AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
CORPORATE COMPLIANCE COMMITTEE MEETING

Thursday, November 6, 2025 at 5:00 pm

Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

Committee Members:	Present	Excused	Absent	Committee Members:	Present	Excused	Absent	Others Present:
Patrick Conley, Ch				Shelley King				BABH: Melissa Prusi, Sarah Holsinger, Christopher Pinter, and Sara McRae
P. Schumacher, V Ch				Patrick McFarland, Ex Off				
Tim Banaszak				Robert Pawlak, Ex Off				Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained
Christopher Girard								

	Agenda Item	Discussion	Motion/Action
1.	Call to Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Corporate Compliance Report 4.2) Corporate Compliance Committee Notes from the meetings dated: a) June 9, 2025 b) July 14, 2025 c) August 11, 1015 4.3) Security Risk Assessment 4.4) MidState Health Network (MSHN) Medicaid Event Verification (MEV) Report		4.1) No action necessary 4.2) No action necessary 4.3) No action necessary 4.4) No action necessary

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<table>
<tr><td></td><td>4.5) MSHN Quarterly Fraud & Abuse Report</td><td></td><td>4.5) No action necessary</td></tr>
<tr><td>5.</td><td>Adjournment</td><td colspan="2">M - S - pm MA</td></tr>
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BAY ARENAC BEHAVIORAL HEALTH

Scale for Status Rating: Good-Improved-Fair-Poor

COMPLIANCE MONITORING

Monitoring	Status at Last Report	Status as of this Report	Comments
Electronic health record security breach monitoring (for violations of role-based security)	Good	Good	No findings.
Sanctioned provider (exclusion/ debarment) checks for employees and officers, contracted clinical service providers and selected vendors	Good	Good	No findings.

Auditing	Status at Last Report	Status at this Report	Comments
Contracted Service Provider Site Reviews	Good	Good	During FY25Q3 and FY25Q4 there were 26 specialized residential site reviews completed. These reviews were for the following providers: • Bay Human Services (96% audit score/100% MEV) • MCSI (99% audit/100% MEV) • Liberty Living (100% audit score/99.5% MEV) • AuGres Care Center (100% audit score/100% MEV) • Fitzhugh (96% audit score/100% MEV) • Valley Residential Services (98% audit score/100% MEV) • CSCS (100% audit score/100% MEV) • Horizon (92.4% audit score/100% MEV) There were also 8 CLS site reviews conducted for the following providers: • AOI (92% audit score/99% MEV) • Do-All (100% audit score/99.9% MEV) • North Bay (98% audit score/100% MEV) • New Dimensions (91% audit score/98% MEV) • Arnold Center (98% audit score/93% MEV) • BHS Hourly (97% audit score/99% MEV) • BABHA Apartments (95% audit score/100% MEV) • MCSI (99.5% audit score/100% MEV) • Carebuilders (100% audit score/99% MEV) • Personal Assistance Options (86% audit score/55% MEV) There were also 3 vocational site reviews conducted for the following providers: • AOI (100% audit score/97% MEV) • Do-All (100% audit score/98% MEV) • New Dimensions (89% audit score/96% MEV) There were also 3 primary provider site reviews conducted for the following providers: • List (71%) • MPA (89%) • Saginaw Psychological (93%)
Record Reviews	Improved	Good	For FY25Q3 there were 84% (98/117) of the records required for review were completed with 78% (42/54) of the training required for FY25Q3 were

Auditing	Status at Last Report	Status at this Report	Comments
			completed; representing a decrease from FY25Q2. In the Leadership Meeting discussion, it was noted that when staff complete their reviews shortly before the report is generated, it can create a timing gap in which a supervisor is not yet aware of the training need, potentially resulting in incomplete training. Trends in training included: -Complete the MDHHS consent and coordination of care form annually. -Ensure the review of progress is completed on or before the date identified in the plan of service. -Complete all sections of both the plan of service and the assessment. -For no-shows, document each outreach attempt with a contact note, and send an outreach letter if the consumer cannot be reached.
Verification of Medicaid services provided for direct operated programs & contracted service providers	Good	Good	During FY25Q3 and FY25Q4 there were 48 MEV reviews with MEV results ranging from 53% (1 provider) to 100% (29 providers). Other MEVs conducted during FY25Q4 which included FY25Q1 and FY25Q2 documentation: • BABH Direct (100% MEV) • Saginaw Psychological (97% MEV) • MPA (99% MEV) • List (100% MEV) • Self Determination Coordinator has been completing monthly spot checks for MEV and quality in documentation and reporting to the CCC.

RISK ASSESSMENT			Status of Action Plans
Dep't of Justice Compliance Program Eval	Triennial	Next eval due in 2025	The 2022 self-evaluation was completed during the reporting period as scheduled. BABHA scored 99-100% on 34 out of 43 standards (80%). Of the 9 standards warranting improvement, action steps include more training for supervisors on compliance, strengthening training on policies and procedures, and post implementation evaluation of process changes to ensure regulatory compliance is fully actualized. Training for Supervisors has been developed, and individual new supervisors have had one on one training. To address education on policies and procedures this has been incorporated into the Relias System. BABHA will conduct a self-evaluation which began on September 30, 2025, and will conclude by 12/10/2025. The 2025 evaluation has been enhanced by the DOJ Updated guidance effective 09/2024 which focuses on Whistleblower protections and AI compliance issues. The DHCA has drafted an AI policy which is being reviewed by the IT Department and will be reviewed by SLT.
Fraud/Abuse Risk Assessment	Triennial	Next Assessment due 12/2026	Completed and presented to CCC 12/2023. Presented and Approved by HCICC 1/2024. The MEV reviews have been completed as scheduled and the increased amount of MEV's being conducted has been implemented. The external providers have been restricted from being able to do stand alone authorizations. A report for expired IPOS is available to external providers now that everyone is on PCE. The Self Determination Coordinator has provided monthly MEV and provider education and reported this to the CCC. A training schedule has been developed and staff development has assigned children's training to staff who need the hours. The EVV system has had a soft launch and is being implemented. IPOS training continues to be missed. Additional training has been conducted at Leadership Meetings and PNOQMC. The children's team has been educated on how to run reports on the training hours within Relias.

RISK ASSESSMENT			Status of Action Plans
Security Risk Assessment	Annual	Completed August 2025, due annually in July	This assessment was completed by the Security Officer on August 6, 2025. The Security Risk Assessment (SRA) is completed to ensure that all electronic Protected Health Information (ePHI) created, received, maintained, or transmitted is adequately protected in accordance with 45 CFR parts 160 and 164. BABHA's SRA's results are as follows: BABHA Is compliant with 121 of the 126 questions. These questions include required elements and addressable elements. With regards to the Required elements BABHA is 96% compliant and 97% compliant with addressable elements. The SRA Remediation Plan addresses the questions within these sections that require remediation: Section 4 – Security and Data Section 5 - Security and the Practice Section 6 – Security and Business Associates

EDUCATION

Persons Served	Frequency	Status
Consumer Council-Bay & Consumer Council-Arenac	Annual/PRN	Website contains Fraud Abuse and Privacy education. Consumer Councils received education regarding Fraud, Abuse and HIPAA/Privacy Practices at the CAC meetings on September 24, 2025, and October 1, 2025. Self Determination education for new consumers has begun to be tracked and reported to MSHN as well as the 5% EOB's that are sent out annually.
Board of Directors	**Frequency**	**Status**
Full Board Corporate Compliance training	Annual	Completed June 19, 2025

Additional compliance information provided for Board of Directors:

Date	Audience	Topic
2/6/2025	CCC Board Members	CC Semi Annual Plan, Annual Litigation Report, CC Plan, Dashboards for Privacy and Fraud, OIG work plan.
5/1/25	CCC Board Members	CC Dashboard, MSHN MEV Findings, Quarterly Fraud and Abuse report for FY25Q1 and FY25Q2.

