AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
HEALTH CARE IMPROVEMENT & COMPLIANCE COMMITTEE MEETING

Wednesday, January 3, 2024 at 5:00 pm

William B. Cammin Clinic, Bay Room, 1010 N. Madison Avenue, Bay City, MI 48708

	Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
	Robert Pawlak, Ch				Patrick McFarland				BABH: Karen Amon, Sarah Holsinger, and Chris Pinter
	Robert Luce, V Ch				Colleen Maillette, Ex Off				
	Tim Banaszak				Richard Byrne, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
	Ernie Krygier								

	Agenda Item	Discussion	Motion/Action
1.	Call to Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Corporate Compliance Report 3.1) Corporate Compliance Report 3.2) Annual Litigation Report 3.3) Corporate Compliance Committee meeting notes from October 10, 2023 & November 14, 2023		3.1) No action necessary 3.2) No action necessary
4.	Other Reports 4.1) Primary Network Operations & Quality Management Committee meeting notes from October 12, 2023		4.1) No action necessary
5.	Unfinished Business 5.1) None		

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6.	New Business 6.1) Fraud and Abuse Risk Triennial Assessment & Plan 6.2) Provider Survey Update for 2023 6.3) CMS Office of Inspector General Work Plan for 2024		6.1) No action necessary 6.2) No action necessary 6.3) No action necessary
7.	Adjournment	M - S - pm MA	

MSHN
Mid-State Health Network

ANNUAL LITIGATION REPORT

CMHSP: Bay Arenac Behavioral Health

Submission Date: **Period Covered: October 01, 2022 through September 30, 2023**

Note: Annual ligitation report shall including the following detail for all civil litigation, relevant to the PIHP contract with the CMHSP and/or MDHHS.

For each litigation report:			
a Case Name	23-200091-0		
b Docket Number			
c Name of Plaintiff (s)	Earlene Spencer		
d Name of Defendant (s)	State of Michigan, et. al		
e Name of Counsel	Maurice Courtez Davis		
f Address of Counsel			
g Nature of Claim			
h Status of Case	Notification		

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Tuesday, October 10, 2023 (2:00 –2:40 pm)

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Karen Amon, Comp.& Privacy Officer, Chair	X	Heather Friebe, Clinical Program Manager	X	Melissa Prusi, Rec. Rights/Cust. Serv. Manager	X
Amy Folsom, Clinic Practice Manager	X	Jennifer Lasceski, director of HR	X	Sarah Holsinger, Quality Manager	X
Denise Groh, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Ellen Lesniak, Finance Manager, Vice Chair	X	Joelin Hahn, Director of Integrated Healthcare	-	Guests: Sarah Mulvaney – Student	X
Heather Beson, Director of Integrated Healthcare	X	Marci Rozek, CFO	X		

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of September 12, 2023, meeting notes.** **c) Next Meeting: November 14, 2023**	a) No additions to the agenda. b) September 12, 2023, meeting minutes – approved as written. c) The next meeting is scheduled for November 14, 2023, from 2:00-4:00.	
2.	**State-Federal Laws and Regulations** a) Review of Log and Subject Matter Expert Report Outs b) Review of Compliance Updates/ Regulatory Education Needed for Staff c) Process for Ensuring Implementation of Policy Changes	a) The log was deferred for this month. Item 363 - Repealing Medicaid Suspension of Medicaid Closures: There is a report out there for those closed and Karen found about 33 individuals who lost Medicaid and are ineligible. b) Defer c) Defer Karen stated they are considering blocking diagnosis. Practitioners would need to be consulted with every diagnosis change, which is a concern.	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Implementation of Coding Consultation Action Plan	a) Retaining the consultant. Ellen questioned if we should have her do another audit. Karen and Amy spoke on the diagnosis work around the prescribers are doing. Karen will speak with Janis about this tomorrow.	Karen to speak with Janis on diagnosis work around.

#	Topic	Key Discussion Points	Action Steps
	b) Status of Employee Attestations/Time for new ones April-May c) Status of Dept. of Justice Compliance Program Evaluation Action Plan	b) Employee Attestation - No update. c) Nothing to report	Carried over from last month: Karen to compare root cause analysis with document.
4.	**Data/Monitoring/Reports:** a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud/Abuse/Convictions during Staff Development Days) c) Monitoring of Group Drives for Unsecured PHI Files d) Security Officer Update e) Security Risk Assessment f) Ethics/Recipient Rights/Customer Service Update g) Corporate Compliance Activity Report h) Review of Fraud Abuse Risk Assessment (Triennial 2023)	a) Monthly monitoring completed; no findings to report regarding Security Breaches in Phoenix and Gallery for September. b) Exclusion - No findings to report. c) No findings of unsecured PHI Files d) Jesse - No security issues to report. e) Jesse - nothing to report. f) Melissa, RR/CS- Customer Service lots of confidentiality things going on with four open complaints. Complaints are trending up. Especially Customer Service complaints. A lot are individuals appealing closures and Customer Services is struggling to get them back into services due to provider capacity issues. One provider denied services on the ABN due to capacity issues. Individuals cannot be denied medically necessary services due to capacity issues. They can have a delay of service. Melissa has scheduled an Ethics meeting for November 13th. g) Karen reported that there are four open fraud, abuse, and waste cases. Five disclosures of confidential information that RR is looking into, one that was not substantiated. Karen completed new employee orientation and presented at the specialized residential provider meeting on documentation. Karen will be doing privacy training and protecting people's health information training with MPA tomorrow. Karen will be sending out the strategic plan by the end of this week. h) Risk assessment is due for 2023. Karen will be working on it and presenting it to the committee when completed. Karen is meeting with Janis tomorrow to review this.	Carried over from last month: Jesse to research products to replace Medworxx. Jesse to give Karen a count of the people using personal devices. Karen to update the Strategic Plan and schedule a meeting.

