Pre-Paid Inpatient Health Plan

Medicaid Event Verification Methodology Report

Fiscal Year 2022

(October 1, 2021 – September 30, 2022)

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Introduction & Background

In accordance and compliance with the Michigan Department of Health and Human Services (MDHHS) Contract[1], Mid-State Health Network (MSHN) submits the Medicaid Event Methodology Report that summarizes the verification activities across the PIHP region. The region includes 12 Community Mental Health Specialty Program (CMHSP) participants; Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Services Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door, and Tuscola Behavioral Health Systems. Also, within the PIHP region are 51 Substance Use Disorder (SUD) treatment providers that include 106 different treatment service locations, 36 agencies that provide prevention services and 3 SUD recovery only providers.

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an on-site review or a desk review of the provider network's policy and procedures and the claims/encounters submitted for services provided for all 12 of the CMHSPs and for all SUD treatment providers who provide services using Medicaid funding. Of the 51 SUD treatment providers, only the providers that were in-region providers, that provided Medicaid eligible services and used Medicaid funding were included in the review. SUD treatment providers that were in another PIHP region and had a MEV review completed in that region were not included in the MEV summary as MSHN accepts the reviews of the other PIHPs.

MSHN's policy is to conduct a full monitoring and evaluation process of each CMHSP and SUD provider, at a minimum once every two years. The full year review process consists of utilizing uniform standards and measures to assess compliance with federal and state regulations, and PIHP contractual requirements. The interim year review process focuses on any elements of the previous year's findings in which compliance standards were considered to be partially or not fully met. MEV reviews conducted for SUD providers during FY22 followed this biennial process and there were no MEV sample selections pulled for SUD interim reviews in FY22. However, CMHSP reviews were conducted biannually (due to provider preference) and MEV sample selections were pulled each time whether full or interim.

During this review period, changes continued to be implemented to the review process in response to the COVID-19 pandemic. Executive Orders and guidance issued from the Michigan Department of Health and Human Services (MDHHS) changed how services were being delivered for both behavioral health and SUD service providers. Beginning in March 2020, MSHN moved to completing the MEV site reviews exclusively by remote access versus on-site and this practice has continued throughout FY22. This worked well for the CMHSPs who have electronic medical records that can be accessed remotely, however, for many of the SUD providers this was a difficult change as many do not have electronic medical records. MSHN followed the guidance in the MDHHS Medicaid Event Verification Process Guideline (MDHHS/PIHP contract attachment),

[1] Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration, Medicaid Verification Process Guideline

performing a review for each major provider in the PIHP network. Major providers include all providers paid via a sub-capitation arrangement and any other providers that represent more than 25% of the PIHP claims/encounters in either unit volume or dollar value, whether directly contracted through the PIHP or subcontracted through a CMHSP, Core Provider, or Managers of Comprehensive Provider Networks (MCPN).

Process Summary/Sampling Methodology

Medicaid claim verifications are conducted for both CMHSPs and SUD providers, utilizing a random sample. Sample selection for the CMHSP providers includes both the direct services provided by the CMHSP and the services provided by the contract providers of the CMHSP. The sample selection for the SUD providers includes only direct services provided as the SUD providers do not utilize subcontracts for services. The random sample is selected using a non-duplicated sample of 5% of beneficiaries served in the previous 2 quarters. The sample selection is set with parameters not to exceed a maximum of 50 and a minimum of 20 beneficiaries. The number of claims/encounters for each beneficiary selected in the sample has a maximum of 50 claims/encounters per beneficiary.

Note: For SUD providers, the sample size was reduced to a maximum of 4 beneficiaries during most of FY22 to align with chart reviews and ease the administrative burden of transferring required documents to MSHN (as most SUD providers do not have an Electronic Management Record). However, to ensure statistical significance and maintain continued compliance, this was modified in late August to 8 beneficiaries.

