AGENDA

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
CORPORATE COMPLIANCE COMMITTEE MEETING

Thursday, February 5, 2026 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, 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) September 8, 2025 b) October 13, 2025 c) November 10, 2025 d) December 8, 2025 4.3) Centers for Medicare & Medicaid (CMS) Office of Inspector General (OIG) Work Plan for 2026		4.1) No action necessary 4.2) No action necessary 4.3) No action necessary

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	4.4) Quarterly Fraud & Abuse Report to Midstate Health Network (MSHN)		4.4) No action necessary
	4.5) 2026 Corporate Compliance Plan		4.5) Consideration of a motion to approve the 2026 Corporate Compliance Plan
	4.6) Corporate Compliance Plan Semi-Annual Report		4.6) No action necessary
	4.7) Dashboard Review		4.7) No action necessary
5.	Adjournment	M - S -	pm MA

BAY-ARENAC BEHAVIORAL HEALTH

BABHA CORPORATE COMPLIANCE COMMITTEE MEETING

Monday, September 8, 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	X	Jennifer Lasceski, Director of HR		Sarah Holsinger, Quality Manager	X
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X		
Nicole Sweet, Director of IHC	X	Joelin Hahn, Director IHC		**GUESTS**	
Michele Perry, Finance Manager	X	Marci Rozek, Chief Financial Officer			
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 August 11, 2025, meeting notes.** **c) Next Meeting: October 13, 2025**	a) No additions to the agenda. b) August 11, 2025 meeting approved as written. c) The next meeting is scheduled for October 13, 2025.	
2.	**State-Federal Laws, MDHHS Notices and Regulations** a) Review of Log and Subject Matter Expert Report Outs	a) Melissa 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. Monitoring. **Log No: 433** MSHN CFA & P Next Steps Plan. No update from any committees/groups/MDHHS memos/ communications or on Michigan.gov. Monitoring. **Log No: 441** EBP for Children's Modifiers. Still being reviewed. No update. In Progress. **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. In Progress. **Log No: 443** Children with IDD and Autism in Child Caring Institution. Nothing to update. In Progress.	Joelin to review

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		Log No: 446 EVV-Home Help and Overlapping Services clarification. When people are using the EVV and there is an overlapping service, whoever enters it in the system first will be paid. One issue discussed: We do not bill through HHA Exchange, how will we know if we have overlapping services. Is the only way to determine if there are overlapping services to run reports or possibly wait until the denial comes through? Needs review. Meeting will be scheduled to ensure this process moves forward.	Jesse to meet with Nicole and Michele
		Log No: 447 SEDW and MichiCANS/CAFAS update. Continuing to move forward. In Progress.	Michele
		Log No: 451 Autism Diagnosis. HB 4146. Referred to the House Health Policy Committee on 02/25/2025, then referred to Committee on Health Policy on 02/26/2025. 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.	
		Log No: 453 EVV- Clarification. Same as Log No. 446, Jessee to meet with Nicole and Michele to ensure this process moves forward. Needs 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.	
		Log No: 456 Intensive Crisis Stabilization – Final Bulletin. Still waiting on MDHHS for clarification/communications. Needs Review.	Nicole to Review
		Log No: 457 MichiCANS Update. The 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 it 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 has made the necessary changes, a lot of them were wording and descriptions. Michele will put together an email regarding the changes and send out to everyone. Needs Review	Michele to review and send summary
		Log No: 459 Respite for Children in Foster Care. Children in foster care are eligible for respite and cannot be denied medically necessary respite if involved in the foster care system. Karen to update Ben. Needs Review	Joelin to review

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		Log No: 461 Waskul HSW. Clarification of Medical Necessity. Limitations of PIHP decisions, SD arrangements, ALJ authority in SD arrangements, ALI authority in SD terminations, CLS inclusions/exclusions including costs for HSW. FMS definition, PCP requirements related to SD arrangements. Effective 10/01/25 This has to do with Self-Directed Services and HAB waiver individuals. There are several changes: • Administrative Law Judge and now Self D arrangements can go to Medicaid Fair Hearing. • Requests not approved in the PCP needed to be identified in the IPOS and reason for the denial. • Transportation costs and payment for staff attending activities must be included. • More specifically, the information on Self D arrangements out to beneficiaries. We will need to look at our brochure on Self D and make sure that it covers this so that when people are going through the Pre-Planning meeting, they can have all the information that is required in the brochure. Sent to SD Coordinator for review. Educate CSMs regarding ABDs and RR/CS needs education on MFH aspect regarding HSW enrollees. Karen to update policy and ensure education through Relias. It needs to be determined where to document in IPOS. Needs Review	Joelin, Nicole, Heather, Karen to review
		Log No: 462 Mcaid/HSW SD. MDHHS Proposed Policy Draft. HSW SD arrangements for CLS. IPOS requirements – Budget requirements. Needs Review	Karen to review
		Log No: 463 Mcaid/HSW SD. MDHHS Final Bulletin. HSW SD for CLS – HCBSR (42 CFR part 441, Subpart G) Appendix D-1. CMHSP must agree during the PCP process to the amounts of the individual budget before the budget is authorized for use. If the budget isn't agreed upon then the CMHSP shall set the budget pending resolution through any internal appeal and Fair Hearing that the beneficiary may pursue. Must consider staff wages and compensation including worker's compensation, unemployment insurance, health insurance, HR requirements, supervision, planning meetings, and payroll taxes. Include the beneficiary's anticipated transportation costs related to the CLS activities except to and from work. Effective 10/01/25 Needs Review	Karen to review
		Log No: 464 MichiCANS Revision requirements for Use. Revisions to the Medicaid policy related to acceptance and use of MichiCANS screener and results that are completed by certified raters from MDHHS. CMHSPs will review the current MichiCANS screener ratings received by another child-serving system, Enter the information in the EHR, Update the information when there are significant changes in conditions or circumstances. Needs Review	Joelin, Karen, Nicole, Heather to review
		Log No: 465 MDHHS Medicaid Policy Update. SED Policy Update – MichiCANS and Children's Therapeutic Foster Family Care. Implementing the Decision Support Model criteria from the MichiCANS Comprehensive Decision Support Model tool to measure functional limitations for the purposes of determining eligibility for the SEDW. Changing from the CAFAS/PECFAS and DECA to MichiCANS. New applicants will use both tools. Needs Review	Joelin and Children's leadership to review and give feedback