#	Topic	Key Discussion Points	Action Steps
	<u>October Reports</u> i) Email Security Phishing Drill Report j) Provider Network Site Review Summary k) Review of Licensure for AFC Homes l) Update Service Code Cheat Sheet & Post to Phoenix Help Tab <u>September Reports</u> m) Quality Review of Medical Records Report – Final draft of Annual Checklist to be completed. <u>Enhanced Monitoring</u> n) Intermittent Checks of Self Determination Service o) List Psychological – IPOS expired with services provided, several months of no documented progress notes, unsigned documents by staff/supervisor, stand-alone AUTH's, back dating of Interim Plans	i) Email Phishing Drills – Jesse reported on the last email phishing drill – of the 248 recipients, sixteen people clicked which is a little higher than he wanted it to be. People are not paying attention to the External Source yellow banner. The October phishing drill will be coming out soon. j) Provider Site Reviews are being performed by Sarah's team. They are currently wrapping up vocational and primary provider site reviews. Specialized residential and CLS reviews have been completed. Her team is moving into some Medicaid event verification for Autism providers. Want to look at the club house and others that have not been done in a few years due to Covid. k) AFC Licensure has been completed and everyone is fully licensed. l) Karen will be updating the Coding Cheat Sheet. The current cheat sheet can be found on the Help Tab in Phoenix. m) Sarah completed the final draft of the annual checklist. It has been sent out and uploaded to the g-drive. Completed, remove from agenda. n) Chelli reviewed progress notes for seven individuals. All were appropriate except one. o) List - Problems with documentation from List – Brenda met with the supervisor at List and when over when to do a POS and when to do IPOS. List has submitted their action plan. Amy asked if she should do Meds only plan or do a second interim plan. Karen suggested she do an interim plan until she talks with Joelin to determine the best course of action.	Karen to update Coding Cheat Sheet Remove "m" from agenda. Karen to talk with Joelin and give Amy the solution to missing plans.
5.	**Outstanding Items/Other:** a) Statewide Credentialing Work Group Updates	a) No updates	

#	Topic	Key Discussion Points	Action Steps
	b) Ability to Pay Changes (PA 92 of 2022; eff. 6-6-22) We will have until 10/2023	b) Ellen stated changes effective October 1, 2023. Based on gross income not Michigan state income taxable income. Compliance regarding ATP has dropped to 93.3%. Ellen to update report. Anyone who does not have active Medicaid needs to have an ATP. This includes anyone with a Medicaid spend-down. Sarah and Melissa to take to PMOQMA. Ellen stated Finance does prepare the ATP then send to the primary worker to go over with the consumer to let them know that they can still get services, but they are to pay for part of their services if they can. Marci felt training with the case managers would be helpful. This will be put on the SLT agenda. Marci went over the review process for the audit. The state's expectation is 100% ATP completion.	Add ATP completion on the SLT agenda
6.	Adjourn/Credentialing Committee Next Meeting	Credentialing meeting to follow. **The next meeting is scheduled for Tuesday, November 14, 2023, from 2:00 – 4:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Tuesday, November 14, 2023 (2:00 –3:00 pm)

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Karen Amon, Comp.& Privacy Officer, Chair	X	Heather Friebe, Clinical Program Manager	-	Melissa Prusi, Rec. Rights/Cust. Serv. Manager	X
Amy Folsom, Clinic Practice Manager	X	Jennifer Lasceski, director of HR	-	Sarah Holsinger, Quality Manager	X
Denise Groh, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Ellen Lesniak, Finance Manager, Vice Chair	X	Joelin Hahn, Director of Integrated Healthcare	X	Guests: Sarah Mulvaney – Student	-
Heather Beson, Director of Integrated Healthcare	-	Marci Rozek, CFO	-		