Supervisors	Frequency	Status
Standing compliance agenda item on Bi-Weekly Leadership meetings	Monthly	Completed
Supervisor-specific corporate compliance training	Annual	Developed initial training and provided training via email to Supervisors.

Additional Educational Activities for Supervisors:

Date	Audience	Topic	Type
None			

Employees	Frequency	Status
New employee orientation to corporate compliance, privacy and confidentiality	Monthly	Completed every month.
Corporate compliance training	Annual	KA completed Telehealth Updates on 12/5/24. All staff receive Annual Corporate Compliance training during Staff Development Days in April, last training 04/2025.
Privacy/security/confidentiality training	Annual	Arenac Staff on Privacy on 12/11/24. All staff receive HIPAA training during Staff Development Days in April, last training 04/2025.
Corporate Compliance Plan in-service	Annual	Board Corporate Compliance approval 02/06/2025, Board approval 02/20/2025 and staff training completed in July.
Email security drills (by Security Officer)	Quarterly	“Hook” replaced our previous Phishing product through KnowBe4, which changed the “phishing” report button on emails and provided a Pop-Up email that was surprising for users. This was done as the result of a decision by our IT Vendor/Support company NSO. The Security Officer conducted email security drills July, August, and September. In July, 267 recipients received one of three randomly selected phishing test emails. 77 staff reported this as a phishing email, and 16 clicked on the email. This is also above the industry standard. The IT department is considering additional education for all staff to help increase the agency’s email security. In August, 264 recipients received one of three test emails. Over 80 staff reported the emails, and 10 clicked on one of the test emails. One version indicated there was a violation of acceptable use of internet, another version indicated that the user had emails in quarantine, and the third version indicated a new method of “passwordless authentication” was being deployed by BABHA. All three included links for staff to click on and an urgency that this needed to be completed timely. In September 263 emails were sent out with three versions of emails as well. Only 3 staff clicked on the phishing emails and 30 staff reported these emails as suspect. This could be due to the “hook” phishing button change or the fact that the test went out late in the month so when the data was pulled it did not include stragglers. One version noted the need to change their password, another version indicated staff needed to install new software, and the third version informed staff they had an email from a blocked user. All three versions indicated staff needed to click a link to address the needs of the email and this needed to be done timely.

Additional Educational Activities for Personnel:

Date	Audience	Topic	Type
12/11/24	Arenac Staff	Privacy	In person
4/8/25	All staff and Primary Providers	How to document Homelessness in demographics	email

7/9/25	Adult MI Team	Compliance with Documentation.	In person

Contracted Service Providers	Frequency	Status
Corporate Compliance Training for Residential/ Community Living Support Providers	Annual	Competed 4/30/25
Corporate Compliance Training for Vocational Providers	Annual	Completed 04/2025 and 09/2025
Corporate Compliance Training for Primary Providers	Annual	Completed 09/2025
Corporate Compliance Training for Autism Providers	Annual	Completed 4/8/25

Additional Educational Activities for Contracted Service Providers:

Date	Audience	Topic	Type
4/8/25	ABA Providers	Video and Security Cameras	In person

Corporate Compliance Staff & Leadership	Frequency	Status
Review of Regulatory Changes	Monthly	Completed
Review of Medicaid and General Fund Contract Boilerplate and Attachments	Yearly	In process
Review of CMS Office of Inspector General [Regulatory Compliance] Work Plan	Yearly	1/13/25

Educational activities for compliance leadership:

Date	Audience	Topics	Type

Report Prepared by:
Melissa Prusi MSHL, LBSW, QIDP
Director of Healthcare Accountability

Date: November 3, 2025

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, June 9, 2025 (1:00 –3:00 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
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Nicole Sweet, Director of IHC	X	Joelin Hahn, Director of Integrated Healthcare	X	**GUESTS**	
Michele Perry, Finance Manager	X	Marci Rozek, CFO			

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of May 12, 2025, meeting notes.** **c) Next Meeting: July 14, 2025**	a) No additions to the agenda. b) May 12, meeting approved as written. c) The next meeting is scheduled for July 14, 2025. There has been a change in the transition plan, the Corporate Compliance role will be extended until the beginning of August, end of July. Karen will still be here for the July 14th CC meeting in the CC role.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.) **Log No: 419** WHODAS Announcement. Full implementation Fall 2026. Have not heard anything in 6 months or more. <u>Monitoring</u>. **Log No: 426** ICCW Billing. The code is now in the system. Can be <u>closed</u>. **Log No: 429** L-24-78. Per a letter of 11/07/2024. The psychologists didn't thing this was going to affect us at all when Karen talked to them relating to the ABA credentials. Karen will go back and look at this to see if she agrees. **Log No: 433** MSHN CFA & P Next Steps Plan. At the QIC meeting last week, again, they brought this up and it is going forward but nothing that would help us plan. Karen states we have been talking internally about how we are going to address this. We have certain areas within our organization that we have to focus on, which is our Horizon Home. We are doing their case management as well. That would be an area that we would have to address if they go forward with the same plan and it doesn't sound like they are changing	

#	Topic	Key Discussion Points	Action Steps
		their ideas about that piece of it. So, we have talked about contracting with a different CMH. In particular, we have talked about looking at Tuscola as they are our closest partner, and we already have a working relationship with them on other cases. So, that might be our best bet but must look at case management also with North Bay CLS staff as well and do we look at it as a choice from the consumer if they want to keep their case management or if they want to keep their CLS through our agency. So, there is still quite a bit of talk regarding how we are going to implement Conflict Free Access and Planning and now with the new proposed procurement for the PIHPs, I'm wondering if that would change in any way the state's thought about how to implement Conflict Free Access and Planning. Karen states Chris is advocating, along with the other CMH's CEOs and CMHA that this goes outside the realm of what is for community mental health. Monitoring. **Log No: 440** Karen closed but wanted to let committee know. It was the elimination of pre-voc services through the HAB waiver and in talking with finance as well as Nicole, we never have offered pre-voc services so this really doesn't affect us at all. **Log No: 441** EBP for Childrens Modifiers. Michele states she just needs to know which modifiers we will be using so she can get them in the system. They don't need to go back to April 1, we just need to use them going forward. Michele sent Joelin an email asking which modifiers we will need in the system. In Progress. **Log No: 442** HCBS Updates 2025 – Delayed Egress and alarms. In Progress. Melanie thinks that we need to look at our policies and make sure that we have covered this under restrictions. The providers have already been trained. Karen to review the policies related to restrictions. Related to this, there is a new behavior treatment technical requirement coming out and there are some meetings and trainings coming through in the next couple of weeks. **Log No: 443** Children with IDD and Autism in Child Caring Institution. The only CCI we have is the juvenile detention center and we are already providing services to it. Joelin needs to check on what to do for COFR arrangements. In Progress. **Log No: 444** Psychiatric Residential Tx. Facilities-Final Revision. Joelin states she is now very familiar with psychiatric residential treatment facilities, and we haven't been able to get anyone in because their waiting list is so long. Monitoring. **Log No: 445** ICSS-Proposed Policy- Proposed effective date 07.01.2025. Not yet finalized. We did submit feedback to MSHN. Monitoring. **Log No: 446** EVV-Home Help and Overlapping Services clarification. This was clarifying that you can't have home help and CLS services at the same time and whoever gets the billing into the system first will get paid. However, we have some unique situations where there might be two staff on, and they are providing two services that might potentially overlap. Needs review. Nicole, Stephanie, and Michele to review. **Log No: 447** SEDW and MichiCANS/CAFAS update. Karen's understanding of the update is that everyone still must do the MichiCANS but to determine eligibility for the SED waiver, we are using CAFAS, PECFAS and DECA, not MichiCANS. Joelin has checked with Emily to assure that there are some trained CAFAS and PECFAS staff and will get with Pam and Heather as well. In Progress. **Log No: 448** 2025 BH Code Chart Update. OT/PT Codes. Michele states we are not going to bundle these as it is not beneficial because the only provider that uses these is Paramount. Closed. **Log No: 449** Open Meetings Act to allow remote participation for people with disability. SB 129 Recipient Rights Advisory MDHHS would fall under this. Senate passed. No movement. Monitoring.	