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		Log No: 466 MDHHS Medicaid Policy Update. Parent Support Partner coverage as a State Plan Service. PSP is a State Plan service as of 10/1/24 and children/youth will no longer be required to meet eligibility criteria or be enrolled in the 1915(i) or SEDW. Parents/primary caregivers of children, youth and young adults who have SED/IDD (including Autism) up to age 21 are eligible. Needs Review PSP Staff qualifications: • Lived experience as a parent or primary caregiver of a child or youth with behavioral or mental health needs and/or intellectual/developmental disability, including autism. • Willing and able to use their lived experiences as a peer parent to support others. • Experience receiving services for their child or youth in a variety of systems (such as child welfare, special education, juvenile justice system, etc.) is preferred; and • Employed by a Prepaid Inpatient Health Plan (PIHP)or its contracted providers. Training Requirements. The PSP shall: • Actively participate in and complete the approved MDHHS training. • Complete the ongoing MDHHS approved model certification and recertification requirements; and • Meet provider qualifications Supervision. PSP Supervisors shall: • Provide regular supervision to PSP at least bi-weekly in person or virtually; and • Participate in supervisor-related training in accordance with the PSP model.	Joelin to review
		Log No: 467 MDHHS Policy Manual Update. CWP – updated coverage. MDHHS is removing the eligibility requirement for CWP that the child must have a GAF score of 50 or below. Payment for CLS may not be made, directly or indirectly, to responsible relatives, ie. spouses or parents of minor children, or guardian of the beneficiary receiving CLS. Enhanced transportation is no longer a benefit under CWP. EAA must be authorized by overseeing PIHP. OHSS updates. Respite updates. CWP requires prior authorization. Specialized Medical Equipment and Supplies, Specialty Services. Enrollment and disenrollment. Needs Review **Log No: 468** MDHHS Policy Manual Update. Mcaid/Healthy Michigan, MIChild, Freedom to work, or full Fee-for-Service Health. Implementation is contingent upon approval of a State Plan Amendment. Behavioral Health Homes and Provider staffing. Effective 10/01/2025. **Log No: 469** MDHHS Policy Manual Update. Mcaid/Healthy Michigan, CSPCS, CWP, MOMS, MI-Choice Waiver. Behavioral and Physical Health and Aging Services Administration renamed to Health Services. **Log No: 470** MDHHS Policy Manual Update. Flint Water Group. USEPA lifted an emergency order on drinking water in the City of Flint on May 19, 2025. Those eligible for the Flint water group must have been served by the Flint water system between 04/01/2014 through 09/30/2025.	Joelin to review

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		Log No: 471 MDHHS Proposed Policy Draft. SUDHHS. Effective 12/01/2025 (Proposed). Implementation is contingent upon approval of a State Plan Amendment. SUDHH services. Update current payment rates and provider requirements for SUDHHS. Adding an addictionologist to the Care Team staff and increase Peer Recovery Coach and Community Health Worker ratio. <u>Needs Review.</u>	
	b) Review of CMHA Update on Legislative and Policy Changes	b) Review of CMHA Update on Legislative and Policy Changes: i.) CMHA and Members Continue to Highlight Facts and Dangers of PHIP Bid Out – CMHA staff recently joined the MichMash podcast to discuss the MDHHS bid out of the state's public PIHP system. MichMash is a podcast produced by WDET Detroit Public Radio and the Gongwer News Service. Co-hosts Zach Gorchow and Cheyna Roth talk to DHHS Director Elizabeth Hertel about why she's leading the charge for the changes. Then they talk to Dan Cherrin, head of the Michigan Behavioral Health and Wellness Collaborative, who supports the overhaul, and Bob Sheehan, Executive Director of the Community Mental Health Association of Michigan, who opposes it. ii.) Registration now Open for the NACBHDD Fall Virtual Legislative & Policy Conference 2025: October 21st – 22nd. iii.) House Passes FY26 Budget – Late Tuesday afternoon, the House approved a $54 billion omnibus budget bill. When combined with the education budgets, passed earlier this summer, total spending amounts to more than $78.5 billion. This figure is roughly $3 billion less than the current year's budget, $5 billion less than the Governor's proposal, and $6 billion below the Senate's plan. A key feature of the House budget is an additional $3.4 billion in revenue dedicated to roads, resulting in a record $10.2 billion Department of Transportation budget. This amount is more than $3.3 billion higher than the Senate's $6.9 billion transportation allocation. House Republicans passed a Fiscal Year 2026 spending plan that not only is $6 billion lower than what the Senate passed, it found room to put $3.4 billion more into the roads, create a $115 million Public Safety Trust Fund, and eliminate state taxes on tips, overtime pay and Social Security income. iv.) Behavioral Health Internship Stipend Program opens August 18. As part of its continuing efforts to increase access to behavioral health services for Michigan residents, the Michigan Department of Health and Human Services (MDHHS) is offering a stipend program to student interns enrolled in accredited behavioral health bachelor's or master's degree programs. The Behavioral Health Internship Stipend Program provides up to $15,000 to students who have obtained a qualifying unpaid internship to cover costs such as tuition, fees, books and living expenses. v.) Michigan Center for Rural Health Releases Rural Health Equity Plan Focused on Advancing Equity in Rural Michigan. The Michigan Center for Rural Health (MCRH) has announced the release of the Rural Health Equity Plan (RHEP), a new statewide report aimed at addressing disparities and improving access to essential services in Michigan's rural communities. vi.) Center for Mental Health Implementation Support – CMHIS and its bioregional Hubs can help your organization or system improve the delivery of mental health care by strategizing to overcome barriers and planning new program implementation from start to finish. CMHIS can help you map the course, navigate roadblocks, and provide support to ensure that the people who need it receive the excellent mental health care that providers always strive to deliver. CMHIS serves grantees funded by SAMHSA's Center for Mental Health Services and organizations that oversee or directly	

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		provide mental health services. These organizations typically work with people with serious mental illness or serious emotional disturbance. vii.) Behavioral Health Conditions T-MSIS Behavioral Health Data Book released August 22, 2025. The purpose of the T-MSIS BH Datta Book is to provide readily accessible information on Medicaid and CHIP beneficiaries treated for a substance use disorder (SUD), a mental health (MH) condition or co-occurring SUB and MH conditions to understand trends within these populations and inform policy decisions. viii.) Leadership Change at SWMBH – The Southwest Michigan Behavioral Health (SMBH) Board and Bradley Casemore, SWMBH CEO have mutually agreed to an amiable separation effective August 1, 2025. Mila Todd has been named as Interim CEO at SWMHB.	
	c) Review of Compliance Updates/Regulatory Education Needed for Staff	c) No updates.	
	d) Process for Ensuring Implementation of Policy Changes	d) Discussed above.	
	e) Updates from CMHAM ED Forum	e) Updates from CMHAM ED Forum. – See Above.	
3.	**Plans, Policies, Procedures, Assessments:** a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).	a) Jennifer to set a meeting with Melissa to 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 August. b) No findings. c) No unsecured PHI found.	