The sample selection for CMHSPs includes at least one beneficiary from each of the following programs (when applicable): Assertive Community Treatment (ACT), Autism, Children's Crisis Intensive Stabilization Services, Crisis Residential, Home Based Services, Habilitation Supports Waiver (HSW), Home and Community Based Services (HCBS), Self Determination, Targeted Case Management (TCM)/Supports Coordination Services, Behavior Treatment, Children's Waiver Program (CWP), and Serious Emotional Disturbance Waiver (SEDW)/Wraparound. SUD provider samples include at least one beneficiary from each of the following service types as applicable to the provider: Case Management, Co-Occurring, Detox, Crisis-Stabilization, Residential, Outpatient Services, Peer Services, Medication Assisted Treatment, Women's Specialty Services, and Recovery Housing.

The samples are pulled using FastLane, which is a product of PEC Technologies. The database pulls all encounters that meet the criteria selected to include procedure codes, modifiers, funding sources, institutions and start and end date filter of encounters. Once the sample is pulled using the selected criteria, the system randomizes the list using a random sorting guide and then pulls out a sample based on the pools and weighs (various procedure codes that are grouped so that certain items are pooled or weighted given those priority in the sample). The configuration has a minimum size, maximum size and percentage of pool sample size. The system checks how many encounters are available and takes that value and multiplies it by the percentage of pool value. If that value is in the minimum-maximum range it uses that value. If it is smaller than the minimum, then the minimum is used. If it is larger than the maximum, then the maximum is used.

Data Analysis/Summary of Results

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2021 – September 30, 2022. Data presented in the chart below is relative to the 12 CMHSPs and 12 SUD providers who had reviews conducted during this period.

Note: In FY21, 37 SUD MEV reviews were conducted compared to 12 in FY22. There are a few reasons for this. For one, five (5) of the providers reviewed in FY21 either terminated contracts early or did not renew contracts for FY22. Secondly, two (2) of the providers reviewed in FY21 are not within the MSHN region. MSHN typically does not review providers outside of the region as we accept the reviews of other PIHPs. Thirdly, four (4) providers received two reviews in FY21 (likely due to COVID-19 rescheduling or not meeting the 90% compliance standard which warranted an additional review). Lastly, MEV reviews were not conducted for interim reviews in FY22. There were sixteen Quality Assurance and Performance Improvement (QAPI) interim reviews conducted where MEV reviews were not included.

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 or in the treatment plan, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

A 90% compliance standard is the expectation per the state technical requirement for Event Verification.

CMHSP

	A	B	C	D	E	F	G
BABHA	100%	100%	100%	99.73%	92.39%	100%	96%
CEI	100%	100%	100%	98.92%	91.55%	100%	50.62%
CMHCM	100%	100%	99.64%	99.37%	94.09%	100%	97.89%
Gratiot	100%	100%	100%	99.18%	92%	99.37%	81.68%
Huron	100%	100%	100%	99.15%	91.80%	97.15%	89.09%
Lifeways	99.70%	100%	100%	97.35%	88.45%	93.26%	81.39%
Montcalm	100%	100%	98.82%	97.51%	88.35%	99.29%	92.35%
Newaygo	100%	100%	99.84%	99.06%	90.28%	100%	81.42%
Saginaw	99.84%	100%	98.64%	93.25%	82.97%	94.32%	89.24%
Shiawassee	100%	100%	100%	98.84%	92.45%	100%	94.07%
The Right Door	99.93%	99.88%	99.46%	99.26%	95.38%	94.91%	82.31%
Tuscola	100%	99.83%	100%	99.64%	95.45%	100%	98.43%
MSHN Average	**99.96%**	**99.98%**	**99.70%**	**98.44%**	**91.26%**	**98.19%**	**86.21%**

Note: CMHSP reviews are completed twice during the fiscal year. The percentages displayed are an average of the scores for both reviews.