#	Topic	Key Discussion Points	Action Steps
		Log No: 450 Recipient Rights. SB 142 & 143. SB 143 requires hospitals to give written recipient rights to voluntary admits. They are required to do that for the people that are involuntarily admitted, but this is proposing that the rights be given out in written notice to all individuals admitted to the hospital. SB 142 adds representatives from advocacy groups to have a permanent standing on the recipient Rights Advisory Committee within the MDHHS and prohibiting executive staff from MDHHS from being appointed or serving on that committee. That was referred to the Senate Committee on Housing and Human Services at this point. Require hospitals to give written notice of their rights to voluntary admits. Monitoring. **Log No: 451** Autism Diagnosis. HB 4146. The intent is so that autism diagnosis will be more consistent and the proposal requires master level MH professional to have at least 3 years of ongoing professional development and to be supervised by a fully licensed Psychologist before diagnosing ASD. This has been referred to the House Health Policy Committee. Monitoring	
	b) Review of CMHA Update on Legislative and Policy Changes	b) Discussed above.	
	c) Review of Compliance Updates/Regulatory Education Needed for Staff	c) No staff education identified.	
	d) Process for Ensuring Implementation of Policy Changes	d) Discussed above.	
	e) Updates from CMHAM ED Forum	e) Nothing to report.	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).	a) Jen states she met with Katie, she had created an MS forms survey attestation and had sent that to both. There were some questions for IT regarding this.	
4.	**Data/Monitoring/Reports:** a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud /Abuse/	a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of May. b) Jennifer reported no exclusions/debarments. Stephanie reported no exclusions/debarments.	

#	Topic	Key Discussion Points	Action Steps
	Convictions during Staff Development Days)		
	c) Monitoring of Group Drives for Unsecured PHI Files	c) No unsecured PHI found.	
	d) Security Officer Update	d) For May, we did not have any security breaches that needed to be cleaned up. Our systems found a total of 18 findings. All of them were false positives. Last month, in April, towards the end of the month, we did have one finding that was not a false positive and that got cleaned up by the system. That was another instance of the malware item PDF skills.EXE. So, our security software saved us for the second month in a row from having an issue and clean up went just as good as it did last month. No other instances of any security issues to report beyond that.	
	e) Ethics/Recipient Rights/Customer Service Update	e) There has been no Ethics meeting since the last time Melissa reported. With regards to Recipient Rights, the complaints that are overlapping with Karen, they are both aware of and Melissa is not aware of any other complaints. For Customer Services, we are looking to find another Medicaid Fair Hearing Officer because Kimberly Cereske is going to begin cross training and start doing recipient rights. Anyone that is doing recipient rights cannot do Medicaid Fair Hearings. As you know, Jackie is coming into and transitioning to the Recipient Rights/Customer Services Dept, so she will also be going through training on both recipient rights and customer services so she also cannot do the Medicaid Fair Hearings. Mr. Pinter will designate a Medicaid Fair Hearings Officer who will handle those issues and then we will get both Jackie and Kim trained and will move forward through the transition. Modules, they are looking to change things with the ABDs to meet the HSAG requirements and a guidance will be going out to everyone regarding ABDs. We are also looking at tag lines being updated and implemented and there needs to be some change to the IPOS language when it prints out, there may be some re-wording needed.	
	f) Report of spot checks for compliance for Self Determination	f) Self Determination Report. Ben reports for the month of May, he reviewed 14 sets of progress notes. The bulk of them were good. He had two families where he provided feedback on the content of what CLS is. The other notes had robust details for the most part and had CLS appropriate activities that were in line with the goals of the person served. EVV is about halfway done, and this is, of course, ensuring that the staff are billing at the places that they mention in their notes, thanks to the GPS component. He had 3 referrals fore the month of May and all of them are underway aside from one exception where the staff has yet to fill out their paperwork. We had three people that were over utilizing but they were all minimal and have plans to dial their hours back. There was only one exception, who was over by 54 hours, so he is trying to work that out to have it become balanced. The others that were over, were minimal hours like 14 hours. He says that overall, over utilization seems to be lessening more and more, given the reports received from Stewart Wilson.	

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	g) Corporate Compliance Activity Report	g) Karen has had very little investigation activity. She has had one investigation that she and Melissa participated on, and it really did not determine fraud. It was some bad/improper documentation issues having to do with trying to correct compliance issues which leads into the next topics: • Trend of overdue assessments and IPOS with multiple interim plans and no established medical necessity was discussed and documents being done out of order. Late documents can prevent consumers from receiving medications if interim plan is not done. • Interim Plan guidelines in question; one interim plan, the rest are exceptions and need a reason? • Reimbursement and recoupments possible if there is no valid assessment to determine medical necessity and services aren't being provided appropriately. • Sanctioning or doing takebacks are an option to look at for overdue documents with no authorizations for services provided. • Monthly reports regarding documentation are sent out. Reports are available to providers in Phoenix. Staff receive alerts for overdue documents. • Whether appointments should be cancelled if there are no authorizations was discussed. • Regarding consumers showing up for Med appts but not keeping meetings with case holders, should an ABD automatically be sent when a person misses their planning meeting and should it be sent to all persons involved with case. Outreach should continue after ABD is sent. • Action Proposed: Come up with a plan, give staff guidance, have approx. a 4 month start up time and a cutoff date. If issues are found after this date, we would start doing takebacks. • Action Proposed: Remedial action, some kind of training, put things in writing, review at leadership and PNOQMC, then let it be known that without control of this using the tools available, we will have to look at recoupments. • Should we be reducing the amount of documents supervisors must review? This was discussed previously with a divide amongst managers and supervisors whether this should be done. Should this topic be revisited?	
	May Reports h) Ability to Pay Compliance Rate – Deferred from last month.	h) Ability to Pay Compliance Rate. Michele states we are at a 94.2% compliance of ATPs. Our average non-compliance is 5.8%. Michele states the finance dept is staying on top of this. They are sending emails to case managers to get them done.	
	June Reports i) Quality Review of Medical Records	i) Quality Review of Medical Records Summary Report. During FY25Q2, 92% of the required trainings were completed. Analysis determined that 10 out of 90 records reviewed found that the Coordination of Care Form wasn't completed, or it was expired, which resulted with a score of 89%; this is a 2% decrease from	

