CAP review plus the elements that received a score of *Met* in either the SFY 2017–2018 or SFY 2018–2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Through the combined compliance review activities, MSHN achieved full compliance in 15 of the 17 standards, indicating most program areas had the necessary policies, procedures, and initiatives in place to carry out the required functions of the contract. The remaining two standards have continued opportunities for improvement.

MSHN is continuing to provide status updates to HSAG regarding the two standards that have not yet achieved full compliance. Once HSAG has reviewed the additional information that has been requested, it will be determined if MSHN is in full compliance with all the standards.

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).

For State Fiscal Year (SFY) 2019–2020, the MHDDS required PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i-iv). In accordance with §438.330(d)(2)(i-iv), each PIP must include:

Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The following is a summary of the 2019-2020 PIP Validation Report. For complete information, please see the 2019-2020 Validation Report: Patient With Schizophrenia and Diabetes Who Had an HbA1c and LCL-C Test.

Study Indicator:

PIP Topic	Study Indicator
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.

Results/Trends

Remeasurement 1 period (01/01/2019 – 12/31/2019) showed an increase from baseline of 33.6% to 36.1% of patients with schizophrenia and diabetes having an HbA1c and LDC-C test completed.

The PIP received an overall *Not Met* validation status as the improvement shown was not statistically significant (p value≥0.05). MSHN received a score of 90% for all evaluation elements met and 90% for critical elements met.

MSHN had scored 100% and received a *Met* validation status for each of the previous years starting in FY2014/2015 through FY2018/2019.

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

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with the lack of improvement.
- Continue to evaluate the effectiveness of each intervention and report the findings of the evaluation analysis with the next annual PIP submission.
- Ensure the plan-specific goal for the second remeasurement period represents a statistically significant improvement over the baseline.

Customer Service/Compliance Reporting

Customer Service Complaints

The total number of Customer Services Complaints received in FY2020 was 133. By comparison, there were 143 complaints in FY2019. This resulted in a decrease of 6.9% in FY2020 from FY2019 and continues with a slight downward trend from previous years.

Customer Service Originator of Contact
(the percentage indicates the percent the originator represents of the total complaints)

Originator:	*Number*	*Percent:*
SUD Provider	25	19%
Advocate	5	4%
CMHSP	36	27%
Guardian	3	2%
Consumer	35	26%
MDHHS	12	9%
Parent of a Minor	3	2%
Other	14	11%

Customer Service Inquiry Category
(the percentage indicates the percent the category represents of the total complaints)

Category:	*Number*	*Percent:*
Access to Treatment	8	6%
Appeal	5	4%
Authorization	3	2%
Complaint/Dissatisfaction	10	8%
Consumer Discharge	11	8%
Denial of Services	3	2%
General Assistance	34	25%
Grievance	8	6%
LEP Assistance	3	2%
Member Handbook	3	2%
Notification Letter	11	8%
Provider Practices	24	18%
Provider Staff Concern	1	1%
Recipient Rights Assistance	6	5%
Recipient Rights Complaint	2	2%
Sentinel Event	1	1%

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

Type of Resolution:	*Number:*	*Percent:*
No follow-up required	65	49%
Resolution pending	2	2%
Resolved in favor of consumer	4	3%
Resolved in favor of provider	8	6%
Resolved through follow up actions	54	40%

Results/Trends

The following trends/changes were noted during FY2020:

- Overall Customer Service complaints decreased by 6.9% in FY2020 (133) from FY2019 (143)
- Consumer contacts requiring follow-up action decreased from 52% (n=75) in FY2019 to 49% (n=65) in FY2020
- The highest number of consumer-based customer service complaints originated from Consumers (26% / n=35)
- The highest number of non-consumer customer service contacts originated from CMHSP (27% / n=36) staff
- The highest consumer complaint category involved complaints addressing Provider Practices (14% / n=18)
- The highest non-consumer category involved requests for General Assistance (25% / n=34)
- For the Customer Service focus areas of Denial, Grievance, Appeals, and Second opinions the provider reported data shows 100% compliance to the standard for Grievance and Second Opinions Notification timeliness, but Denials (98% - 95%) and Appeals (100% - 97%) did not consistently meet the 100% standard for the previous 4 quarters (FY19Q4 to FY20Q3).

Activities Implemented in FY2020

The following activities were implemented during FY2020.