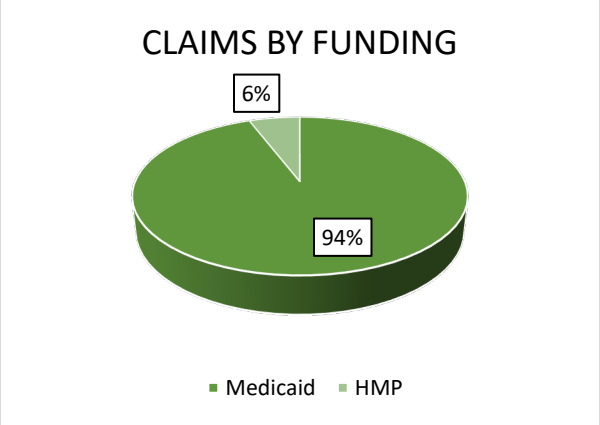
SUD

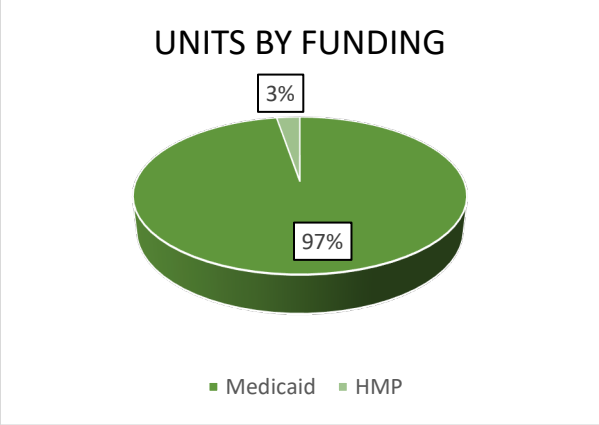
	A	B	C	D	E	F	G
SUD Providers	99.85%	100%	95.55%	97.21%	94.28%	100%	87.57%

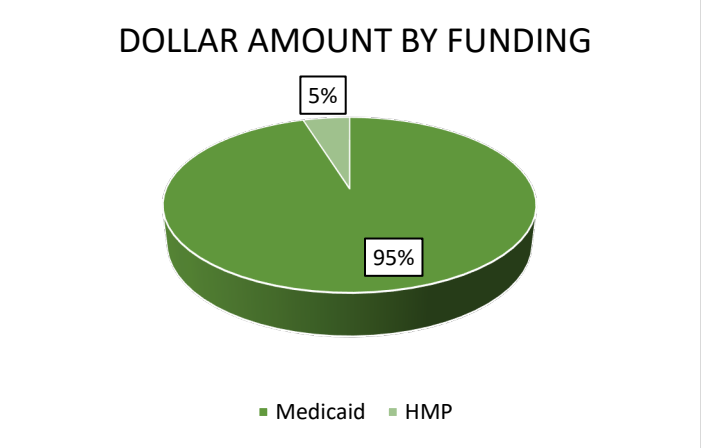
Note: This chart represents an average of the scores for all 12 SUD providers who had an individual site review.

Summary of CMHSP Claims Reviewed by Funding Source:

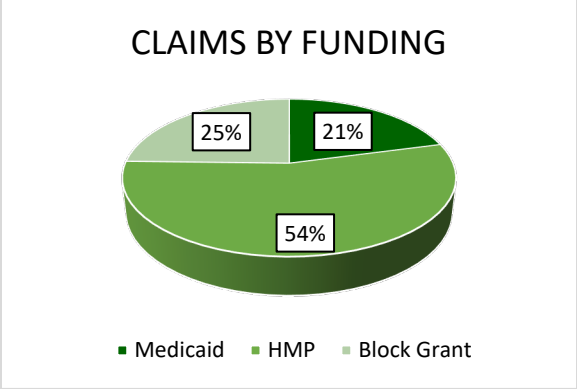
In total, 12,671 claims were reviewed. Of the 12,671 claims reviewed, 11,930 of the claims were billed as Medicaid and 741 of the claims were billed using Healthy Michigan Plan funding. The 12,671 claims included 113,313 units of service. Of the 113,313 units reviewed, 110,278 were billed as Medicaid and 3,035 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $4,046,959.15. Of the $4,046,959.15 reviewed, $3,852,154.61 were billed using Medicaid funding and $194,804.54 were billed using Healthy Michigan funding.