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		FY25Q1. There were 23 out of 93 records reviewed that indicated that the Assessment was unsigned, had blank items, or had the incorrect designation marked. This resulted with a score of 75%, which is a 22% decrease from Q1. There were 6 out of 92, or 93%, the plan of service didn't contain complete information, so there were things that were left blank on that. Six out of 68 records reviewed or 91%, showed the Review of Progress was either completed late or wasn't completed at all. That is something that we have been monitoring. For the Termination /Transfer section, there were a lot that were significantly lower but after reviewed, there was a staff that was marking "no" for things that should have been marked as "na". So, staff education has been done regarding this issue. Joelin asks if the report that Sarah just went over if the reviews were done internally. Sarah states that these are done internally for this report. Karen says that if we are thinking that we need some kind of reporting on that to help us out, the best place to talk about that would be at Data Governance Meeting. That way Joelin could attend, and the other parties that are involved in it could attend and then that would be a good place to have everyone on board talking about how to gather that information, what needs to be gathered and Jesse is the facilitator of that meeting. That is probably where we should have that discussion, if it is needed. Sarah states that from her recollection from the past, that we had done a report like that similarly when we were starting to have issues with this. Greg and Lisa met with Sara recently to go over reports that Sarah had requested to archive, things we hadn't used in a long time. Sarah thinks if that was one of the reports, it could be something that they could resurrect. Karen states the next Data Governance Meeting is May 16th at 9:30 am. Jesse will put this on the agenda.	
5.	**Outstanding Items/Other** a) Implementation of EVV	a) There was an issue that came up regarding two different designations. Jesse states this issue is in progress. Apparently, there is a difference between a provider portal and a payer portal. We should be doing some stuff in a payer portal but we have been doing all of our EVV stuff in a provider portal. We allegedly need both because we have some contracted services and some internal services. We are in the process of figuring out how to access both sides of it and make sure that all of the stuff that we're doing is getting done correctly. We also had another issue where some providers that we contract with didn't have anything showing up in the system. We've been working with them and sending out some communications to see if they are using the system like they are supposed to or what is going on.	
6.	**Adjourn:**	**The next meeting is scheduled for Monday, July 14, 1:00 – 3:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, July 14, 2025 (1:00 –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	E
Amy Folsom, Clinic Practice Manager	E	Jennifer Lasceski, Director of HR	X	Sarah Holsinger, Quality Manager	X
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Nicole Sweet, Director of IHC	X	Joelin Hahn, Director of Integrated Healthcare	X	**GUESTS**	
Michele Perry, Finance Manager	E	Marci Rozek, CFO	E		

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of June 9, 2025, meeting notes.** **c) Next Meeting: August 11, 2025**	a) No additions to the agenda. b) June 9, meeting approved as written. c) The next meeting is scheduled for August 11, 2025.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.) **Log No: 419** WHODAS Announcement. Full implementation Fall 2026. Have not heard anything in 6 months or more. Monitoring. **Log No: 429** MDHHS-Lara-Manuel. L-24-78. LBA only required for ABA services. Close. **Log No: 433** MSHN CFA & P Next Steps Plan. No updates at the June QIC. It is showing up on the proposed bulletins under the 45-day review. Tentative plans to contract out our CM for the Horizon home and the apartment programs, also still looking at CM options for North Bay. Tuscola has been talked to regarding the possibility of sharing CM between the two agencies. Monitoring. **Log No: 441** EBP for Childrens Modifiers. Still being reviewed. Nothing to do at this time. In Progress.	

#	Topic	Key Discussion Points	Action Steps
		Log No: 442 HCBS Updates 2025 – Delayed Egress and alarms. Need to update policies according to new standards. Karen to reschedule meeting with Melanie to discuss. Need to come up with a solution/plan for those that do not need this resource or restriction. In Progress. **Log No: 443** Children with IDD and Autism in Child Caring Institution. Nothing to update. In Progress. **Log No: 444** Psychiatric Residential Tx. Facilities-Final Revision. A few referrals have been made. The waitlist is over a year. Close. **Log No: 445** ICSS-Proposed Policy- Proposed effective date 07/01/2025. Close. **Log No: 446** EVV-Home Help and Overlapping Services clarification. This was to clarify that you can't have home help and CLS services at the same time and whoever gets the billing into the system first will get paid. However, we have some unique situations where there might be two staff on, and they are providing two services that might potentially overlap. Needs review. Nicole, Stephanie, and Michele to review. **Log No: 447** SEDW and MichiCANS/CAFAS update. We have enough trained staff. In Progress. **Log No: 448** 2025 BH Code Chart Update. In the file folder under Code Update. Closed. **Log No: 449** Open Meetings Act to allow remote participation for people with disability. SB 129 Recipient Rights Advisory MDHHS would fall under this. Senate passed. No movement. Monitoring. **Log No: 450** Recipient Rights. SB 142 & 143. SB 143 requires hospitals to give written recipient rights to voluntary admits. That was referred to the Senate Committee on Housing and Human Services at this point. Require hospitals to give written notice of their rights to voluntary admits. Monitoring. **Log No: 451** Autism Diagnosis. HB 4146. This has been referred to the House Health Policy Committee. Monitoring **Log No: 452** Code Chart Updates – New chart in folder. To be reviewed and reported at next meeting. **Log No: 453** EVV- Clarification. Same as Log No. 446. Needs Review. Nicole, Stephani and Michele to review. **Log No: 454** EVV- Outside a Consumer Home. Logging CLS and Adult Home health in the same day is currently an exemption from EVV and is considered overlapping. Needs Review. Nicole, Stephani and Michele to review. **Log No: 455** Targeted CM – Recuperative Care. Does not seem to apply to us. Needs Review. **Log No: 456** Intensive Crisis Stabilization – Final Bulletin. Needs Review. **Log No: 457** MichiCANS Update. Proposed policy's purpose is to establish requirements related to acceptance and use of the MichiCANS results completed by certified raters from MDHHS designated systems during the intake and assessment process. We will need to take their information, load it into our system and update as needed. This will ensure the information families have already shared will be used, which reduces duplication in assessments. Comments to be submitted by August 12. Joelin with get with our in-house experts and get their input and submit to Mid-State. Needs Review. **Medicaid Manual Updates for 07/01/2025:** • **ACT: The** ACT Team Leader must have a master's degree with the MHP credential. • **ABA:** Language was added regarding the ABA Rate which is outlined with the most recent executed PIHP Contract. We have already implemented this. • **MI Choice Waiver:** Private Duty Nursing. It was added in that a need for 24/7 PDN/RC cannot be used as a primary reason for denying MI Choice eligibility.	

#	Topic	Key Discussion Points	Action Steps
	b) Review of CMHA Update on Legislative and Policy Changes c) Review of Compliance Updates/Regulatory Education Needed for Staff d) Process for Ensuring Implementation of Policy Changes e) Updates from CMHAM ED Forum	b) Discussed above. c) No staff education identified. d) Discussed above. e) Nothing to report.	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).	a) Karen, Jen and Melissa to discuss creating a form internally.	
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	a) Monthly monitoring was completed; Lynn reported no security breaches in Phoenix or Gallery for the month of June. b) No findings for providers. No findings for employees and Officers. c) No unsecured PHI found. d) No findings for the previous month and only 3 false positives.	

#	Topic	Key Discussion Points	Action Steps
	e) Ethics/Recipient Rights/Customer Service Update	e) Defer	
	f) Report of spot checks for compliance for Self Determination	f) No updated info.	
	g) Corporate Compliance Activity Report	g) Karen received one complaint of a potential privacy violation that was referred to Area on Aging since it wasn't BABH jurisdiction. Area on Aging will be handling this report. Previous Privacy Breach being worked on has been finalized. No other Fraud/Abuse investigation.	
	<u>July Reports</u> h) Email Security Phishing Drill	h) Email Security Phishing Drill for June showed 263 recipients, 88 people reported, 26 people clicked. Per the last three phishing tests, clickers and reporters are both up but reporters are way up. More people clicked than should have. Jesse will be sending out education. It was brought up that when clicking the Phish Alert button the email disappears. If it comes back as a legitimate email, it has been removed and now is unable to be addressed. Jesse states this was by design. If the phishing alert button is clicked, it means that you have determined that this is a phishing email and it needs to be reported to the help desk and removed from your inbox. The button is not there for the help desk to determine if it is a phishing email, it is for users to tell the help desk that this is a phishing email, and it needs to be removed. The email is then removed in its entirety because there are phishing emails that have a dangerous malware attached to them. Education will be sent out regarding Phishing and reminding staff when clicking on the phishing alert button, that the email will be deleted. It has been successful for some staff to take a screen shot and send it to the help desk and wait on their response before clicking the phish alert button.	
	i) Security Risk Assessment	i) Security Risk Assessment. Defer until August.	
	j) Review of Compliance Audit Findings	j) Compliance Audit Findings. Defer. Karen did receive email with the Active admissions with Missing ATPs report for May showing List has the highest percentage of noncompliance. We have increased a little to 94.7% from the 94.2% in April. The Active admits in this report look low for List, Saginaw Psych and ACT. Active Admits needs to be reviewed for accuracy.	
	k) Corporate Compliance Semi-Annual Progress Report	k) CC Semi-Annual Progress Report. • There have been no findings or breaches in EHR or exclusion/debarments. • No update for Site reviews.	