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of October 10, 2023, meeting notes.** **c) Next Meeting: December 12, 2023, move to 19th?**	a) No additions to the agenda. b) October 10, 2023, meeting minutes – approved as written. c) The next meeting is scheduled for December 12, 2023, but requesting reschedule to December 19, 2023? from 2:00-4:00.	
2.	**State-Federal Laws and Regulations** a) Review of Log and Subject Matter Expert Report Out	a) Karen has asked to be part of the Legislation and Policy Committee through the Community Mental Health Association. The committee goes through House and Senate bills that may affect us as an agency. It also keeps a running tally of where they are in the process. Karen felt this would be a better way to keep track of the changes. Karen would send out and bring back important changes to the committee to discuss and then add them to the Log. Sent out the new items on the log for review. Karen will still log and make notes on special issues. Still need to track Lara and Medicaid Manuel communications. The first meeting is tomorrow. Karen asked for any other suggestions which streamline log issues. Joelin suggested putting issues which directly impact one of our programs on the Leadership agenda or extended SLT agenda. Chris sent out a memo on the proposal to eliminate the social work test and base it on experience and supervision. This is an attempt to make the workforce more stable. Item 382 – Jesse stated there is not much new on EVV provider enrollment – discussions are going on at Midstate.	
	b) Review of Compliance Updates/ Regulatory Education Needed for Staff	b) Defer	
	c) Process for Ensuring Implementation of Policy Changes	c) Karen spoke with Janis regarding blocking the diagnosis. Janis indicated that they do not want to lock down the diagnosis and would like to continue to do the work around, so prescribers don't have to approve every change. This wouldn't allow the documents to be signed. Ellen said there will be a procedure change for the ATP coming. Will get a work group together to go over that.	Ellen to get a group together to go over ATP procedure changes.

#	Topic	Key Discussion Points	Action Steps
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones April-May b) Status of Dept. of Justice Compliance Program Evaluation Action Plan c) Site Review Templates Plan	a) Employee Attestation – Jennifer not present so no update. b) Take off agenda. c) Sarah and Karen have gone over our site review tools. They would like to include Janis in this process and have her go over different site review tools. Karen has spoken with Jen, and she will reach out to Janis regarding contracting back. They are considering using a tool similar to the one CARF uses. Looking at overall administrative areas that all providers have to comply with and then a separate section specific to the program or service provision. Sarah has reached out to other regions to see how they are doing their site reviews. Weve changed our Medicaid event verification process. Previously we did the event verification at the time of site reviews and now we have a schedule that is more comprehensive depending on the service that is being provided and the type and amount of service.	Take 2b off agenda.
4.	**Data/Monitoring/Reports:** a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud/Abuse/Convictions during Staff Development Days) c) Monitoring of Group Drives for Unsecured PHI Files d) Security Officer Update e) Security Risk Assessment	a) Monthly monitoring completed; no findings to report regarding Security Breaches in Phoenix and Gallery for October. b) Exclusion - No findings to report. c) No findings of unsecured PHI Files d) No security issues to report. One of the outstanding issues from last month was the researching the replacement of Medworxx. Most staff feel Medworxx is hard to use. Some staff reported issues with Chrome. Jesse suggested adding policies to Teams. Karen suggested Jesse meet with Theresa and Brenda regarding specific issues, replacement and/or solutions since they use the system frequently. e) Jesse - nothing to report. f) Melissa, RR/CS- Customer Service sent Karen two Excel spreadsheets, one for the full fiscal year of 2023 and the other for September to review by Corporate Compliance Officer. We have had four complaints. Melissa stated the Ethics meeting will need to be rescheduled.	Jesse to meet with Brenda and Theresa regarding Medworxx.

#	Topic	Key Discussion Points	Action Steps
	f) Ethics/Recipient Rights/Customer Service Update g) Corporate Compliance Activity Report h) Review of Fraud Abuse Risk Assessment (Triennial 2023) <u>November Reports</u> i) Verification on Medicaid Services Q3 j) Plan within 15 days/Health Care	g) Karen reported she and Melissa have been busy with fraud investigations. There are two levels, one for issues under $5000 which Karen must do a full investigation, plan of correction and then it is report to the OIG through our quarterly reporting system. Issues over $5000, Karen completes a special referral to OIG and they do the investigation. Karen did a complete investigation on one fraud issue. Fraud was substantiated and a plan of correction is in place. Several issues are still pending. Privacy issues usually go to Karen and then she works with Melissa to correct the problem. She recently did a training at MPA regarding privacy. h) Fraud Abuse Risk Assessment is due for 2023. These assessments are done every three years, the last one was done in 2021. Karen met with Janis on this. Janis stated these are the categories for risk levels which do not change. When high ones are identified an action plan is completed. Karen will go over the 2021 assessment to see if everything has been completed. Then decide whether we want to continue as we are or if we need to get alternative goals and actions steps. Regarding medical necessity – Sarah said Melissa Duel is looking for medical necessity issues and reporting when anything is missing. The completion of medical necessity criteria in the clinical assessment was being left blank. Putting in a hard stop was considered, and it was decided not to implement this. Sarah will check with Melissa Duel to see if blank areas continue to be a problem and report back on this. Assessment is confusing due to how many things must be marked. There has been lots of education on this but still having issues. Melissa found one provider is still having issues so more training and education will be done with them. Create a new report comparing disability designation, DSM coding, medical necessity Locus, or CAFAS. Karen suggested we look at a sample from each program. The risk assessment states that outpatient therapy, completion of medical necessity criteria and the annual clinical assessment update are not reviewed enough to ensure specialty behavioral health criteria continues to be met. Joelin said an action step to add is that same day access would mean that all assessment were completed internally. She also stated she has a way to pull reports specific to each provider on CAFAS and PECFAS information. CLS and Self-determination – most consumers are dependent on their staff. Some spot checks are being done. Waiting for the Event Verification System which is not yet in place. Chelli continues to do her CLS spot checks. Add reports for checks to CCC data monitoring plan. Karen will go through the Risk Assessment again to make sure that it is accurate and seek feedback from this committee. i) Nothing to report. j) Sarah's Summary Report can be found on the g-drive. Completion of the Coordination of Care forms are below the 95% standard for SPSI and MPA. Bay Direct scored 98%. List had a decrease of 11%. Action: Continue to use the PCE Coordination of care form and upload evidence. POS in 15 days – change in	Karen will go through the Risk Assessment.