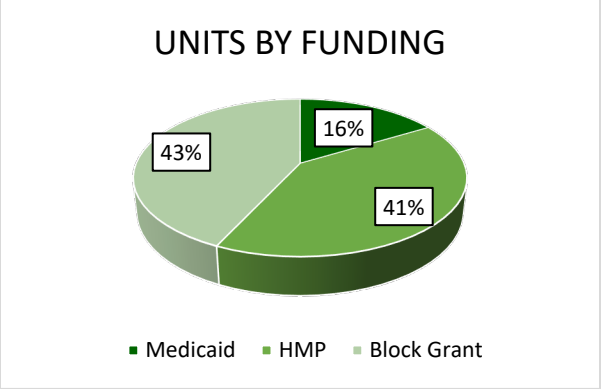


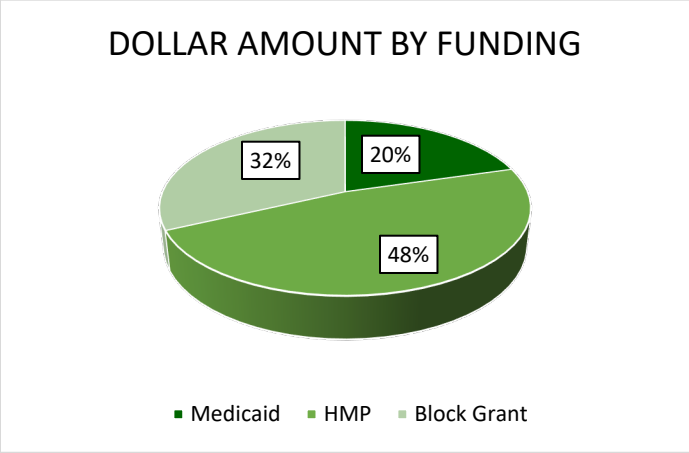




Summary of SUD Claims Reviewed by Funding Source:
In total, 561 claims were reviewed. Of the 561 claims reviewed, 117 of the claims were billed as Medicaid, 306 of the claims were billed using Healthy Michigan, and 138 of the claims were billed as Block Grant funding. The 561 claims included 1,545 units of service. Of the 1,545 units reviewed, 253 were billed as Medicaid, 627 were billed as Healthy Michigan Plan and 665 were billed as Block Grant funding. The dollar amount of the claims reviewed totaled $98,820.28. Of the $98,820.28 reviewed, $20,253.50 were billed using Medicaid funding, $46,992.78 were billed using Healthy Michigan, and $31,574 were billed using Block Grant funding.







The services reviewed for the CMHSPs included Assertive Community Treatment (ACT), Autism, Behavior Treatment, Children's Waiver Program (CWP), Crisis Residential, Habilitation Supports Waiver (HSW), Home Based Services, Self Determination, Serious Emotional Disturbance Waiver (SEDW), Targeted Case Management and Supports Coordination, and Wraparound. As some beneficiaries were enrolled in more than one program and services were counted in more than one program, the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, outpatient, treatment plan reviews, and medication reviews.

CMHSP Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
ACT	786	1,707	$150,715.81
Autism	1,828	19,125	$341,000.94
Behavior Treatment	890	13,598	$726,098.14
Children's Waiver Program	720	7,765	$124,722.55
Crisis Residential	789	2,726	$362,272.42
Habilitation Supports Waiver (HSW)	2,126	29,475	$876,166.89
Home Based Services	1,539	6,415	$505,294.69
Self Determination	1,199	20,990	$145,113.40
Serious Emotional Disturbance Waiver (SEDW)	508	1,654	$169,185.91
Targeted Case Management and Supports Coordination	5,049	38,350	$1,414,946.51
Wraparound	229	705	$73,494.74

The services reviewed for the SUD providers included Detox, Medication Assisted Treatment (MAT), Outpatient, Peer Supports, Recovery Housing, Residential, Stabilization (Residential), and Women's Specialty Services. As some people were enrolled in more than one program and services were counted in more than one program the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, psychotherapy, treatment plan reviews, and medication reviews.