- Due to an increase in complaints regarding provider practices, Customer Services worked in coordination with the treatment team to provide technical assistance to improve quality of services for providers withing MSHN's network
- Ongoing training to the provider network as needed in areas of customer service, grievance and appeals and recipient rights

Recommendations for FY2021

Based upon FY20 Customer Service data, the following is being recommended:

- During FY2020, there was an identified need to develop a training focused upon welcoming standards, consumer sensitivity, and professionalism for the provider network. The training continues to be in development by MSHN Customer Service through research activities, but the COVID-19 pandemic elevated the need to focus upon more pressing Customer Service areas, thus delaying the completion of the training.
- Implement standardization of provider practices for MSHN's SUD provider network regarding the issuance of Adverse Benefit Determinations and the Grievance and Appeals process.
- Utilize MSHN's REMI system to issue Adverse Benefit Determination notices and for the Grievance and Appeals resolution tracking process.
- Continue to provide technical support for providers who receive a high volume of consumer complaints to assist them in improving their service delivery.
- Providers who fall below the 100% standard for Denial, Grievance, Appeals, and Second opinions will complete the Plan of Correction (POC) process to bring their performance up to the required 100% standard.

Compliance Reporting

Compliance Investigations

The total number of compliance investigations completed in FY2020 was 18. By comparison, there were 16 completed in FY2019. This resulted in an increase of 12.5% in FY2020 from FY2019.

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

Originator:	*Number:*	*Percent:*
SUD Provider Staff	2	11%
CMHSP Staff	7	39%
Office of Inspector General	3	17%
MSHN Staff	6	33%

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

Category:	*Number:*	*Percent:*
Credentialing	2	11%
Fraud/Abuse/Waste	12	68%
Treatment/Services	2	11%
Ethical Violations	1	5%
Duplicate Claims	1	5%

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

Type of Resolution:	*Number:*	*Percent:*
CMHSP	1	5%
SUD Provider	4	22%
MSHN Staff	3	17%
Pending OIG Resolution	10	56%

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

Agency:	*Number:*	*Percent:*
Office of Inspector General	6	33%

Fraud referral investigations still open with the OIG from previous fiscal years: 6

Office of Inspector General Quarterly Report for FY2020

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, the following activities: data mining, analysis of paid claims, audits performed, overpayments collected, identification of fraud, waste and abuse, corrective action plans implemented, provider dis-enrollments and contract terminations.

FY2020 Q1: 352 activities were reported
FY2020 Q2: 102 activities were reported
FY2020 Q3: 37 activities were reported
FY2020 Q4: 88 activities were reported

Most of the activities reported were a result of local and region wide Medicaid Event Verification activities and clinical record reviews, but also included activities related to double billing for services, credentialing and training, lack of supporting documentation and overpayment.

Data Mining Activities

Data mining is a process for finding anomalies, patterns and correlations within data sets.
During FY2020, MSHN completed the following data mining activities.

1. Community Living Supports (CLS) (Code H0043)
   a. CLS services are presumed to be provided in the recipients own home or group AFC home when using this CLS code. This data mining activity identifies the location the CLS service is provided. The data is then reviewed to determine if the location is appropriately identified or if corrections are needed.

2. Multiple Case Managers
    a. Typically, recipients only have one assigned case manager. This data mining activity identifies when there is more than one case manager providing services to a recipient. The data is then reviewed to determine if it is appropriate that more than one case manager is involved with the service provision.
3. Overlapping Residential Services
    a. There should be no circumstances where a recipient is identified as present at two residential facilities on the same day. This data mining activity identifies any instance where a recipient is present at more than one residential facility on the same day and the data is reviewed for any needed corrections.
4. 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.

Results/Trends

The following are the data mining activities and results for FY2020 Q1.

1. Community Living Supports
    a. Five recipients were identified from three providers as not having CLS services provided in their own home or in an AFC home.
    b. The location identified was corrected for one recipient. The other four recipient's information was determined to be acceptable.
2. Multiple Case Managers
    a. There were many instances identified where recipients had more than one case manager providing services from several different providers.
    b. All instances were identified as appropriate due to reasons of case managers covering for one another during vacations and when recipients were transferred to a different case manager within the quarter reviewed. Note: Through this process there were 4 corrections made regarding incorrect codes that were unrelated to having multiple case managers.
3. Overlapping Residential Services
    a. Three recipients were identified from two different providers as being present at two residential facilities on the same day.
    b. Two recipients had their overlapping claims voided as they were paid in error. The other recipients overlapping services were not paid and therefore they did not require any correction.

The following are the data mining activities and results for FY2020 Q2.

1. Community Living Supports
    a. Four recipients were identified from two providers as not having CLS services provided in their own home or in an AFC home.
    b. After review, it was determined that location identified was acceptable and no corrections were required.
2. Multiple Case Managers
    a. There were many instances identified where recipients had more than one case manager providing services from several providers.
    b. All instances were identified as appropriate due to reasons of case managers covering for one another during vacations and when recipients were transferred to a different case manager within the quarter reviewed.
3. Overlapping Residential Services

   a. Two recipients were identified from two providers as being present at more than one residential facility on the same day.
   b. The services identified as overlapping were caught by MSHN information management system when the claims were submitted by the providers. Therefore, the overlapping dates of services were not paid and no corrections were needed.
4. Death Data Report
   a. There were 165 unique recipients identified on the death list.
   b. There were no instances where a service was provided after the date of death.