#	Topic	Key Discussion Points	Action Steps
	Coord/Crisis Plan/Medical Necessity k) ATP Compliance Rate Report <u>Enhanced Monitoring</u> l) Intermittent Checks of Self Determination Service m) List Psychological – IPOS expired with services provided, several months of no documented progress notes, unsigned documents by staff/supervisor, stand-alone AUTH's, back dating of Interim Plans	process: Using the PCP header to track when sent out. List has a 0% score for this quarter since they recently started using the new process and have provided them with education on this. MPA and Bay Direct scored below the 95% standard. SPSI scored above 95%. Sarah's team is working with BI/IT to create a graph showing the amount of POS that are given/mailed within 15 days, outside of 15 days, and number of times the Update Sent Link is not used. Action: Staff to use the Update Sent Link. Crisis Plan Completion: QI is reviewing all the crisis plans for each quarter. Completed plans have decreased since the last quarter for MI-SED and MI-SMI populations. The following trends were found; Objective does not include scope, frequency, or duration, blank sections in the assessment, 'Waiver Service Array' not checked, POS Training Plan not completed, no explanation for Pre-plan and POS being completed same day or if POS was done on a different date then requested. Summary of the needs is not being completed by one provider. k) ATP – Ellen reported that we are holding steady September is 93.4 % August is 93.3 %. This was presented at PMOQMC meeting. Melanie is concerned that the total number of 115 was low considering the number of people case managers are serving. Ellen gets that number from the report she pulls. She will look at it again to be sure it is accurate. l) Chelli did her review and sent Karen results. m) Most recent issue with List is that they are requesting to have authorizations added for 2022. These are services that they provided without a completed POS. Karen stated we are refusing to allow them to bill for those services.	
5.	**Outstanding Items/Other:** a) Statewide Credentialing Work Group Updates b) Ability to Pay Changes (PA 92 of 2022; eff. 6-6-22) We will have until 10/2023	a) No updates b) Ellen had no updates.	
6.	Adjourn/Credentialing Committee	Credentialing meeting to follow.	

#	Topic	Key Discussion Points	Action Steps
	Next Meeting	**The next meeting is scheduled for Tuesday, December 12, 2023, but may be rescheduled to the 12-19-23, from 2:00 – 4:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, October 12, 2023

1:30 p.m. - 3:30 p.m.

Lincoln Center - East Conference Room

MEMBERS	Present	MEMBERS	Present	AD-HOC MEMBERS	Present
List Psychological Assistant Site Supervisor: Abbi Burns	X	BABH Integrated Care Director: Joelin Hahn (Chair)	X	BABH Medical Records Associate: Denise Groh	
BABH ACT/MI-A/Sr. Outreach Mgr.: Allison Gruehn	X	BABH BI Secretary: Joelle Sporman (Recorder)	X	BABH Finance Department: Ellen Lesniak	
BABH Clinical Team Leader: Amanda Johnson		BABH Corporate Compliance Healthcare Accountability Director: Karen Amon	X	List Psychological Site Supervisor: Kaitlyn Tobin	
BABH Clinic Practice Manager: Amy Folsom	X	BABH IMH/HB Supervisor: Kelli Maciag	X	Consumer Council Rep (Jan/Apr/Jul/Oct): Kathy Johnson	
BABH EAS Supervisor: Anne Sous	X	MPA Adult/CSM Program Supervisor: Laura Sandy		List Psychological Site Supervisor: Megan Smith	
Saginaw Psychological COO: Barb Goss		BABH North Bay Team Supervisor: Lynn Blohm		BABH Clinical Services Manager: Nicole Sweet	
Saginaw Psychological Asst. Supervisor: Chelsea Hewitt	X	BABH Adult ID/DD Manager: Melanie Corrion	X	BABH Clinical Supervisor: Pam VanWormer	X
Saginaw Psychological CSM-A Supervisor.: Chelsee Baker	X	BABH Quality & Compliance Coordinator: Melissa Deuel	X	BABH MI-A Specialist/Intern: Sarah Mulvaney	X
BABH Children Services Team Leader: Emily Gerhardt		BABH RR/Customer Services Manager: Melissa Prusi	X	BABH Nursing Manager: Sarah Van Paris	
MPA Adult OPT Supervisor: Emily Simbeck		Saginaw Psychological CEO: Nathalie Menendes		BABH Contracts Administrator: Stephanie Gunsell	
BABH Integrated Care Director: Heather Beson	X	BABH Children Services Manager: Noreen Kulhanek		BABH Clinical Team Leader: Stephani Rooker	
BABH Clinical Services Manager: Heather Friebe		BABH Quality Manager: Sarah Holsinger (Chair)	--	BABH Access/ES Clinical Specialist: Tyra Blackmon	X
Saginaw Psychological OPT Supervisor: Jaclynn Nolan	X	BABH Access/ES/MRT Program Manager: Stacy Krasinski	X	**GUESTS**	**Present**
List Psychological COO: Jacquelyn Thompson-List		MPA Child OPT Supervisor: Tracy Hagar	X		
BABH Access/ES MRT Supervisor: James Spegel	X				