SUD Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
Detox	6	17	$7,623.50
Medication Assisted Treatment	0	0	$0.00
Outpatient	223	310	$18,184.78
Peer Supports	192	479	$13,959.00
Recovery Housing	56	356	$7,125.00
Residential	27	211	$40,256.50
Stabilization (Residential)	4	36	$3,438.00
Women's Specialty Services	53	136	$8,233.50

Deficiencies/Corrective Action

Fiscal Year 2022 Deficiencies

MSHN requires deficiencies found during the Medicaid Event Verification process be resolved through one or more methods that may include the following:

- Billing records re-billed with correct information (e.g., code change, funding source change);
- Billed services in error voided;
- Person centered plans, treatment plans updated with correct authorization; and
- Reduction to future payments on subcontractor claims as necessary

For deficiencies found as a system issue, network providers are required to document a corrective action plan and demonstrate sufficient monitoring and oversight to ensure implementation. MSHN requires this for every claim/encounter determined to be invalid. Therefore, corrective action plans must be completed for every review that does not obtain 100% for all attributes tested. Corrective action plans may consist of, among other things, education and training, data software system changes, and process changes along with related expected timelines for implementation.

MSHN reviews and monitors the corrective action plans during the following review cycle to ensure implementation of the corrective action. SUD provider claims/encounters determined to be invalid are voided by MSHN. CMHSPs complete their own corrections and voids for claims/encounters found to be invalid and MSHN reviews to ensure this has been completed correctly. If deemed necessary by MSHN, additional follow up and sampling of selected elements is completed to ensure system and process change.

During FY2022, all 12 CMHSPs were placed on new corrective action plans (since CMHSP reviews, as a whole, had findings for every attribute tested). Of the 12 SUD treatment providers reviewed, 10 were placed on new corrective action plans. SUD reviews for FY2022 had findings for 5 (A,C,D,E,G) of 7 attributes tested. In addition, all CMHSPs and SUD treatment providers who were placed on corrective action plans during FY2021 were removed from those plans during FY2022 due to successful implementation.
Note: Definitions for Attributes A, C, D, E, and G are listed above.

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

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

If suspicion of fraud or abuse was present, the CMHSPs and SUD treatment providers were required to report to MSHN for further review and follow up. There were no reports required during this report year as a result of the MEV reviews. As part of MSHN's ongoing compliance

process, MSHN completes an initial investigation to determine if reporting to MDHHS Office of Inspector General (OIG) is required. This process occurs throughout the year as the reports are received. Beginning with the FY2019 review cycle and continuing through FY2022, all MEV reviews were reported quarterly to the Office of Inspector General (OIG).

Accuracy Standard

The FY22 MSHN combined average for CMHSPs (83.70%) and SUD (88.51%) providers fell slightly below the department's 90% accuracy standard. There were providers that had attributes tested that fell below the standard. The 90% accuracy standard is defined as the total number of valid claims reviewed for all attributes tested. The formula used to determine the percentage of valid claims is total valid claims reviewed/total claims reviewed = percentage of valid claims. A valid claim is defined as a claim included in the sample that does not have a finding identified. During FY2022, ten (10) CMHSPs and five (5) SUD Providers fell below the 90% accuracy standard when combining all the invalid claims together for all attributes tested. By comparison, during FY2021, there were two (2) CMHSP and two (2) SUD Providers that fell below the 90% accuracy standard.

The attributes that had the most deficiencies identified for both the CMHSPs and the SUD providers included the following:

1. Attribute E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed.
2. Attribute G: Modifiers are used in accordance with the HCPCS guidelines.