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	d) Security Officer Update	d) Jesse reported we did not have any security incidents. July's phishing test report had a 10% click rate and 85% user report rate.	
	e) Ethics/Recipient Rights/Customer Service Update	e) Ethics/RR/CS Update – i.) Meeting scheduled for 10/15/2025 11:00 am – Discussion will be regarding AI and ethical communications with AI. ii.) Three investigations into privacy violations, two of which were very straightforward, one was electronic communications were sent, and one was an after-visit summary provided to the wrong person under the wrong name. Sarah is getting more information about that to confirm who it was so we can begin the investigation process. We are looking into whether the after-visit summary was received back from anyone to ensure it was destroyed. There is another ongoing investigation where the allegation was a staff member was facetiming while in a specialized residential home with recipient and potentially being seen in the video and heard over the telephone. Melissa to follow up.	
	f) Report on spot checks for compliance for Self Determination	f) Self D Spot Checks Update: 13 sets of progress notes reviewed with no education required. Enrolled 1 individual in SD with education provided. New Budget process that accounts for ESTA. MEV audit completed with one note missing appropriate documentation. Education was provided as a result of the MEV audit from the SD coordinator.	
	g) Corporate Compliance Activity Report – Summary of log	g) Melissa reported MEV was discussed, one of our CLS providers had a significant gap in documentation for their last MEV audit requiring around $14,000 in recoupment. Sarah reported we may see a small amount of that for our next quarterly as well because they had a significant leadership change, but it would have impacted Q3 also but the one that required a $14,000 recoupment was for Q2. We may see some residual effects with our next review as well, but not as significant. There is a concern about how the provider will financially be able to handle this recoupment.	
	<u>August Reports</u> h) Verification of Medicaid Services Direct Operated & Contracted Service Providers	h) MEV/PI Report for FY25Q2. Bay Direct scored 100% for the MEV. MPA scored 99%, Saginaw Psychological scored 97% and List scored 100%. The most common findings being no goals selected within the Progress Note, the amount/frequency/scope/duration of services not being included in the IPOS and blank "Risk Factors/Barriers and Strategies to Minimize" sections in the IPOS. Staff were reminded where to put things and how to document.	
	i) Plan within 15 Days; Health Care Coordination; Crisis	i) For the plan of service given within 15 days, MPA scored 91% which is a 4% increase from FY25Q1. Bay Direct scored 89%, which is the same score they received in FY25Q1. Saginaw Psychological scored 94%, which is a 1% decrease from FY25Q1. List scored 100%. The biggest issues are the ones that are being left blank. We have an "update sent date" link in PCE, we've given guidance about how to use that but	

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	Planning; Medical Necessity	internally we have 1 ½ times from the quarter before that it is not being updated. We will keep providing education for staff. Regarding Coordination of Care, this quarter we have a significant decrease overall for everyone except MPA. The most common findings were there was a Coordination of Care form, but no MDHHS Consent which there shouldn't be a COC form without a consent, or there is not a COC form at all. Action steps included continuing to use the new COC form that is in PCE. The MDHHS Consent does meet the standard for COC. If the consumer does not have a primary care physician, or refuses the COC, the MDHHS form needs to be completed with the "Withdraw" option. Of the Quality issues, the following trends were observed: - No explanation of why the Pre-Plan and Plan of Service were completed on the same day or if the Plan of Service was completed on a different date than what was requested. - Unsigned or expired documents. - Back-to-back Interim Plans. It is recommended that staff double-check their documents to ensure that all areas are completed.	
	j) Ability to Pay Compliance Rate	j) Active Admissions with Missing Documents for June shows we are at 93.9% ATP completion. No concerns at this time	
	<u>September Reports</u> k) Quality Review of Medical Records	k) Quality Record Review Summary Report for FY25Q3 shows that 84% of the records required for review for FY25Q3 were completed. It shows 78% of the training required was completed, which is a decrease from FY25Q2. We do send out monthly reminders. We are starting to administratively close those reviews that have been open a significant amount of time, approx. 6 months, and the staff is not getting to them because it isn't relevant anymore. In six months, they could be closed or not in the program anymore. Analysis of compliance of each section is as follows: • Coordination of Care: Out of 84 records reviewed, 13 either lacked a complete COC form, contained an expired form or had no MDHHS Consent. This resulted in an 85% compliance score. • Assessment Identifies Needs for Specialty Health Svs: Out of 84 records, two were overdue, one contained a blank check box, one included a LOCUS score below the need, and one lacked updated information in the Reasons for Seeking services section. This resulted in a 94% compliance score. • Assessment – All Sections complete and contain Updated Information: Seven of 84 records were either overdue, contained blank sections, or did not include updated information. The resulting score was 92%. • Plan of Service: Of 81 records, six were incomplete or overdue resulting in a score of 93%.	

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		• Pre-Planning – Person Given the Choice of service: Of 29 records, four had the "N/A" box marked for waiver services was applicable while the consumer was enrolled in 1915i services, and one record was overdue resulting in a score of 83%. • Pre-Planning/Plan of Service Alignment: Six of 79 records showed issues where the Plan of Service was overdue, completed the same day as the Pre-Plan without explanation, or where the Pre-Plan date followed the Plan of Service date. The resulting score was 91%. • Review of Progress: Seven of 54 records showed the Review of Progress was either late or not completed, resulting in a score of 87%. • Service Delivery Consistency: Seven of 79 records showed that services documented in the Plan of Service were not delivered at the identified frequency. In two cases, the cancellations were made by the consumer or family. This resulted in a score of 91% • Outreach: Four of 64 records lacked evidence of outreach when consumers missed appointments. The resulting score was 94%. Action Steps – Staff Reminders: • Complete the MDHHS consent and COC 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 and the Assessment. • For no-shows, document each outreach attempt with a contact note and send an outreach letter if the customer cannot be reached.	
5.	**Outstanding Items/Other** a) Implementation of EVV	a) Implementation of EVV Update – Jesse will work with Nicole, Stephani and Michele to look into the EVV/HHA exchange. It was suggested to follow up with Michelle Hill, EVV specialist, to see if there is anything that we are missing so we can move forward.	Jesse will work with Nicole, Michele and Stephani.
6.	**Adjourn:**	**The next meeting is scheduled for Monday, October 13, 2025 @ 1:00 – 3:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH
BABHA CORPORATE COMPLIANCE COMMITTEE MEETING
Monday, October 13, 2025 (1:00 - 3:00 pm)

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

#	Topic	Key Discussion Points	Action Steps
1.	a) **Agenda**: Review/Additions b) **Meeting Notes**: Approval of September 8, 2025, meeting notes c) **Next Meeting**: November 10, 2025	a) 4.l. Department of Justice Evaluation b) The September 8, 2025, meeting notes were approved as written. c) The next meeting is scheduled for November 10, 2025.	
2.	**State-Federal Laws, MDHHS Notices and Regulations:** a) Review of Log and Subject Matter Expert Report Outs b) Review of CMHA Update on Legislative and Policy Changes c) Review of Compliance Updates/Regulatory Education Needed for Staff	a) Review of Log and Subject Matter Expert Report Outs – Melissa and the committee reviewed the log (Log can be found at G:\BABH\Corp Comp Regs-Codes-Manuals - CC Committee Law-Reg Mgt Log). Log Issue 419 – WHODAS Announcement - There still is no date for full implementation but looking at Fall of 2026. Continue to monitor. Log Issue 433 – MSHN CFA & P Next Steps Plan - On 09/22/25, the CFAP has been approved in 3 of the 4 waivers. The Association has sent the state suggestions on how to transition and implement the mechanics of CFAP and are hopeful they will use the suggestions. Using that as evidence as to why the PIHP procurement is necessary. Continue to monitor.	