Topic	Key Discussion Points	Action Steps/Responsibility
1. **a. Review of, and Additions to Agenda** **b. Approval of Meeting Notes: 09/14/23** **c. Program/Provider Updates and Concerns**	a. There was an addition to the agenda; b. The September 14th meeting notes were approved as written. c. **Bay-Arenac Behavioral Health**: - Access/Emergency Services/Mobile Response Team – - ACT/MI-A – - Arenac Center – - Children's Services – - CLS – - Contracts – Nothing to report this month. - Corporate Compliance – Nothing to report this month. - Family Support/ABA – Nothing to report this month. - Finance – Nothing to report this month. - IDD Adult –	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, October 12, 2023

1:30 p.m. - 3:30 p.m.

Lincoln Center - East Conference Room

	Topic	Key Discussion Points	Action Steps/Responsibility
		- Madison Clinic – - Medical Records – Nothing to report this month. - North Bay – - Quality – Nothing to report this month. - Recipient Rights/Customer Services – **List Psychological**: **MPA:** **Saginaw Psychological:**	
2.	**Plans & System Assessments/Evaluations** a. QAPIP Annual Plan (Sept) b. Organizational Trauma Assessment Update	a. Nothing to report this month. b. Nothing to report this month.	
3.	**Reports** a. QAPIP Quarterly Report (Aug, Nov, Feb, May) b. Harm Reduction, Clinical Outcomes & Stakeholder Perception Reports **i. MSHN Priority Measures Report (Jan, Apr, Jul, Oct)** **ii. Recipient Rights (Jan, Apr, Jul, Oct)** iii. Recovery Assessment Scale (RAS) Report (Mar, Jun, Sep, Dec) iv. Consumer Satisfaction Report (MHSIP/YSS) v. Provider Satisfaction Survey c. Access to Care & Service Utilization Reports **i. MMBPIS Report (Jan, Apr, Jul, Oct)**	a. Nothing to report this month. b. i. ii. iii. Nothing to report this month. iv. Nothing to report this month. v. Nothing to report this month. c. i ii. iii. iv. Nothing to report this month. v. Nothing to report this month. vi. d. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month.	

	Topic	Key Discussion Points	Action Steps/Responsibility
	ii. LOCUS (Mar, Jun, Sep, Dec) **iii. Leadership Dashboard - UM Indicators (Jan, Apr, Jul, Oct)** iv. Service Requests Disposition Report (Feb, May, Aug, Nov) v. Discharge Summary Disposition Report (Feb, May, Aug, Nov) **vi. Customer Service Report (Jan, Apr, Jul, Oct)** d. Regulatory and Contractual Compliance Reports i. Internal MEV/Performance Improvement Report (Feb, May, Aug, Nov) ii. MSHN MEV Audit Report (Apr) iii. MSHN DMC Audit Report (Oct) iv. MDHHS Waiver Audit Report (Oct when applicable) e. Periodic Review Reports **f. Ability to Pay Report** g. Review of the Referral Status Report	iv. Nothing to report this month. e. Nothing to report this month. f. g. Nothing to report this month.	
4.	**Discussions/Population Committees/ Work Groups** a. Harm Reduction, Clinical Outcomes and Stakeholder Perceptions i. CAFAS Reports for Performance Improvement/LOC Utilization Mgmt. ii. PCP Treatment Team Input iii. Consumer Council Recommendations (as warranted)	a. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month. b. i. Nothing to report this month. ii. Nothing to report this month. iii. Nothing to report this month. c. i. ii. Nothing to report this month. iii. Nothing to report this month.	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, October 12, 2023

1:30 p.m. - 3:30 p.m.