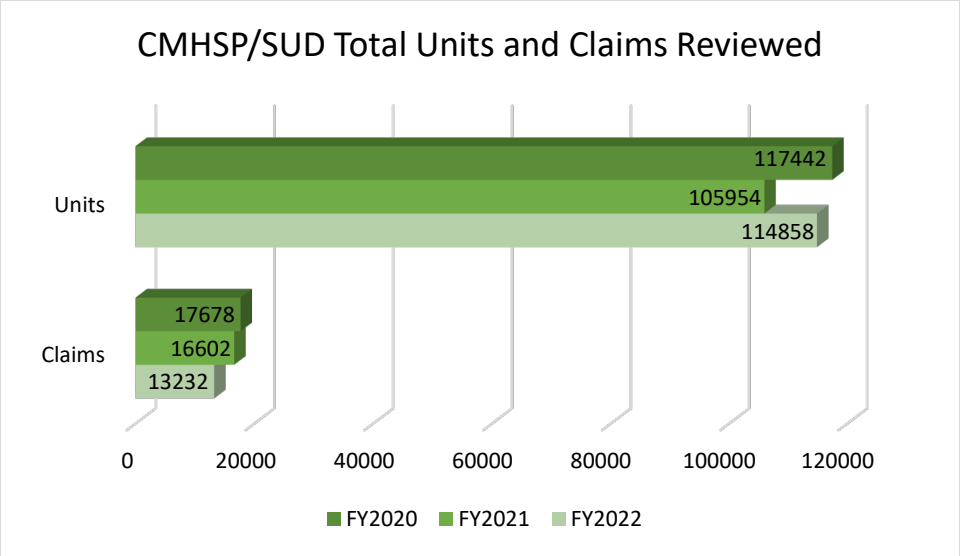
Note: Attribute G findings were the most prevalent findings of all attributes for both CMHSP and SUD providers during FY22. When averaged for individual attributes, this was also the only attribute to fall under the 90% standard for both CMHSP and SUD providers. It should be noted that the providers had the ability to resubmit claims using the correct modifiers, therefore positively affecting the 90% standard post-review.

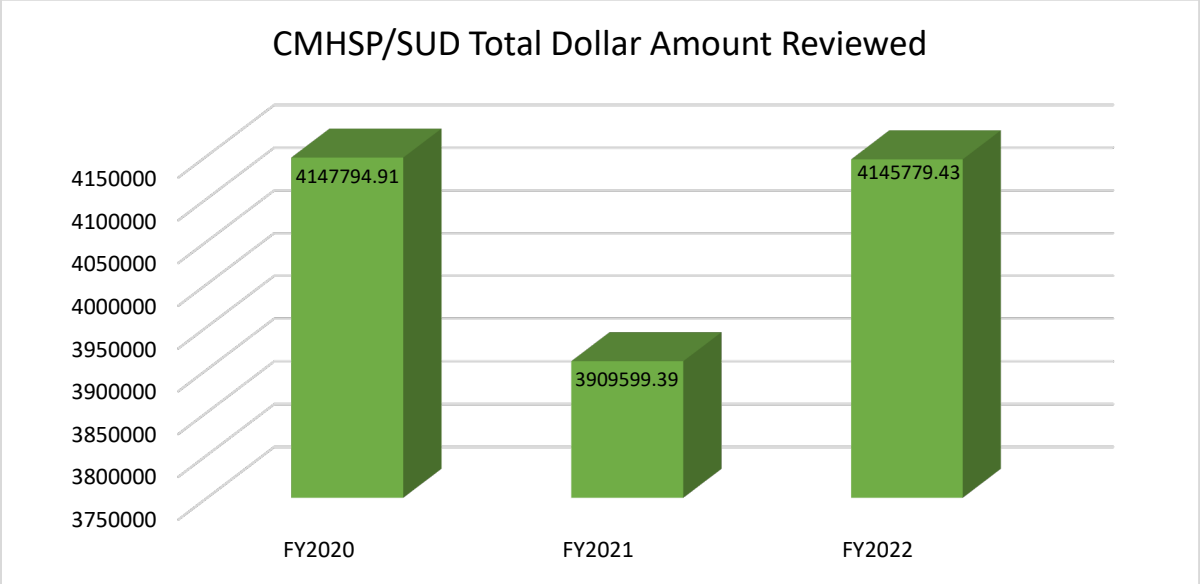
Process/Performance Changes and Improvements

Process Changes:
The claims, units, and dollar amount reviewed for CMHSPs were higher in FY2022 than in FY2021. However, the claims, units, and dollar amount reviewed for SUD providers were significantly less in FY2022 than in FY2021; mostly due to the reduction in SUD providers reviewed during FY22. (There were several reasons for this reduction as noted previously.)