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	d) Process for Ensuring Implementation of Policy Changes e) Updates from CMHAM ED Forum	Log Issue 441 – EBP for Children's Modifiers - There are no updates to report. In progress. Log Issue 442 – HCBS Updates 2025 - Policies are updated. We can close this issue. Log Issue 443 – Children with IDD and Autism in Child Caring Institutions - Joelin is in the process of scheduling a meeting with in-house experts to go over the COFR guidelines to make sure we are incorporating everything. Meetings will be scheduled to provide education with leadership, especially with EAS and Children's Leadership, and Finance. In progress. Log Issue 446 – EVV-Home Help and Overlapping Services Clarification - This is a work in progress. Accounts have been made and staff logged in. Jesse is attending the EVV meetings. Jesse is responsible for passing information on to staff. Jess will be working on this after the phones have been rolled out. The EVV system is not being used to bill; there is no way to tell when Home Health is being billed. We can close this issue due to billing issues. Needs review. Log Issue 447 – SEDW and MichiCANS/CAFAS update - Staff are trained and will continue to do the CAFAS and PECFAS until told otherwise. No updates to report this month. We will continue to monitor this issue. Continue to monitor. Log Issue 451 – Autism Diagnosis - Requires a 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. No updates to report this month. Continue to monitor. Log Issue 452 – Code Chart Updates - Working through a code-chart issue which is changing a lot of things in the code chart. It is eliminating H2023, Individual Supported Employment and underneath is the Y5 modifier for IPS.	

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		By eliminating that code, for people on the HMP, it's going to affect several people at every vocational provider. The Medicaid Provider Manual is confusing. They are also eliminating the H2014 for HMP which is Skill Building. Karen is discussing at extended SLT to devise a plan moving forward. Needs review. Log Issue 453 – EVV Clarification - This is a continuation of Issue 446. This is still a work in progress. Combine with Issue 446. Needs review. Log Issue 454 – EVV- Outside a Consumer's Home - Community Based CLS and vacations. We need to make sure the location is noted through the EVV portal as an acceptable location and shared with the providers. Needs review. Log Issue 456 – Intensive Crisis Stabilization Services - On 09/30/25, MMP 25-42 fully rescinded this to allow for more time and will be reissued in April 2026. Need further updates/clarifications from MDHHS. Continue to monitor. Log Issue 457 – MichiCANS Update - Is there a state database that tells us if a MichiCANS screening was completed within the past year? Care Connect 360 - going through MSHN and more information coming from Skye Pletcher. EAS Access Screening: Incorporate asking about past MichiCANs screenings: Previous MH treatment should indicate that a MichiCANs comprehensive was completed, Involvement with DHHS (CPS or Foster Care) should indicate a MichiCANs screening was completed and use previous MichiCANS screenings/comprehensive eval for closed cases when the individual is calling to re-engage in services. Determine process for updating data points with significant changes. EAS: develop process to obtain copy of previous MichiCANs screening/comprehensive evaluation. EAS Access, Same Day Assessment Specialist, Program Assessment Specialist: Need to determine the most efficient process for using the obtained MichiCANS details (what should be copied/pasted or duplicated in our system, who is responsible for that task).	

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		Per the memo, we need to add the details of the previous screen and/or comprehensive evaluation to our MichiCANS screen/eval and NOT ask the individual/ family/caregiver to repeat the details from a previous screening/eval. We do need to update the details as needed due to significant changes. Joelin will be meeting with staff on 10/20/25 to determine the process. Needs review. Log Issue 458 – CPT/HCPS Code updates - There are no updates. Needs review. Log Issue 459 – Respite for Children in Foster Care - No policies requiring updates. We can continue to monitor this issue. Log Issue 461 – Waskul HSW - Karen sent this to the SD Coordinator for review. Will educate the case manager regarding ABD's and RR/CS needs education on Medicaid Fair Hearing aspect regarding HSW enrollees. Needs review. Log Issue 462 – Mcaid/HSW SD - Karen sent this to the SD Coordinator for review. Will educate case managers regarding ABD's and RR/CS needs education on Medicaid Fair Hearing aspect regarding HSW enrollees. Needs review. Log Issue 463 – Mcaid/HSW SD - Karen send this to the SD Coordinator for review. Will educate case managers regarding ABD's and RR/CS needs education on Medicaid Fair hearing aspect regarding HSW enrollees. Needs review. Log Issue 464 – MichiCANS Revision Requirements for Use - There was an issue with updating the electronic record. Needs review. Log Issue 465 – MDHHS Medicaid Policy Manual Update: SED Policy Update - MichiCANS and Children's Therapeutic Foster Family Care - We will have to	Log Issue 465 - Joelin will inform staff about using the different tools.

#	Topic	Key Discussion Points	Action Steps
		use the MichiCANS, CAFAS, PECFAS or DECA tools and Joelin will inform staff of that. Needs review. Log Issue 466 – MDHHS Medicaid Policy Manual Update: Parent Support Parter Coverage as a State Plan Service - Continued to be on hold due to budget constraints because it was considered and unfunded mandate. Continue to monitor. Log Issue 467 – MDHHS Medicaid Policy Manual Update: CWP-updated Coverage - MDHHS CWP changes: Joelin will review memo details with Bay and Arenac Children Leadership Teams. Needs review. Log Issue 472 – CMHA Legislative and Policy Meetings and MI Public Arts - There are no updates to report this month. Needs review. Log Issue 473 – CMHA Legislative and Policy Meetings and MI Public Acts - There are no updates to report this month. Melissa to send to Nicole for review. Needs review. Log Issue 474 – CMHA Legislative and Policy Meetings and MI Public Arts - There are no updates to report this month. Melissa to send to Nicole for review. Needs review. Log Issue 475 – CMHA Legislative and Policy Meetings and MI Public Arts - No updates to report this month. Needs review. Log Issue 476 – Opiod Package - No updates to report this month. Needs review. Log Issue 477 – Mental Health Framework - No updates to report. Needs review. Log Issue 478 – CMHA Legislative and Policy Meetings and MI Public Arts - No updates to report this month. Needs review.	Log Issue 473 - Melissa to send to Nicole for review. Log Issue 474 - Melissa to send to Nicole for review.

#	Topic	Key Discussion Points	Action Steps
		Log Issue 479 – Guardian and Conservator Licensure - No updates to report this month. Needs review. Log Issue 480 – ICSS Recission - This has been rescinded, and new guidance will be issued. Needs review. Log Issue 481 – PDN for EPSDT - Remove existing limits to the PDN benefit and services. Addresses existing limitation to PDN to EPSDT beneficiaries (16hr limit of PDN with 8hr requirement for primary caregivers) adds requirements that PD providers provide skills training and complete a skills checklist with caregivers annually which is effective 11/01/25. Joelin will check with Emily to see if anyone on the Family Supports Team needs education. Needs review. Log Issue 482 – Use of Credentialing/Privilege Forms for HCBS Annual Site Review - No updates to report. Needs review. b) Review of CMHA Update on Legislative and Policy Changes – Melissa went through the Alan Bolter summary memo which is saved in the meeting folder. BABH will not be made whole for FY26. This budget will not be the final product, intense negotiations are still expected, but the trajectory suggests we may be heading toward a budget shutdown. Other standout aspects of this budget include: 4,300 unfilled FTE positions being eliminated, State workers would have to return to work in the office, No taxes on tips or overtime, Gets rid of Strategic Outreach and Attraction Reserve (SOAR) funding, Ban on use of state funds for diversity, equity and inclusion measures, Cuts to the Michigan State Police, and the Department of Health and Human Services budget removed $26.4 million from the Medicaid budget for “assumed reductions related to changes in federal eligibility requirements.” Legislative item: SB 413 - Psychologist Supervision: Senate Bill 413, introduced in June 2025 by Sen. Paul Wojno, makes changes to licensing rules for limited licensed psychologists. It expands representation on the Board of Psychology, loosens certain supervision requirements	Log Issue 481 - Joelin to follow-up with Emily regarding education for the Family Supports Team.