Lincoln Center - East Conference Room

Topic	Key Discussion Points	Action Steps/Responsibility
b. Access to Care and Service Utilization i. MMBPIS Work Group ii. Services Provided during a Gap in IPOS iii. Repeated Use of Interim Plans c. Regulatory Compliance & Electronic Health Record **i. 1915 iSPA** ii. Ability to Pay Assessments iii. Periodic Reviews - Including Options for Blending with Plan of Services Addendums iv. Management of Diagnostics v. MDHHS Standard Consent Module in Phoenix vi. PHE Ending Update and PCE Changes d. Juvenile Competency Hearing/Referral to MH treatment e. BABH/Policy Procedure Updates f. Conflict Free Case Management g. OPT Group Therapy h. Youth Protocol **i. Coordination of Care – PCE** **j. Gaps between Assessment and IPOS** **k. ABD** **l. Appeals Process - New Referrals and Returning to Care** **m. Tracking Staff Qualifications** **n. MDHHS Universal Consent** **o. Clinical Capacity Issues Update**	iv. Nothing to report this month. v. Nothing to report this month. vi. Nothing to report this month. d. Nothing to report this month. e. Nothing to report this month. f. Nothing to report this month. g. Nothing to report this month. h. Nothing to report this month. i.	

BAY-ARENAC BEHAVIORAL HEALTH

PRIMARY NETWORK OPERATIONS & QUALITY MANAGEMENT COMMITTEE MEETING

Thursday, October 12, 2023

1:30 p.m. - 3:30 p.m.

Lincoln Center - East Conference Room

	Topic	Key Discussion Points	Action Steps/Responsibility
5.	**Announcements** a. DHHS Outreach Worker i. MIBridges System b. Great Lakes Bay FAN – Monthly meeting reminder: Delta College, Thursdays 7:00-8:00PM	a. FYI b. FYI	
6.	**Parking Lot** a. Addendums (Primary Case Holder vs. Add-On Services)	a. Future discussion	
7.	**Adjournment/Next Meeting**	The meeting adjourned at 3:30 pm. The next meeting will be on November 9, 2023, 1:30 - 3:30 in-person at the Lincoln Center in the East Conference Room.	

Responding to Residual Fraud Risks

- Avoid the risk (i.e., eliminate asset or activity if controls are too expensive)
- Transfer the risk (i.e., purchase fidelity insurance policy)
- Mitigate the risk (i.e., implement countermeasures, such as prevention and detection controls)
- Assume the risk (i.e., if probability of occurrence and impact of loss are low)
- Combination approach

Action Plan

The following workflow areas received the highest risk scores during the BABH Fraud and Abuse Risk Assessment and were given priority for action

Provider Network Area:	Contracted Organizations Using Phoenix and Other
Provider Type(s):	CSM; OTP; Prescribers/RN; ABA Autism; CLS-Self Determination
Workflow Area:	Claims
Risk Analysis:	MEV process has changed and evaluation of the effectiveness of the changes will need to occur. Contracted Organizataions do not bill claims directly through a SAL attached to a document. There has been an increase in claims and authorizations being submitted without an active IPOS. Self Determination is higher risk because there is limited oversight and the consumers are the person's employers. There can be a conflict when the consumer relies on the staff to not address things.

Action Steps	Person(s) Responsible	Target Date	Completion Date
BABH and MSHN MEV reviews ongoing throughout the year and enhanced reviews as necessary.	Quality and Compliance Dept.	ongoing-evaluate 9/1/24	
Evaluate and restrict providers from being able to complete stand alone authorizations without an active IPOS.	K. Amon, T. Adler	02/01/24	
Develop a report to address expired IPOS with claims; Monitor and addres with contracted providers out of compliance.	BI Department	03/01/24	
Self Determination Coordinator to complete monthly checks to assure that claims and services are accurate and that documentation is compliant with standards.	Self Determination Coordinator	Monthly to Corp. Comp. Committee	
MDHHS Event Verification System implemenation when finalized.	J. Bellinger, K.Amon, H. Beason	12/01/24	

Provider Network Area:	Direct Operated and LIP; Contracted Organizations Using Phoenix and Other
Provider Type(s):	All CLS; Children's CSM; OTP
Workflow Area:	Provider Qualifications
Risk Analysis:	Ongoing issues with the IPOS not being trained to the staff providing the services. Repeat citations have occurred. Eventually this may be a situation for take backs. New ABA credentialing process put into place and will need to be evaluated for effectiveness. Children's clinician's are required to have a certain number of children's specific training in order to be qualified to provide the services. BABHA has had repeat citations in this area.