The reduction in claims and units reviewed can also be attributed to continued changes implemented in response to COVID -19. The number of beneficiaries included in SUD reviews were reduced to a maximum of 4 during most of FY22 to align with chart reviews and lessen the administrative burden of transferring required documents to MSHN due to completing the reviews as desk audits.

Most of the SUD providers do not have electronic health records (EHR) so all documents were required to be uploaded to a secure location for review versus being accessed electronically.





Process Improvements:

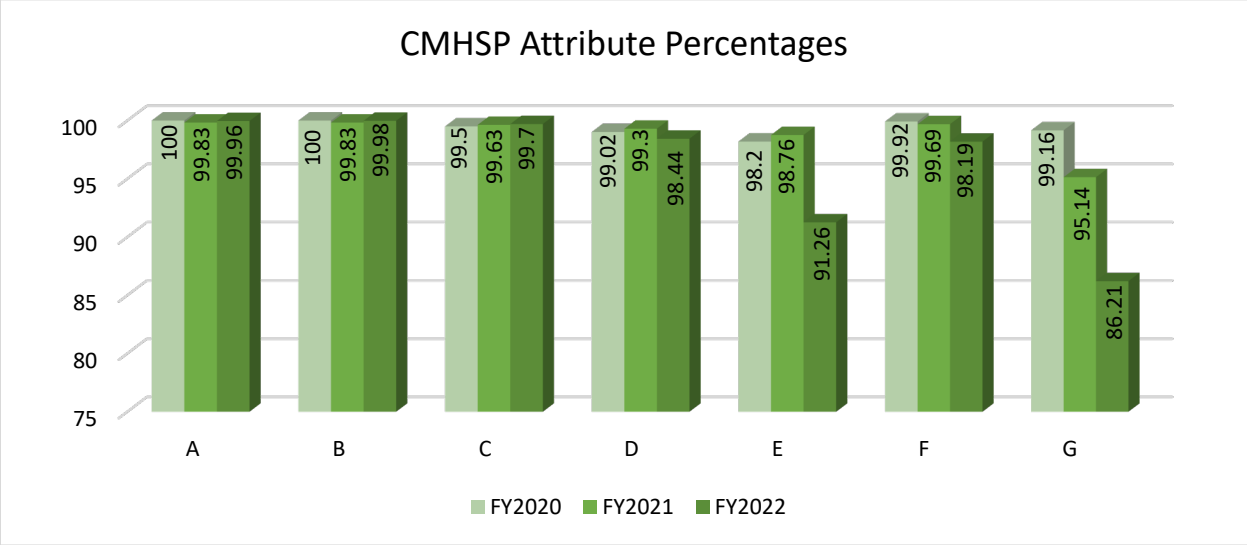
Process improvements implemented from previous MEV reviews included modifications to the revised forms for the claims review, summary report, plan of correction and data tracking to improve accuracy and ease of understanding how the data was represented. Improvements were also implemented to ensure proper and accurate reporting of information as part of the Office of Inspector General new reporting requirements for audit activities. The MEV forms continue to be standardized for consistency for each review. Additional improvements are being considered for FY2023 based on feedback received through the Regional Compliance Committee and Quality Improvement Council. The recommendations for improvement include creating a MEV review guide for providers which would establish what documentation is required for each attribute and which findings will require voiding versus a plan of correction.

Performance Improvements:

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.