#	Topic	Key Discussion Points	Action Steps
		• For record reviews, in FY25Q1, 89% of records assigned were completed and 85% of trainings were completed. Areas that fell under the threshold included COC not evident, IPOS not reviewed for effectiveness within the timeframes indicated. This was an improvement from FY24Q4. In FY25Q2, 86% of records assigned were completed and 92% of trainings were completed. Areas under the threshold increased and included Termination/transfer sections were not completed accurately, IPOS not reviewed for effectiveness within timeframe, all sections of the IPOS and Assessments were not completed and COC not evident. Overall, a decrease from FY25Q1. • MEV: For Q2-Q3 ancillary providers, which include ABA, CLS and FMS and Dietary providers, 42 MEV audits were completed. Eight MEV audits were completed for Q2-Q3 for Primary providers which includes Bay Direct operated. Ancillary services reviewed were $492,015 of claims with a recoupment amount of $678.64. However, some still have not had a finalized amount of recoupment so this may be slightly higher. Primary provider services reviewed $107,096.96 of claims with recoupment of $1,527.07. • Self Determination Coordinator has been completing monthly spot checks for MEV and quality in documentation and reporting to the CCC. • Fraud/Abuse Risk Assessment has been completed and reviewed. • Security Risk Assessment is due in July. Jesse will complete. • Education: Karen has not been to a Consumer Council meeting this year to do any annual updates, but we do have Fraud Abuse and Privacy education on our website. Self Determination education for new consumers has begun to be tracked and reported to MSHN as well as the 5% EOB's that are sent out annually. The Board of Directors was trained in Corporate Compliance on June 19, 2025. There have been two Corporate Compliance Board Meetings, one in February and one in May, where we covered those topics. Corporate Compliance was covered at the Leadership Meeting. • New Employee orientation was completed every month. Karen completed a Telehealth in-service update on 12/05/2024. Privacy training was completed at Arenac on 12/11/2024. HCICC approved the Corporate Compliance Plan in June of 2024 and staff training was completed in July. • Additional Education that was provided to our personnel and other providers: Compliance with Documentation processes with the Adult MI Team this week. Corporation Compliance for the Residential/CLS providers and Corporate Compliance for Autism Providers were both completed in April. Vocational and Primary Providers need to be completed. Additionally, we provided training to ABA Providers on Video and Security Cameras.	
	l) Dashboard Fraud-Abuse-Privacy-Security	l) Fraud-Abuse Privacy and Security. For FY25Q1, we looked at $86,000 of claims overall and recouped $25,000. The largest one included lost CLS progress notes. This required encounters to be backed out for that amount. Since that time, we have scanned the CLS notes into the electronic health record, so this doesn't happen in the future. We had a couple of investigations, but they did not result in overpayment. For FY25Q2 there were no complaints, only audits. There was an audit of CLS-Self D staff where notes were	

#	Topic	Key Discussion Points	Action Steps
		copied from day to day and between staff. No overpayment was determined; staff education was done. The rest are MEV audits and out of $104,305.69 worth of claims, we had $913.18 that we recouped.	
	m) DOJ Compliance Programs Evaluation	m) DOJ Compliance Programs Eval. This report was done in September of 2022 and is to be done every three years. It is due to be done again in September of 2025. This is not a required evaluation. Karen and Melissa discussed whether to continue this eval, and discussed the value added from this versus the Fraud and Abuse assessment that we do. DOJ Compliance Report – Action Plan. • Section 1-B Responsibility for Operation Integration. 1. To ensure compliance info goes thru supervisors to line staff, we added a standing agenda item to leadership meetings. We have increased intranet announcements and updates. 2. We worked with CCC to revise the section of policies and procedures that indicate additional education. This item to be discontinued due to feedback. 3. Karen has been doing individual training with new supervisors and managers who are coming on board and developed a powerpoint. • Section 2-B Funding and Resources. Revaluate compliance program capacity needs during FY23. It was determined the Compliance Program has adequate resources. • Section 3-A Culture of Compliance. Added supervisor training, added Manager encounter reports, added Leadership and Supervisor Dashboards. • Section 1-A Risk-Tailored Resource Allocation. This refers to our providers that were on stabilization fund during Covid. We are trying to get those providers back but still have some outstanding providers on cost settlement arrangements. We will continue to monitor Telehealth that is being provided throughout our system. This is up for a topic discus at SLT. • Section 1-D Investigation Response. Investigations are being done in a timely manner. • Section 1-B Accessibility. We continue to explore other options for replacement of Medworxx. • Section 1-B Gatekeepers. Need to re-assign Policy & Procedures to new Directors. • Section 1-D Resources and Tracking of Results. Have received at least two complaints from the Hotline for people that want to report anonymously. • Section 1-C Risk-Based Training. Will be included in new annual supervisor compliance training. Completed. • Section 1-B Design. Not completed, will continue for FY25. • Section 3-C Prior Weaknesses. Add questions regarding root cause analysis to CC record template. Completed.	

#	Topic	Key Discussion Points	Action Steps
5.	**Outstanding Items/Other** a) Implementation of EVV	a) EVV. There have been no updates regarding the payer portal versus the provider portal. No other updates.	
6.	**Adjourn:**	**The next meeting is scheduled for Monday, August 11, 1:00 – 3:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, August 11, 2025 (1:00 –3:00 pm)

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Melissa Prusi, Compliance & Privacy Officer (Chair)	X	Heather Friebe, Clinical Program Manager	X	Jackie Kish, RR/CS Manager	
Amy Folsom, Clinical Program Manager		Jennifer Lasceski, Director of HR	X	Sarah Holsinger, Quality Manager	
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X		
Nicole Sweet, Director of IHC		Joelin Hahn, Director IHC		**GUESTS**	
Michele Perry, Finance Manager	X	Marci Rozek, Chief Financial Officer	X		
Karen Amon, Directory of IHC	X	Stephanie Gunsell, Contract Manager	X		

#	Topic	Key Discussion Points	Action Steps
1.	**a) Agenda: Review/Additions** **b) Meeting Notes: Approval of July 14, 2025, meeting notes.** **c) Next Meeting: September 8, 2025**	a) No additions to the agenda. b) July 14, meeting approved as written. c) The next meeting is scheduled for September 8, 2025.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.) **Log No: 419** WHODAS Announcement. Full implementation Fall 2026. There is still no date for full implementation, but they are looking at Fall of 2026. <u>Monitoring</u>. **Log No: 433** MSHN CFA & P Next Steps Plan. <u>Monitoring.</u> The State is continuing forward. **Log No: 441** EBP for Childrens Modifiers. Still being reviewed. No update. <u>In Progress.</u> **Log No: 442** HCBS Updates 2025 – Delayed Egress and alarms. Need to update policies according to new standards. Karen to reschedule meeting with Melanie to discuss. Need to come up with a solution/plan for those that do not need this resource or restriction. Updating Policies. <u>In Progress.</u> **Log No: 443** Children with IDD and Autism in Child Caring Institution. Nothing to update. <u>In Progress</u>.	