The following are the data mining activities and results for FY2020 Q3.

1. Death Data Report
   a. There were 217 unique recipients identified on the death list.
   b. There were no instances where a service was provided after the date of death.

The following are the data mining activities and results for FY2020 Q4.

1. Death Data Report
   a. There were 72 unique recipients identified on the death list.
   b. There were no instances where a service was provided after the date of death.

Subpoena(s)

MSHN received two subpoenas during FY2020 requesting client specific information regarding treatment and services to be utilized in civil lawsuits. MSHN was not the plaintiff nor the defendant in any of the cases.

Notification of Breach(s):

During FY2020, within the MSHN region, there were five instances reported to MSHN from the provider network involving a breach of protected health information. There were 4 instances reported from CMHSPs and 1 instance reported from an SUD provider. In all situations, MSHNs breach policy and procedure was followed to remediate the situation and lessen the probability for future reoccurrence. All instances were able to be remediated at the local level and did not require reporting to MDHHS.

Results/Trends

The following results/trends were identified through compliance investigations.

- There was an increase in the total number of compliance complaints reported from MSHN staff and CMHSP staff and a decrease in reports from SUD providers.
- Suspected Fraud/Waste/Abuse continues to be the highest reported category at 68%
- Eight investigations were completed and achieved a closed status
- Ten compliance investigations have a "pending resolution" status as these are investigations that are awaiting follow up from the Office of Inspector General
- The number of referrals to the OIG regarding suspected fraud increased 100%

The following results/trends were identified through the OIG quarterly report.

- FY2020 had an increase of 52% of reported activities from FY2019 (this was due to a large increase in activities reported during FY20 Q1)
- The largest number of findings reported include the following:
    - Lack of documentation to support the claims submitted
    - Documentation identical as in previous episodes of care
    - Service times on documentation not matching times on billing record

The following results/trends were identified through subpoenas.

- There was a notable decrease in the number of subpoenas received during FY2020
- Neither of the subpoenas involved consumers served through region
- There has been a growing trend, albeit small, of receiving subpoenas involving civil lawsuits that do not involve consumers served by MSHN

The following results/trends were identified for notification of breaches.

- There were a similar number of breach notification in FY2020 as in FY2019
- In all instances, the cases were remediated locally and did not require state level reporting

Activities Implemented in FY2020

The following activities were implemented during FY2020.

- Data Mining Activities included:
  - Community Living Supports provided in wrong location
  - Services by Multiple Case Managers
  - Overlapping Residential Services
  - Death Audit Compared to Encounters
- Any inaccuracy identified through the data mining activities required corrective action on the part of the provider including MSHN
- Revised the MSHN Compliance Plan
- Ensured compliance with revisions to state and federal policies and regulations, including but not limited to:
  - Department of Justice Compliance Program Guidelines
  - Office Guidance of Civil Rights Protections
  - Summary of 42 CFR Part 2 Final Rule
  - COVID-19
  - Changes in the Stark Law

Recommendations for FY2021

The following are recommendations for improvements in FY2021.

- Continue to work with PCE to make improvements on the OIG quarterly report logs, including contracted entities and disenrollment forms
- Advocate with the OIG regarding the increasing demands related to reporting and changes being made outside of the contract
- Develop a post test, in coordination with the PIHP Compliance Officers Workgroup and the Regional Compliance Committee, to accompany the compliance training in Relias
- Identify region wide data mining activities to detect possible deficiencies and/or non-compliance with established standards
- Look at opportunities for standardization to gain efficiencies where possible and appropriate
- Utilize the Constant Contact for compliance related updates for SUD providers

Compliance Training/Review

Internal

MSHN Compliance Committee

Reviewed and Approved MSHN Compliance Plan on August 13, 2020
Compliance Policies

MSHN Regional Compliance Committee

Reviewed and Approved MSHN Compliance Plan on August 21, 2020
Compliance Policies

MSHN Operations Council

Reviewed and Approved MSHN Compliance Plan on September 21, 2020
Compliance Policies

MSHN Staff

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

Board of Directors

Received and approved MSHN Compliance Plan on November 10, 2020

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 Director of Customer Services, Compliance and Quality.

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 2020
2. Medicaid Services Verification Methodology Report for Fiscal Year 2020
3. MDHHS HSW, CWP and SEDW site review reports and corrective action plans
4. MSHN FY20 SUD Protocol Report
5. Health Services Advisory Group Validation of Performance Measures State Fiscal Year 2020
6. Health Services Advisory Group 2019-2020 Compliance Monitoring Report for Pre-Paid Inpatient Health Plans Corrective Action Plan Implementation Review
7. 2019-2020 Validation Report: Patient With Schizophrenia and Diabetes Who Had an HbA1c and LCL-C Test