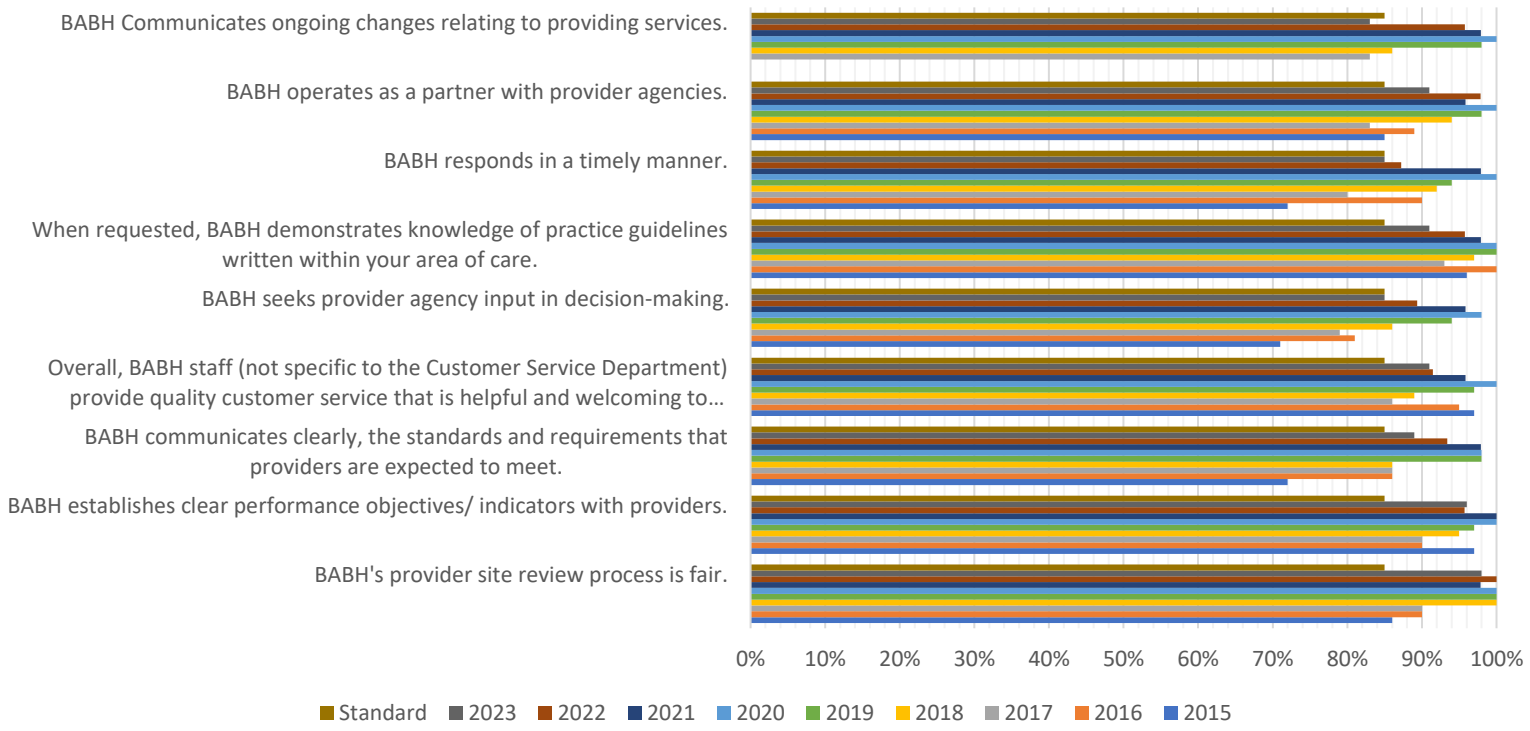
Action Steps	Person(s) Responsible	Target Date	Completion Date
Annual Site Review at Provider Agencies to assure that staff are trained in the IPOS. Monitoring corrective action.	Quality and Compliance Coordinator	Ongoing-9/1/24	
Development and Utilization of a Monthly Report to monitor primary case holders training the provider agency.	Sarah H, Greg L and Lisa N	03/01/24	
ABA providers credentialling is completed by the Quality Department. Revised the Policy and implement the procedures.	Quality and Compliance Coordinator	Ongoing-9/1/24	
Develop a training schedule and curriculum for Children's staff; Develop reports on the status of training for supervisors to monitor; Review training status at supervision monthly.	Children's Program Manager; Staff Development; Human Resources Depart.	03/01/24	

Provider Network Survey 2023

The Provider Network Survey obtains feedback from contracted clinical service providers who provide care to individuals within our service area. The survey was sent to all provider types, including the following organizations: residential, vocational, clubhouse, primary care, applied behavioral analysis, community living supports, and inpatient. Fifty-five responses were received, which was consistent with the number of surveys returned in previous years.

Figure 1 shows the percentage of favorable responses to the nine survey statements. Eight statements scored over the 85% standard. The statement, "BABH communicates ongoing changes related to providing services" scored 83% and also had the biggest decrease (13%) from 2022. Overall, scores have been decreasing since 2020. Eight of the questions scored lower in 2023 compared to 2022. It should be noted that there were two statements that had a high number of NA responses (4.35% and 8.51%) which would impact the percentage of agree/disagree responses.

Figure 1



There were comments provided that would support opportunities for improvement. The two common trends received from the responses were that there was a lack of timely responses from BABH staff and, overall, a lack of communication. One response noted that when staff go into the provider location, they do not communicate or coordinate with the staff. There were comments from providers that they have to reach out to BABH staff on multiple occasions to get a response. There were also comments that changes occur and are not communicated

to providers until after they are already in place or that providers find out about changes when they are told that corrections need to be made. All of the 'disagree' comments were made by 11 out of 55 providers; seven of these 11 had more than one 'disagree' response. There was the opportunity for those completing the survey to add any additional comments at the end of the survey. There were 10 responses received, nine of which were positive toward BABH, and one response that noted difficulty with staff turnover at their agency. Additional comments highlighted a great partnership and collaboration, assistance during a staffing crisis, and providing quality services to consumers.