#	Topic	Key Discussion Points	Action Steps
		Log No: 446 EVV-Home Help and Overlapping Services clarification. Needs review.	Nicole, Stephani and Michele to review.
		Log No: 447 SEDW and MichiCANS/CAFAS update. Continuing to move forward. In Progress. **Log No: 449** Open Meetings Act to allow remote participation for people with disability. Close. **Log No: 450** Recipient Rights. SB 142 & 143. Close. **Log No: 451** Autism Diagnosis. HB 4146. This has been referred to the House Health Policy Committee. No updates. Monitoring	
		Log No: 452 Code Chart Updates – New chart in folder. Need to review the code changes. Still anticipated but not ready due to contract language needing amending. Needs Internal review and public comment then can be implemented.	All to review.
		Log No: 453 EVV- Clarification. Same as Log No. 446. Needs Review.	Nicole, Stephani and Michele to review.
		Log No: 454 EVV- Outside a Consumer Home. Must seek approval/give notification of addresses outside of the individual's home if services provided elsewhere for longer periods of time. Needs Review.	Nicole, Stephani and Michele to review.
		Log No: 455 Targeted CM – Recuperative Care. Does not seem to apply to us. Needs Review.	
		Log No: 456 Intensive Crisis Stabilization – Final Bulletin. Needs Review.	Nicole to Review
		Log No: 457 MichiCANS Update. Proposed policy's purpose is to establish requirements related to acceptance and use of the MichiCANS results completed by certified raters from MDHHS designated systems during the intake and assessment process. We will need to take their information, load it into our system and update as needed. This will ensure the information families have already shared will be used, which reduces duplication in assessments. Needs Review.	Joelin to Review
		Log No: 458 CPT/HCPS Code updates**.** New codes effective July 1. Discontinued codes effective June 30.	Michele to Review
	b) Review of CMHA Update on Legislative and Policy Changes	b) MDHHS announces movement toward private Medicaid Health Plan covering specialized mental health services as part of Mental Health Framework initiative – MichiCANS Screener and LOCUS All Provider Draft Rate Meeting Date: August 6, 2025 Time: 1:00 PM – 2:00 PM. MDHHS Compliance Examination Guidelines have been updated.	Melissa to review and compare to previous year.

#	Topic	Key Discussion Points	Action Steps
	c) Review of Compliance Updates/Regulatory Education Needed for Staff d) Process for Ensuring Implementation of Policy Changes e) Updates from CMHAM ED Forum	MDHHS launches New "Mental Health Framework". Beginning in October of 2025 all qualified mental health providers contracted with MHPs or PIHPs will need to incorporate the use of standardized assessment tools and follow the new referral protocols. c) No updates. d) Discussed above. e) Updates from CMHAM ED Forum. i.) 08.06.2025 Prevention Supervision 101 – Virtual ii.) 08.06.2025 In-Person ACT 201 Team Leader/Supervisor + Team Training iii.) 08.07.2025 Virtual – LOCUS: Train the Trainer iv.) 08.11.2025 Integrated Dual Disorder Treatment 201 Advanced – Virtual	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).	a) Melissa, Karen and Jen to discuss. Katie created a draft template, and it has everything that we need but she doesn't feel it's appropriate for her to send out. Her thought was it should come from IT.	Melissa, Karen and Jennifer – will meet and discuss
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	a) Monthly monitoring was completed; Lynn reported no security breaches in Phoenix or Gallery for the month of July. b) No findings for providers. No findings for employees and Officers. c) No unsecured PHI found.	

#	Topic	Key Discussion Points	Action Steps
	d) Security Officer Update	d) No findings.	
	e) Ethics/Recipient Rights/Customer Service Update	e) Ethics/RR/CS Update – Deferred from July. i.) Meeting scheduled for 10/15/2025 11:00 am – Discussion will be regarding AI and ethical communications with AI. ii.) One new HIPAA/Privacy Complaint for August. The investigator and Melissa will be working together on this.	
	f) Report of spot checks for compliance for Self Determination	f) Self D Spot Checks Update: 11 sets of notes reviewed and overall, looked good. SD Coordinator provided education to one individual as the employer of record regarding documenting the activities thoroughly, rather than referring to TV as an activity. Two individuals, staff members, improved their notes as evidenced by the note reviews. One transferred to EVV and the documentation became unsatisfactory as staff were relying on boxes being checked, i.e. "money management" or "socialization" to describe what they did over the course of the shift rather than using a narrative. As a result, their narrative Progress Notes evolved into "nothing to report" or "just another day." SD Coordinator provided education to that EOR. Three new referrals for July which included education for these individuals from the SDC and one termination of the SD agreement which will be effective as of September 5, 2025.	
	g) Corporate Compliance Activity Report – Summary of log	g) Summary of log. We have had several recoupments due to the MEVs totaling approximately $5,000. Also, due to MEV reviews there were two reports, one regarding backdating of IPOS and Assessment. An investigation was done, and this was already billed so there was no recoupment. Another was where an interim plan was done and dated in July, but they were able to backdate an auth to June. Dimitry looked into this and discovered that originally that staff member had had a start date of 06/09 for that interim plan and then altered the start date of the plan. That has been corrected.	
	<u>July Reports</u> h) Security Risk Assessment – Deferred from July	h) *Please see Security Risk Assessment Findings and Remediation Plan 2025 in the Corporate Compliance folder for detailed Remediation Plan. In summary, the SRA is a tool that has 126 different security assessment questions across 7 different sections to evaluate our security risks within HIPAA against other frameworks. We were 100% compliant on Section 1 – Basics, Section 2 – Security Policies and Section 3 – Security and Workforce. On Section 4 – Security and Data, we were overall 96.7% compliant with one question not in full compliance. Section 5 – Security and the Practice was overall 96% with one question not in full compliance, Section 6 – Security and Business Associates was 80% compliant with three questions not in full compliance. Section 7 – Contingency Planning we were 100% compliant. The Security Risk Assessment Findings Summary showed BABH to be 96% compliant overall.	

#	Topic	Key Discussion Points	Action Steps
	August Reports i) Verification of Medicaid Services Direct Operated & Contracted Service Providers j) Plan within 15 Days; Health Care Coordination; Crisis Planning; Medical Necessity k) Ability to Pay Compliance Rate	Jesse created a new WAN and Security Map showing a detailed diagram of our Network which can be seen in the Corporate Compliance Folder. i) Deferred to September. j) Deferred to September k) Deferred to September	
5.	**Outstanding Items/Other** a) Implementation of EVV b) Organizational Risk Assessment – Publicize Risk "Report Card"	a) Implementation of EVV Update. There are two separate sets of credentials, each will allow access to the different portals. Jesse worked with EVV Specialist at MDHHS and set up access to payer portal now and they will work to ensure that all who need access have access. b) Organizations are scored to determine whether it is recommended to contract with them. Each provider got a score, and this was publicized every 2 years. This is now updated annually on our website.	Jesse will work with Nicole and Stephani.
6.	**Adjourn:**	**The next meeting is scheduled for Monday, September 8, 2025 @ 1:00 – 3:00 pm via MS Teams.**	

Security Risk Assessment Findings and Remediation Plan 2025
Bay-Arenac Behavioral Health

Completed By: Jesse Bellinger, IT Manager/Security Officer
Date Completed: 08/06/2025

I. Overview

Bay-Arenac Behavioral Health (BABH), in accordance with 45 CFR Part 160 and Part 164, must complete a HIPAA Risk Assessment to ensure all electronic protected health information (ePHI) created, received, maintained, or transmitted by a covered entity is adequately protected.

This BABH security risk assessment process utilizes the Security Risk Assessment (SRA) tool provided by the United States Department of Health and Human Services. The SRA tool lists 126 security assessment questions, provides several different response choices to each question, and ways in which to comply when a non-compliant response is selected.

This document includes a summary of the 7 sections within the SRA tool, a breakdown of compliance in each section, and a description of the areas where BABH was not in full compliance with the requirement.

II. Security Risk Assessment Findings

Section 1 – SRA Basics

This section focuses on basic information about our SRA, including if we have ever completed an SRA, how often we conduct an assessment, the processes used to complete one, and how the results are reported.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	9	9	100%
Addressable	1	1	100%
Total	10	10	100%

BABH is fully compliant within this section.

Section 2 – Security Policies

Section 2 concentrates on agency policies and procedures, risk management processes, document retention of our completed SRA materials, and the role of the Security Officer in managing risk.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	8	8	100%
Addressable	0	0	N/A
Total	8	8	100%

BABH is fully compliant within this section.