#	Topic	Key Discussion Points	Action Steps
		(currently limited-licensed psychologists must be overseen by doctoral-level psychologists), and clarifies standards for experience, continuing education, and confidentiality. The intent is to reduce barriers to practice and improve access to mental health care, with no expected fiscal impact. The bill was reported out of the Senate Health Policy Committee with a substitute (S-1), passed the full Senate unanimously on September 18, 2025, and is now in the House Health Policy Committee for consideration. BABH is good with this for Flavia. Melissa went through some of the changes on the CMHA Leg.Policy.Scanned Packet 09.24.25 PDF which is saved in the meeting folder. The mental health framework is something we need to be aware of. They are moving the mild to moderate population inpatient crisis stabilization crisis residential services to the health plan. Reducing money from the budget but has to be taken from agency overhead costs and not from the direct care work wages through the agencies which will be difficult for people to manage. Staff can read through this. c) <u>Review of Compliance Updates/Regulatory Education Needed for Staff</u> – Melissa reviewed with the committee in item 2b. d) <u>Process for Ensuring Implementation of Policy Changes</u> – Melissa reviewed with the committee in item 2b. e) <u>Updates from CMHAM ED Forum</u> – Melissa reviewed with the committee in item 2b.	
3.	**<u>Plans, Policies, Procedures, Assessments</u>:** a) Status of Employee Attestations/Time for new ones (end of Summer/early Fall)	a) <u>Employee Attestations</u> – This is started but Melissa is waiting for things to be sent to her for testing so there are results from beginning to end. Make sure the attestation is set the way you want it to be, and you do not have to be the owner of the document. Allow for automatic emails when the questions are answered with regards to new conviction and yes you're aware of potential abuse/fraud.	

#	Topic	Key Discussion Points	Action Steps
4.	**<u>Data/Monitoring/Reports</u>:** 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) Ethics/Recipient Rights/Customer Service Update f) Report on spot checks for compliance for Self Determination g) Corporate Compliance Activity Report – Summary of log **<u>October Reports</u>:** h) Email Security Phishing Drills i) Provider Network Site Review Summary j) Review of Licensure for AFC Homes k) Update Service Code Cheat Sheet and Post to Phoenix Help Tab l) Department of Justice Evaluation	a) <u>Phoenix and Gallery Breach Monitoring</u> – Monthly monitoring was completed; Lynn reported there were no security breaches in Phoenix or Gallery for the month of September. b) <u>Exclusion/Debarment</u> – There were no findings to report this month. c) <u>Monitoring for Unsecured PHI Files</u> – There was no unsecured PHI found this month. d) <u>Security Officer Update</u> – Jesse reported there were 8 false positives that the system picked up, but none were live security incidents. e) <u>Ethics/RR/CS Update</u> – The next Ethics Committee meeting is Wednesday, October 15th. Another ethical issue was brought up about guardians not wanting an individual to know they are terminal and the conflict between caregivers and legally responsible party and physician. There are no Recipient Rights/Customer Services updates this month. f) <u>Report on spot checks for SD</u> – 16 sets of progress notes reviewed with little education required. Enrolled 1 individual in SD with education provided. New budget reports from Stuart Wilson are in effect for everyone that has transitioned to the EVV application through MDHHS. Two individuals have overutilization of CLS budget by 3% and 4% for which the SD Coordinator is developing a plan to keep utilization within the budget. Education provided as a result of the one new Respite staff being onboarded. One termination of the Self-D arrangement due to overutilization and other employee of record concerns. One potential termination due to no utilization over a five-month period. g) <u>Corporate Compliance Activity Report</u> – No trends coming in that haven't already been reported to the committee. There were a few documents mailed out to the wrong person and education was provided. MEV recoupments.	

#	Topic	Key Discussion Points	Action Steps
		h) Email Security Phishing Drills – The phishing test for July sent out 263 recipients and 4 people clicked with 1.52%, 30 people reported which is 11.41%. There has been a very low click rate but the reported rate also went down. The emails seem to get ignored by staff so wondering if they seem too easy or are just being ignored. The emails were sent the end of the month so it might be best for the date to be collected longer since staff are not getting to their emails in a timely manner. Jesse will change the report to collect data for two weeks instead of one week. Melissa is requesting for staff to be educated on phishing emails/logo so nothing is being overlooked. The 'Report Phishing' logo has been changed. The difference of phishing and spam emails is phishing emails try to get you to do something, where spam emails are blasting an advertisement. i) Provider Network Site Review Summary – The Residential site reviews were completed in July. The CLS site reviews were completed in July/August. The Vocational and Primary Care site reviews were completed. The Quality Department is getting ready to start the regional ABA site reviews. May through September is the peak site review timeframe. We are working on MEV's with the exception of regional ABA site reviews. j) Review of Licensure for AFC Homes – There are no issues with the review of AFC Homes licensure. k) Service Code Cheat Sheet – There have not been any updates on the service code cheat sheet in a while. Nothing to report this month. l) DOJ Evaluation – Melissa added this to the agenda. Melissa would like to discuss the Department of Justice Evaluation of the Corporate Compliance System. She sent out a document and would like ideas on how to handle this. Two biggest changes are the use of AI and how to prepare, monitor and audit for that, and Anti-harassment retaliation program policies and procedures that strengthens whistleblower protection. Melissa will schedule a meeting to go through the areas we look at and discuss what is currently	h) Email Security Phishing Drills – Jesse will make a change to the report to collect data for 2 weeks instead of 1 week. Jesse will send out education to staff. l) DOJ Evaluation – Melissa will schedule a meeting to discuss the DOJ Evaluation of the CC System.