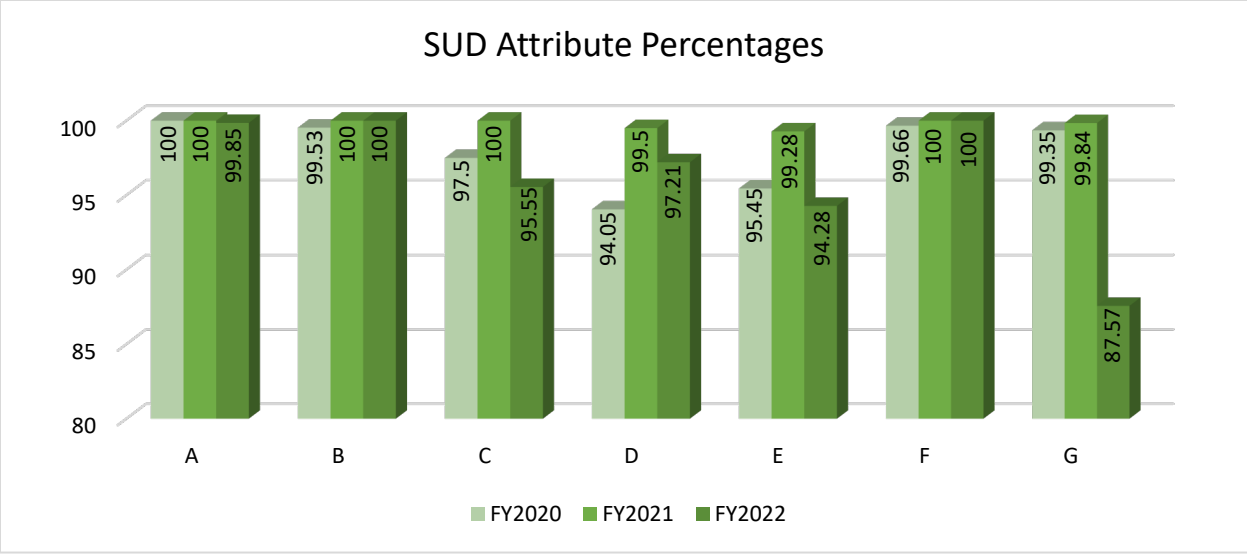
These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. In addition, MSHN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



Regionally the SUD providers did not show improvements from FY2021 to FY2022. However, the SUD provider scores were already at a high level and most of the scores remained in the mid-high nineties. The following attributes remained at 100% from FY2021 to FY2022:

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

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their understanding of the required supporting documentation to show compliance with the attributes. The reduction in performance may be attributable to the decrease in providers reviewed during FY2022 (12) as compared to FY2021 (37).



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

MSHN will continue to provide ongoing support to our provider network to ensure compliance with the attributes reviewed during the MEV site reviews. This will include training opportunities and identified quality improvements based on data trends.
MSHN also reviews the event verification results with the following council and committees:

- MSHN Compliance Committee (internal committee)
- Regional Compliance Committee (external committee consisting of members of the CMHSPs)
- MSHN Quality Improvement Council (external committee consisting of members of the CMHSPs)
- MSHN Operations Council (internal committee)

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Future Outlook

MSHN is beginning its eighth year of reviews and will continue to focus on plans of corrections from previous reviews to ensure indicated quality improvements are taking place as well as providing ongoing technical assistance in the areas that demonstrate the lowest percentages. MSHN will work with the CMHSPs and the SUD provider network to collaboratively share information in the areas of best practice documentation and processes that have been identified during reviews. The MEV policy and procedure will be reviewed internally on an ongoing basis to ensure compliance with Federal and State standards and to ensure consistency and best practices are followed. The quarterly reports that were implemented in FY2020 have continued and include the findings, recommendations, plans of correction and quality improvement opportunities based on data trends. Some of the recommendations from the FY2022 quarterly reports include encouraging CMHSPs to use standardization among shared providers, providing ongoing monitoring on the correct use of telehealth codes and modifiers, and identifying training

opportunities and resources for the Medicaid Event Internal Auditor. MSHN also continues to report all the findings from the MEV reviews on the OIG quarterly reports for feedback and approval.