Section 3 – Security and Workforce

Section 3 concentrates on the security aspects of workforce members. The questions focus on security awareness training, employment screening procedures, system and application access processes, and the competence of the Security Officer. Protection from malicious software and monitoring of login attempts is also addressed in this section.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	11	11	100%
Addressable	8	8	100%
Total	19	19	100%

BABH is fully compliant within this section.

Section 4 – Security and Data

This section focuses on access to electronically protected health information (ePHI). The questions center around how users are granted access, how are users identified when accessing ePHI, is access appropriate, the use of encryption, automatic logoff from systems, and backups.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	20	19	95%
Addressable	10	10	100%
Total	30	29	96.7%

BABH is not compliant within this section. Below are the question(s) that are not in full compliance.

Question 23 (Required): How do you determine the means by which ePHI is accessed?

Answer: Applications which access ePHI are identified, evaluated, approved, and inventoried, but we do not manage which devices can access these applications (e.g. workforce members personal devices accessing a cloud-based EHR without first identifying and approving the device)

DHHS Guidance: Unsecured points could compromise data accessed through an otherwise secure application. Consider implementing a device management process to ensure security standards are in place for all points accessing ePHI. Assign a separate user account to each user in your organization. Train and regularly remind users that they must never share their passwords. Require each user to create an account password that is different from the ones used for

personal internet or e-mail access (e.g., Gmail, Yahoo, Facebook). For devices that are accessed off site, leverage technologies that use multi-factor authentication (MFA) before permitting users to access data or applications on the device. Logins that use only a username and password are often compromised through phishing e-mails. Implement MFA authentication for the cloud-based systems that your organization uses to store or process sensitive data, such as EHRs. MFA mitigates the risk of access by unauthorized users.

Section 5 – Security and the Practice

Section 5 targets physical security of devices, facilities, and the data center. The questions concentrate on how facilities are protected from unauthorized access, how devices protected from theft and unauthorized access, and an inventory of all equipment that store, process, or access ePHI.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	12	12	100%
Addressable	12	11	92%
Total	24	23	96%

BABH is not compliant within this section. Below are the question(s) that are not in full compliance.

Question 10 (Addressable): How do you validate a person's access to your facility?

Answer: We do not have lists of authorized persons or controls in place to identify persons attempting to access the practice, grant access to authorized persons, or prevent access by unauthorized persons.

DHHS Guidance: Consider appropriate methods of validating access to your facility. Implement and document safeguards determined to be reasonable and appropriate. Always keep data and network closets locked. Grant access using badge readers rather than traditional key locks.

Section 6 – Security and Business Associates

This section concentrates on how business associates are handled, the terms within our Business Associate Agreements (BAA), and assurances of compliance of our business associates.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	15	12	80%

Addressable	0	0	N/A
Total	15	12	80%

BABH is not compliant within this section. Below are the question(s) that are not in full compliance.

Question 7 (Required): How do you maintain awareness of business associate security practices?

Answer: We rely on the language of our BAAs to ensure that Business Associates are securing ePHI.

DHHS Guidance: Consider monitoring, auditing, or obtaining information from business associates to ensure the security of ePHI and include language about this in BAAs.

Question 14 (Required): Does the organization require business associates and third-party vendors to implement security requirements more stringent than required in the HIPAA Rules?

Answer: No, contracts with vendors or BAs outline requirements to follow the HIPAA Rules as applicable to BAs without additional cybersecurity protocols.

DHHS Guidance: The HIPAA Rules require a covered entity to obtain satisfactory assurances from its business associate that it will appropriately safeguard PHI it receives or creates on behalf of the covered entity. Organizations could consider protocols within their business practice to include enhanced cybersecurity and supply chain requirements beyond those required by the HIPAA Rules that third parties can follow and how compliance with the requirements may be verified. Rules and protocols for information sharing between the organization and suppliers are detailed and included in contracts between the two.

Question 15 (Required): How do you track and verify business associate and third-party vendor compliance to security policies and where are these policies documented?

Answer: The organization verifies business associate and third-party vendor status each year but does not perform evaluations.

DHHS Guidance: The organization could require business associates and third-party vendors to disclose cybersecurity features, functions, and known vulnerabilities of their products and services for the life of the product or the term of service. Contracts could require evidence of performing acceptable security practices through self-attestation, conformance to known standards, certifications, or inspections. Business associates and third-party vendors could be monitored to ensure they are fulfilling their security obligations throughout the relationship lifecycle.

Section 7 – Contingency Planning

The final section of the SRA emphasizes contingency planning and security incidents. The questions center around identifying, documenting, and testing security incidents and emergency situations.

Results

Question Type	Questions	Compliant Answers	Compliance %
Required	19	19	100%
Addressable	1	1	100%
Total	20	20	100%

BABH is fully compliant within this section.

III. Security Risk Assessment Findings Summary

SRA Results

BABH is compliant with 121 of the 126 questions within the DHHS SRA tool.

Question Type	Questions	Compliant Answers	Compliance %
Required	94	90	96%
Addressable	32	31	97%
Total	126	121	96%

IV. Security Risk Assessment Remediation Plan

Section 4 – Security and Data

Question 23 (Required): How do you determine the means by which ePHI is accessed?

Answer: Applications which access ePHI are identified, evaluated, approved, and inventoried, but we do not manage which devices can access these applications (e.g. workforce members personal devices accessing a cloud-based EHR without first identifying and approving the device)

Remediation Plan: Available options to limit device access to the cloud based EHR include IP Filtering and/or a browser cookie. Due to BABH's use of contracted providers, both options present an unreasonable burden to both end users and IT staff.

Standard 164.312(d) "Person or Entity Authentication" is the referenced rule for Section 4, Question 23. This standard has no implementation specifications and requires a covered entity to "Implement procedures to verify that a person or entity seeking access to electronic protected health information is the one claimed".

Access to PHI via our EHR software is protected by username, password, and 2 factor authentication. This ensures the person seeking access is who they say they are by requiring them to combine something they have (the time sensitive 2FA code generated by the token or authenticator app) and something they know (their username and password).

Our current practice provides reasonable security without placing an unreasonable burden on end users and IT staff. It is therefore not reasonable for us to follow the guidance within the SRA tool in this case.

Section 5 – Security and the Practice

Question 10 (Addressable): How do you validate a person's access to your facility?

Answer: We do not have lists of authorized persons or controls in place to identify persons attempting to access the practice, grant access to authorized persons, or prevent access by unauthorized persons.

Remediation Plan: Access to most facilities is controlled except for Mulholland second floor, which uses a shared hallway with Hospital staff; individual offices are able to be locked on that floor when not occupied. Most sites have video monitoring to track attempts to access the facility, except for North Bay, although a recent policy change requires the ability for consumers to opt out of being recorded, which creates a conflict between privacy and security.

The Security Officer will work with the Senior Leadership Team to navigate the conflict in privacy and security, and if necessary, recommend appropriate cameras to monitor access attempts.

Section 6 – Security and Business Associates

Question 7 (Required): How do you maintain awareness of business associate security practices?

Answer: We rely on the language of our BAAs to ensure that Business Associates are securing ePHI.

Remediation Plan: BABH will not be pursuing the DHHS Guidance within the DHHS SRA Tool. The hhs.gov website contradicts the guidance provided within the tool. The hhs.gov website explicitly states that covered entities are not required to monitor or

oversee the means by which their business associates carry out privacy safeguards or the extent to which the business associate abides by the privacy requirements of the business associate agreement. Our current practice adheres to the guidance provided on hhs.gov website. (Reference: FAQ 236-Is a covered entity liable for, or required to monitor the actions its business associates? https://www.hhs.gov/hipaa/for-professionals/faq/236/covered-entity-liable-for-action/index.html)

Question 14 (Required): Does the organization require business associates and third-party vendors to implement security requirements more stringent than required in the HIPAA Rules?