#	Topic	Key Discussion Points	Action Steps
		being done, but the members can score outside of the meeting and get the information to Melissa. Melissa would not like the evaluation emailed to her, but staff can email it or print a copy off for Melissa to fill it out herself.	
5.	**<u>Outstanding Items/Other</u>** a) Implementation of EVV	a) The use of credentialing/privileged forms as evidence of staff qualification for home and community-based services for annual site review. This is to clarify the requirements of CMHSP's using credentialing/privileged forms as a primary documentation demonstrates that staff members meets the qualification requirements. The use of credentialing/privileged forms alone does not constitute sufficient evidence to the purposes of external verifications by the site review team. To ensure compliance with Medicaid regulations, the site review team must independently verify the individuals providing home and community-based services under the 1915c waivers and 1915 iSPA meet the applicable qualifications. Examples are; copies of professional licenses and certifications, educational transcripts or diplomas, resumes or CD's detailing relevant experienced verification of training specific to home and community-based services. Other sources of documents supporting staff qualifications as outlined in applicable policy, program manual, or regulations. The credentialing form being used basically includes the resume on there. The form requests where you worked, what the timeframe was, what population you worked with. The change was made after an audit last year. Joelin feels we need to include those questions that are on the credentialing form, on the application for employment when it's a clinical job.	a) Remove from agenda.
6.	**Adjourn**	**The next meeting is scheduled for Monday, November 10, 2025, from 1:00 - 3:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH
BABHA CORPORATE COMPLIANCE COMMITTEE MEETING
Monday, November 10, 2025 (1:00 - 2:20 pm)

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

#	Topic	Key Discussion Points	Action Steps
1.	a) **Agenda**: Review/Additions b) **Meeting Notes**: Approval of October 13, 2025, meeting notes c) **Next Meeting**: December 8, 2025	a) The agenda was reviewed with no additions. b) The October 13, 2025, meeting notes were reviewed and approved as written. c) The next meeting is scheduled for December 8, 2025.	
2.	**State-Federal Laws, MDHHS Notices and Regulations:** a) Review of Log and Subject Matter Expert Report Outs	a) Review of Log and Subject Matter Expert Report Outs – Melissa and the committee reviewed the log (Log can be found at G:\BABH\Corp Comp Regs-Codes-Manuals - CC Committee Law-Reg Mgt Log). Log Issue 419 – WHODAS Announcement - There are no updates to report. We continue to monitor. Log Issue 433 – MSHN CFA & P Next Steps Plan - There are no updates to report. We continue to monitor. Log Issue 441 – EBP for Children's Modifiers - There are no updates to report. Closed.	

#	Topic	Key Discussion Points	Action Steps
		Log Issue 442 – HCBS Updates 2025 - Policies are updated. We can close this issue. Log Issue 443 – Children with IDD and Autism in Child Caring Institutions - We can close this issue. Log Issue 447 – SEDW and MichiCANS/CAFAS update - Continue to monitor till the reg is eliminated. Log Issue 451 – Autism Diagnosis - Continue to monitor. Log Issue 452 – Code Chart Updates - Working through a code-chart issue which is changing H2023 (indiv Y5 modifier for IPS). People on HMP at every vocational provider. Karen is discussing at extended SLT to devise a plan moving forward. There was clarification from MDHHS, so we were instructed to continue to have the providers bill the code from Healthy MI. MDHHS is revising the code chart to include fund source and they are taking recommendations as to how we would like the code chart to be displayed. We can monitor this reg. Log Issue 453 – EVV Clarification - IT is involved but only one staff member is allowed. Jesse will forward the meeting invite on to see if someone else is able to attend along with one IT staff. Needs review. Log Issue 454 – EVV - Outside a Consumer's Home - Needs review. Log Issue 456 – Intensive Crisis Stabilization Services - No further updates. Continue to monitor. Log Issue 457 – MichiCANS Update - Joelin met with staff, and a draft process was developed. Waiting on further information from MDHHS. Needs review.	Log Issue 453 – Jesse will forward the EVV meeting invite on to see if other staff can attend.

#	Topic	Key Discussion Points	Action Steps
		Log Issue 458 – CPT/HCPS Code updates - There are no updates to report. Needs review. Log Issue 459 – Respite for Children in Foster Care - We can continue to monitor this issue. Log Issue 461 – Waskul HSW - There are no updates to report. We will monitor this log. Log Issue 462 – Mcaid/HSW SD - We are not sure how to implement and if we have a choice. There are no updates but there was discussion re: Waskul settlement. Milliman $31/hr for HSW staff, and $7.03/unit rate and these do not match. No follow-up received from MDHHS re: per hour for HSW staff. Waiting further clarification. Minimum wage is increasing in January 2026. Some CMHSPs are interpreting this and how it impacts staff. MSHN reached out regarding the "L" letter. Some CMHSPs are increasing hourly rates as a result of this letter. BABHA is not making these changes until we get clarification from MDHHS. SCCMHA increased their provider rates to pay DCW staff an extra $1/hr. Karen to respond to BHS, Inc. regarding this. For BHS - SCCMHA is not in the same budget situation that BABHA is at and has the additional funding to provide that increase. Waiting on a response from MDHHS. We will monitor this log. Log Issue 463 – Mcaid/HSW SD - There are no updates to report. Waiting on a response from MDHHS. We will monitor this log. Log Issue 464 – MichiCANS Revision Requirements for Use - We can update MichiCans, but we are going through the process to get the assessment specialists access to Care360. Only 2 out of 5 people in the system had a MichiCans assessment. We will monitor this log. Log Issue 465 – MDHHS Medicaid Policy Manual Update: SED Policy Update - We will monitor this log.	Log Issue 462 – Karen to follow-up with BHS.

#	Topic	Key Discussion Points	Action Steps
		Log Issue 466 – MDHHS Medicaid Policy Manual Update: Parent Support Parter Coverage as a State Plan Service - There are no updates to report this month. Continue to monitor. Log Issue 467 – MDHHS Medicaid Policy Manual Update: CWP-updated Coverage - Joelin needs to review and follow-up. We will monitor this log. Log Issue 472 – CMHA Legislative and Policy Meetings and MI Public Arts - There are no updates to report this month. Needs review. Log Issue 473 – CMHA Legislative and Policy Meetings and MI Public Acts - There are no updates to report this month. Melissa to send to Nicole for review. Needs review. Log Issue 474 – CMHA Legislative and Policy Meetings and MI Public Arts - There are no updates to report this month. Melissa to send to Nicole for review. Needs review. Log Issue 475 – CMHA Legislative and Policy Meetings and MI Public Arts - No updates to report this month. Needs review. Log Issue 476 – Opiod Package - No updates to report this month. This can be closed. Log Issue 477 – Mental Health Framework - No updates to report. Needs review. Log Issue 478 – CMHA Legislative and Policy Meetings and MI Public Arts - No updates to report this month. Needs review. Log Issue 479 – Guardian and Conservator Licensure - No updates to report this month. This will be monitored.	Log Issue 467 – Joelin to review and follow-up. Log Issue 473 - Melissa to send to Nicole for review. Log Issue 474 - Melissa to send to Nicole for review.