In addition to nine main survey questions, the survey included two additional questions regarding unmet community need. This information is used in strategic planning and is included by BABH in the State Annual Submission Needs Assessment Stakeholder Survey that is completed every two years.

What do you see as being the most significant mental health needs that are not currently being adequately addressed in our community? (number of respondents are in parentheses)
Lack of psychiatric inpatient hospitals or programs for consumers with high behavioral needs (5), staff wages/turnover/burnout/available quality staff (8), training for staff and consumers such as trauma and mental health first aid (5), needs in a rural community, safe and affordable housing, Autism services for those over 21, residents in specialized residential settings not having access to 'day programs' or 'CLS programs' because they live in group homes, ways to treat mental health issues without using psychotropic medication, ADHD, substance use, homelessness, support for teens and youth
What mental health trends have you identified that BABH should be aware of?
Staff burnout due to lack of staffing and low wages (4), aging community, increase in depression and anxiety as well as dual diagnosis; especially for children and youth (6), mental health needs of staff, increased substance abuse, rural county is harder to access resources, need for a parent support, families waiting for the intake process and knowing what other services they are eligible for, case worker burnout

Interventions Based Upon Survey Results:

Eight of the nine survey statements were above 85% standard, but we have had a steady decrease over the past three years. The survey results will be taken to provider meetings, leadership meetings, and Consumer Councils to discuss the results and any potential interventions and strategies for improvement.

- BABHA will share the comments received related to the timeliness of response time from BABHA staff at the Leadership Meeting so leadership can follow-up directly with individual teams.
- The new remote work policy requires timeframes for returning calls.
- BABHA sends out a staff directory to contract providers with who to contact and this information will be added to the provider tab.
- BABHA added an agenda item to review policies at PNOQMC.
- Co-chairs of committee meetings will lead discussions about their preferences with how to communicate changes effectively.
- Comments made about specific staff have been sent to the appropriate supervisor.

The information from the survey results will be incorporated into the annual BABH Strategic Plan and Annual Submission Needs Assessment.

Submitted by: Sarah Holsinger, LMSW, CAADC Quality Manager **Date:** 07/27/2023

CMS Office of Inspector General Work Plan

Audit of Emergency Preparedness, Infection Prevention and Control, and Life Safety at Intermediate Care Facilities for Individuals With Intellectual Disabilities

Previous OIG audits on infection prevention and control, emergency preparedness, and life safety at nursing homes identified multiple issues that put Medicaid enrollees at increased risk. Our objective is to determine whether selected States' ICF/IIDs complied with Federal requirements for infection prevention and control, emergency preparedness, and life safety.

Timeliness of Mental Health Care Following a Suicide Attempt or Intentional Self-Harm Incident for Children Enrolled in Medicaid

Rates of suicide attempts and intentional self-harm among youth are on the rise. A previous suicide attempt is the most important predictor of death by suicide, and the risk of death by suicide is highest in the period immediately after a hospitalization or emergency department visit for a suicide attempt or intentional self-harm incident. As such, providing timely mental health follow-up care is critical to decreasing the likelihood of rehospitalization and preventing suicide. We will conduct an evaluation to assess whether children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) who had an emergency department visit or hospitalization for a suicide attempt or intentional self-harm incident received mental health follow-up care within established timeframes. We will also examine whether certain groups of children in our population were less likely to receive timely mental health follow-up care after a hospitalization or emergency department visit. Finally, we will interview subject matter experts to identify the challenges and best practices that States encountered when working to ensure that youth enrolled in Medicaid and CHIP receive timely mental health follow-up care.

Access to Providers Prescribing or Dispensing Medications for Opioid Use Disorder in Medicare and Medicaid

Access to medications for opioid use disorder (MOUD) is essential for addressing high rates of opioid addiction and overdose mortality. This study will determine what percentage of providers are treating Medicare or Medicaid patients with MOUD. It will also identify geographic areas where access to MOUD remains challenging for people enrolled in Medicare and Medicaid.

Maintaining Buprenorphine Treatment for Medicare Enrollees With Opioid Use Disorder

Research has shown that discontinuing treatment medications-such as buprenorphine-increases the likelihood of overdose deaths. Moreover, longer retention in treatment is also associated with improved outcomes, such as decreased rates of emergency room visits. This study will look at the extent to which people enrolled in Medicare Part D maintain buprenorphine treatment for at least 6 months. It will also look at the extent to which these enrollees-including the setting in which they start their treatment and the services they receive-differ from enrollees who do not maintain treatment.

Medicare Part C Audits of Documentation Supporting Specific Diagnosis Codes and Health Risk Assessment Diagnosis Codes

We will perform a targeted review of these diagnoses and will review the medical record documentation to ensure that it supports the diagnoses that MA (Medicare Advantage) organizations submitted to CMS for use in CMS's risk score calculations and to determine whether the diagnoses submitted complied with Federal requirements. One tool that MA organizations use to collect risk-adjusted data is the health risk assessment (HRA), which gathers information about enrollees, including health status and health risks. We will determine whether these diagnosis codes, as submitted by MA organizations to CMS for use in CMS's risk-adjustment program, complied with Federal requirements.