Answer: No, contracts with vendors or BAs outline requirements to follow the HIPAA Rules as applicable to BAs without additional cybersecurity protocols.

Remediation Plan: We have language in our BAAs that BAs are to take "appropriate safeguards" to protect PHI in addition to compliance with the Security Rule and HITECH act. We do not necessarily require adherence to more stringent standards from our BAs than what is outlined in the HIPAA rules, but the language of our BAAs does not rule that out. The question referenced here does not refer to any current HIPAA regulation, but the proposed changes to the HIPAA security rule that have not yet been published may include this. The current language of this rule may make compliance challenging with large providers who only issue boilerplate BAAs and will not change their practices for individual customers. Smaller providers could face significant administrative challenges adhering to this standard as well. The Security Officer will work with SLT to evaluate question 14's impact, and what steps could be taken to prepare for potential rule changes, as well as evaluate if compliance with this question is currently feasible.

Question 15 (Required): How do you track and verify business associate and third-party vendor compliance to security policies and where are these policies documented?

Answer: The organization verifies business associate and third-party vendor status each year but does not perform evaluations.

Remediation Plan: This question appears to be related to question 14, both of which are new in the SRA for this year. Currently there is no HIPAA rule referenced that would require compliance with either question. Proposed changes to the Security rule that is currently NPRM status could likely impact this. The Security Officer will work with SLT to evaluate question 15's impact, and what steps could be taken to prepare for potential rule changes, as well as evaluate if compliance with this question is currently feasible.

August 2025 Mid-State Health Network (MSHN) Medicaid Event Verification (MEV) Results

Bay Arenac Behavioral Health Authority received **74.63%** for the MSHN MEV review that took place in August 2025. There were a total of 319 claims reviewed.

Findings:

- **63** claims contained errors with the *Plan of Service Training Form*.
- **20** claims were missing consumer/guardian signatures on an Addendum or Interim Plan.
- **18** claims were submitted with the incorrect modifier.
- **12** claims had documentation issues, including missing provider signatures, start/stop times, narratives, or mismatched units.
- **8** claims were billed under H2021 instead of H2022 for children enrolled in SEDW.
- **4** claims lacked verification of Registered Behavior Technician training.
- **1** claim was a duplicate of another claim with a different time.
- **1** claim was billed as treatment planning, but the documentation did not support treatment planning activities.

BABHA staff submitted a corrective action plan to address the findings.

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Activity Report for Corporate Compliance Committee

FY25 Q4 OIG Report to MSHN

Date Initiated	Source of Activity	Service/ Program	Provider Name	Brief description of issue/allegation	Codes Involved	# of Claims Reviewed	# of invalid Claims	# of Staff	# of Cons	Total Paid Amount Related to Complaint/ Activity	Overpay Identified?	Potential Fraud?	Date Referred to MIOHSIG	Total Over-payment	Disposition	Date Resolved
03/17/25	Audit - Scheduled	Dietician	Nutrition for Wellness	Scheduled MEV audit	H0032, 97802, S9470	83	6	Various	Various	$ 7,813.30	Yes	No	NA	$ 678.20	Closed - Recovered	07/24/25
06/18/25	Audit - Scheduled	Community Living Service Provider	ARENAC OPPORTUNITIES, INC	Scheduled MEV audit	H2015	193	1	1	Various	$ 31,825.56	Yes	No	NA	$ 170.20	Closed - Recovered	07/25/25
07/02/25	Audit - Scheduled	Community Living Service Provider	DO-ALL, INC.	Scheduled MEV audit	H2015	590	1	1	Various	$ 9,433.34	Yes	No	NA	$ 38.34	Closed - Recovered	07/26/25
06/19/25	Audit - Scheduled	Community Living Service Provider	NEW DIMENSIONS	Scheduled MEV audit	H2015	198	3	Various	Various	$ 4,662.21	Yes	No	NA	$ 15.05	Closed - Recovered	07/27/25
06/20/25	Audit - Scheduled	Community Living Service Provider	ARNOLD CENTER	Scheduled MEV audit	H2015	45	3	Various	Various	$ 4,573.46	Yes	No	NA	$ 830.34	Closed - Recovered	08/29/25
07/17/25	Audit - Scheduled	Community Living Service Provider	BHS, INC.	Scheduled MEV audit	H2015, T2027	189	6	Various	Various	$ 47,930.79	Yes	No	NA	$ 1,103.45	Closed - Recovered	08/30/25
06/20/25	Audit - Scheduled	Community Living Service Provider	CAREBUILDERS AT HOME, LLC	Scheduled MEV audit	H2015	147	3	Various	Various	$ 33,614.79	Yes	No	NA	$ 461.30	Closed - Recovered	09/29/25
07/23/25	Audit - Scheduled	Community Living Service Provider	PERSONAL ASSISTANCE OPTIONS, INC	Scheduled MEV audit	H2015, T2027	282	128	Various	Various	$ 35,889.14	Yes	No	NA	$ 13,404.06	Closed - Recovered	09/29/25
07/23/25	Tip/Grievance	Case Management and OPT	N/A	Poor documentation practices		2	0	1	1	$ -	No	No	NA	$ -	Closed - No Findings	09/10/25
07/23/25	Tip/Grievance	Case Management and OPT	N/A	Authorization outside of IPOS		1	0	1	1	$ -	No	No	NA	$ -	Closed - No Findings	09/05/25
08/05/25	Tip/Grievance	Community Living Service Provider	N/a	Using videochatting in the presence of recipients		n/a	n/a	n/a	n/a	$ -	No	No	NA	$ -	Closed - not substantiated	10/20/25
08/22/25	Tip/Grievance	Case Management and OPT	n/a	Provided recipient information to wrong provider in Phoenix		n/a	n/a	n/a	n/a	$ -	No	No	NA	$ -	Closed - substantiated - low level breach	08/27/25
09/04/25	Tip/Grievance	Physician Services	n/a	Provided recipient information to wrong recipient at the Madison site		n/a	n/a	n/a	n/a	$ -	No	No	NA	$ -	Closed substantiated - low level breach	09/03/25
09/09/25	Tip/Grievance	Unknown	Arenac	Consumer given wrong medication listing.		n/a	n/a	n/a	n/a	$	No	No	NA	$ -	Closed- substantiated - low level breach	09/11/25
09/09/2025	Audit - Scheduled	Vocational	New Dimensions - IPS	Scheduled MEV audit	H2023	87	4	Various	Various	$ 10,312.04	Yes	No	NA	$ 466.82	Closed - Recovered	09/29/25
09/09/2025	Audit - Scheduled	Vocational	New Dimensions - Traditional Vocational	Scheduled MEV audit	H2025, H2014	95	2	Various	Various	$ 1,309.02	Yes	No	NA	$ 0.04	Closed - Recovered	09/29/25
09/12/2025	Audit - Scheduled	Vocational	Arenac Opportunities, Inc.	Scheduled MEV audit	H2014	69	2	Various	Various	$ 3,941.81	Yes	No	NA	$ 665.55	Closed - Recovered	09/29/25
09/09/25	Audit - Scheduled	Vocational	DO-ALL, INC.	Scheduled MEV audit	H2023	190	3	Various	Various	$ 11,351.19	Yes	No	NA	$ 126.51	Closed - Recovered	10/01/25
09/09/25	Audit - Scheduled	Vocational	DO-ALL, INC.	Scheduled MEV audit	H2023, H2014	190	3	Various	Various	$ 4,740.22	Yes	No	NA	$ 0.12	Closed - Recovered	10/03/25
09/24/25	Audit - Scheduled	Behavioral Analyst	Flourish - LIP	Scheduled MEV audit	97155	61	3	Various	Various	$ 12,330.00	Yes	No	NA	$ 360.00	Closed - Recovered	10/03/25
Totals										$175,742.59				$16,700.94		