#	Topic	Key Discussion Points	Action Steps
		Log Issue 480 – ICSS Recission - Reinstated MMP 25-20. Issued a grant for ICSS services. We can close. Log Issue 481 – PDN for EPSDT - No updates to report this month. Needs review. Log Issue 486 – LPH out of State - No updates to report this month. Needs review. Log Issue 487 – MICH - HIDE SNP - No updates to report this month. Needs review. Log Issue 488 – HCBS Final Rule - Behavioral Health - No updates to report this month. Needs review. Log Issue 489 – Expanded Coverage of maternal depression and/or mental health screenings - No updates to report this month. Needs review. Log Issue 490 – OT/ST/PT for Autism Spectrum Disorder – No updates to report this month. Needs review. Medicaid Provider Manual Updates – Joelin went through the updates that were made to the Medicaid Provider Manual effective 10/01/25. The Medicaid Provider Manual Review 10-1-2025 Changes document is saved in the meeting folder. 1. Overview – Added "Psychiatric Residential Treatment Facilities" 2. General Information for Providers – 14.7 Clinical Records: Electronic signatures must be HIPPA compliant and specifically identify and authenticate the individual practicing practitioner. All providers must refer to their specific coverage policy in this manual for additional documentation and signature requirements (added). Physical, occupational, and speech language pathology therapy providers should	

#	Topic	Key Discussion Points	Action Steps
		refer to the Therapy Services chapter of this manual for therapy documentation requirements (revised). 3. Beneficiary Eligibility – 12.1.C. State-Owned and -Operated Facilities/PIHPs/CMHSPs – MDHHS Health Services (revised) 4. 5.1 Program Approval – Health Services was revised throughout the section. 5. 17.1.A. Needs-Based Criteria – Health Services revised throughout this section. 6. Section 2 - Provider Qualifications – LLPs are not eligible to be directly reimbursed by Medicaid (added). Section 1 - General Information – 'not included under the specialty services and supports benefit.' 1.1 MDHHS Approval – 'community-based mental health, substance abuse and developmental disability specialty services and supports.'	
	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) <u>Review of CMHA Update on Legislative and Policy Changes</u> – Nothing to review this month. c) <u>Review of Compliance Updates/Regulatory Education Needed for Staff</u> – Nothing to review this month. d) <u>Process for Ensuring Implementation of Policy Changes</u> – No other updates to report. e) <u>Updates from CMHAM ED Forum</u> – No updates to report this month.	
3.	**<u>Plans, Policies, Procedures, Assessments</u>:** a) Status of Employee Attestations/Time for new ones (end of Summer/early Fall)	a) <u>Employee Attestations</u> – Working on the process to ensure we have a way of sending documentation out to individuals. Melissa reached out to Justeen but needs to reach out to Stephani Rooker. The form will be completed online and can be signed online. If staff are aware of fraud and abuse situations, it automatically gets emailed to Melissa. If staff are aware of	a) Melissa needs to reach out to Stephani Rooker.

#	Topic	Key Discussion Points	Action Steps
		criminal convictions that have been or need to be reported to HR, it automatically gets emailed to Jennifer Lasceski. There is a meeting this week to go over all the details for moving forward.	
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) Ethics/Recipient Rights/Customer Service Update f) Report on spot checks for compliance for Self Determination g) Corporate Compliance Activity Report – Summary of log **November Reports:** h) Verification of Medicaid Services direct operated & contracted service providers i) Plans within 15 Days; Health Care Coordination; Crisis Planning; Medical Necessity j) Checkpoint for Changes that may be needed for Site Review Templates	a) Phoenix and Gallery Breach Monitoring – Monthly monitoring was completed; there were no security breaches in Phoenix or Gallery for the month of October. b) Exclusion/Debarment – There were no findings to report this month. c) Monitoring for Unsecured PHI Files – There was no unsecured PHI found this month. d) Security Officer Update – Jesse reported there were 8 false positives that the system picked up, but none were live security incidents. e) Ethics/RR/CS Update – There's a need for AI to ensure the human element is a part of that. We can't use it to do our work, but there are so many uses for it. AI can assist you through approved means, but it needs to be reviewed as to what is being utilized. There are no Recipient Rights/Customer Services updates this month. f) Report on spot checks for SD – There was one case of overutilization and 1 case of underutilization. There was one termination of a SD agreement as there was no utilization since March 2025. Ben reviewed 18 sets of CLS progress notes and provided education regarding how to improve the documenting of those progress notes and improving what the goal is for the IPOS. There were two sets of respite notes being reviewed and education will be provided as a result of a MEV review where the EVV progress notes were not completed. g) Corporate Compliance Activity Report – There were two incidences of privacy violations that were substantiated by Phoenix message or handout. Education was provided. Allegation of privacy violations; staff was video	

#	Topic	Key Discussion Points	Action Steps
	k) Ability to Pay Compliance Rate	chatting in a group home, but it actually did not take place. Documentation errors in regard to an auth outside of the IPOS effective date. The clinician had a start date of the IPOS and had an auth and later the clinician changed the start date of the IPOS to a later date. It was corrected and staff was educated. OIG issues being addressed, waiting for the results on that. h) <u>Verification of Medicaid Services</u> – Nothing to report this month. i) <u>Plans within 15 Days; Health Care Coordination; Crisis Planning; Medical Necessity</u> – Sarah H. went through the FY25Q3 Summary Report. Bay Direct and MPA had a significant number of plans of service that left the date blank in the 'Update Sent Link.' These blanks are not included in the overall percentage of compliance, but supervisors should be addressing this with staff and monitoring. It is recommended that providers indicate that the IPOS was sent under the Update Sent Link above the IPOS/IPOS Pre-Plan. Continue to use the new Coordination of Care Form that is in PCE. The MDHHS Universal Consent does not meet the standard for coordination of care. There needs to be evidence that coordination occurred including services the consumer is receiving and any psychotropic medications being prescribed. If the consumer does not have a primary care physician, or refuses the coordination of care, the MDHHS form needs to be completed with the "Withdraw" option. Of the quality issues, the trends observed are: No explanation of why the Pre-Plan and Plan of Service were completed on the same day or if the Plan of Service was completed on a different date than what was requested. Blank sections within the Pre-Plan. Back-to-back Interim Plans. No Coordination of Care form. It is recommended that staff double-check their documents to ensure that all areas are completed. j) <u>Checkpoint for Changes for Site Review Templates</u> – The site review templates used to be reviewed and if there were any areas that needed to be added to the site review process that would be done during the CCC meetings. BABH staff would check for health and safety key issues that would put consumers at risk. Every year trainings would be replaced with another training to make sure staff are still being checked for all trainings. If	

#	Topic	Key Discussion Points	Action Steps
		any trainings are being overlooked, BABH staff can look into that during the site reviews. k) <u>Ability to Pay Compliance Rate</u> – The ATP completion rate through August 2025 is 94%, which is up slightly from last month.	
5.	**<u>Outstanding Items/Other</u>** a)	Nothing to address this month.	
6.	**Adjourn**	**The next meeting is scheduled for Monday, December 8, 2026, from 1:00 - 3:00 pm via MS Teams.**	

BAY-ARENAC BEHAVIORAL HEALTH
BABHA CORPORATE COMPLIANCE COMMITTEE MEETING
Monday, December 8, 2025 (1:00 - 2:30 pm)

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

#	Topic	Key Discussion Points	Action Steps
1.	a) **Agenda**: Review/Additions b) **Meeting Notes**: Approval of November 10, 2025, meeting notes c) **Next Meeting**: January 12, 2026	a) The agenda was reviewed with no additions. b) The November 10, 2025, meeting notes were reviewed and approved as written. c) The next meeting is scheduled for January 12, 2026.	b) Log Issue 453 - Melissa will follow-up with Theresa on forwarding the EVV meeting invite. Log Issue 462 – Leslie Thomas from MSHN is waiting on clarification from MDHHS regarding the $31/hourly rate. All CMH's are waiting till there is direction from MDHHS.

#	Topic	Key Discussion Points	Action Steps
2.	**State-Federal Laws, MDHHS Notices and Regulations:** a) Review of Log and Subject Matter Expert Report Outs	a) Review of Log and Subject Matter Expert Report Outs – Melissa and the committee reviewed the log (Log can be found at G:\BABH\Corp Comp Regs-Codes-Manuals - CC Committee Law-Reg Mgt Log). Log Issue 419 – WHODAS Announcement - There are no updates to report. We continue to monitor. Log Issue 433 – MSHN CFA & P Next Steps Plan - There are no updates to report. We continue to monitor. Log Issue 447 – SEDW and MichiCANS/CAFAS update – PCE is piloting with BABH for the CAFAS, LOCUS, API conversions in Phoenix where it's directly connected and is no cost to BABH. This will allow everything to be done in Phoenix with the links. Staff can pilot and test it, and after testing, education can be done. Continue to monitor. Log Issue 451 – Autism Diagnosis - Continue to monitor. Log Issue 452 – Code Chart Updates - Working through a code-chart issue which is changing H2023 (indiv Y5 modifier for IPS). People on HMP at every vocational provider. Karen is discussing at extended SLT to devise a plan moving forward. Removing H2014 as well. Got clarification from the state and we have been instructed to continue to have our providers bill from a code from the paying source. The edit group is talking about editing the code chart to include payor source in order to distinguish payor. In the state's hands right now for revision. The services are still being paid for through HMP. The individuals must be iSPA in order to be paid. Received direction from state. Code chart being updated, a code that can be billed to HMP. We can close out this log. Log Issue 453 – EVV Clarification - IT is involved but only one staff member is allowed. Jesse will forward the meeting invite on to see if someone else is able to attend along with one IT staff. IT Help Desk to forward meeting to	

#	Topic	Key Discussion Points	Action Steps
		Melissa to attend meeting and BABHA rep will be Michele in Finance. Needs review. Log Issue 454 – EVV - Outside a Consumer's Home - Needs review. Log Issue 456 – Intensive Crisis Stabilization Services - No further updates. Updated ICSS certification which is due 01/19/26. Continue to monitor. Log Issue 457 – MichiCANS Update – No updates. Continue to monitor. Log Issue 461 – Waskul HSW - Wait to hear from Karen. Continue to monitor. Log Issue 462 – Mcaid/HSW SD – Wait to hear from Karen. Continue to monitor. Log Issue 463 – Mcaid/HSW SD – Wait to hear from Karen. Continue to monitor. Log Issue 464 – MichiCANS Revision Requirements for Use - No updates. Continue to monitor. Log Issue 465 – MDHHS Medicaid Policy Manual Update: SED Policy Update - No changes made. Continue to monitor. Log Issue 466 – MDHHS Medicaid Policy Manual Update: Parent Support Parter Coverage as a State Plan Service – No updates. Continue to monitor. Log Issue 467 – MDHHS Medicaid Policy Manual Update: CWP-updated Coverage – We can close this log. Log Issue 472 – CMHA Legislative and Policy Meetings and MI Public Arts - There are no updates to report this month. Continue to monitor.	

#	Topic	Key Discussion Points	Action Steps
		Log Issue 473 – CMHA Legislative and Policy Meetings and MI Public Acts SB219 - Has been passed by the Senate but pending House approval. If approved, this will need to be addressed. Continue to monitor. Log Issue 474 – CMHA Legislative and Policy Meetings and MI Public Arts SB 220 - Has been passed by the Senate but pending House approval. If approved, this will need to be addressed. Needs review. Log Issue 475 – CMHA Legislative and Policy Meetings and MI Public Arts SB221 - Has been passed by the Senate but pending House approval. If approved, this will need to be addressed. Needs review. Log Issue 477 – Mental Health Framework - No updates to report. Continue to monitor. Log Issue 478 – Proposed direct payment of PPS to CCBHCs - No updates to report this month. Needs review. Log Issue 479 – Guardian and Conservator Licensure - No updates to report this month. Continue to monitor. Log Issue 480 – ICSS Recission - Reinstated MMP 25-20. Issued a grant for ICSS services. Needs review. Log Issue 481 – PDN for EPSDT - No updates to report this month. Joelin to follow-up. Needs review. Log Issue 485 – Rescission of MMP 25-42, reinstate MMP 25-20 - Needs review. Log Issue 487 – MICH - HIDE SNP – BABHA has not been selected for this and most likely this will not impact us. We can close this log.	Log Issue 481 – Joelin to follow-up.

#	Topic	Key Discussion Points	Action Steps
		Log Issue 488 – HCBS Final Rule - Behavioral Health MMP 25-53 - Person-Centered Planning - requires the beneficiary to direct and lead the process to the extent possible and desired. Choose participants. Guardian should have a participatory role unless decision-making authority is granted to guardian. PCP - must occur timely and support beneficiary. Informed choice of supports and identify provider. Mechanism to request updates in the IPOS. Document alternatives considered but not chosen. Strategies for resolving disputes. Discuss SD service arrangements and how budgets are developed and can be flexibly used to implement services. Summary of methods to implement SD service arrangements. Allowable use of budget dollars to spend on all components of medically necessary service. Discuss all components of medically necessary service - including transportation, activities, staff wages, employer costs training time. Also amount, scope, duration, and frequency of each component. IPOS - Be written format and signed by the beneficiary and their guardian and providers for responsible for the implementation of the IPOS. Be distributed to the beneficiary and any others involved in the IPOS. Must be reviewed at least every 12 months or more frequently if the beneficiary chooses or has a change in service fees. Reflect the services and supports that are important for the beneficiary to meet the identified needs through an assessment of functional need. Include beneficiary preferences for the delivery of the services and supports. Reflect beneficiary choice of the setting where they reside, including non-disability specific settings. The settings considered will be identified by name within the IPOS. Reflect the beneficiaries' strengths, preferences, clinical and support needs as identified through an assessment of functional need. Include identified goals and desired outcomes and plan to reach goals. Reflect services and supports that will assist the beneficiary to achieve goals/identify the providers of those services and supports. Reflect risk factors and measure in place to minimize risks, including back-up plans and strategies. Identify the person/entity responsible for monitoring IPOS. Signature of beneficiary and guardian through informed consent. Include SUD services. Prevent provision of unnecessary/inappropriate services and supports. Employment opportunities, Satisfaction with Living situation. Community Integration. Needs review.	

#	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	<u>Log Issue 489</u> – Expanded Coverage of maternal depression and/or mental health screenings - Staff can be provided information regarding this benefit through the PCP. Needs review. <u>Log Issue 490</u> – OT/ST/PT for Autism Spectrum Disorder - We can close this log, this has been BABH's interpretation for several years. Close this log. <u>Log Issue 491</u> – Proposed Policy 2549-EVV – EVV compliance standards - must come up with a plan to meet the standards. Nicole to coordinate meetings to plan and address. Needs review. <u>Log Issue 492</u> – BPHASA - Home Help Billing for Hospital Admission Date - Effective 01/01/26, MDHHS will no longer mail the BPHASA-2207 to providers. Needs review. b) <u>Review of CMHA Update on Legislative and Policy Changes</u> – Joelle emailed the CMHA Legislative Policy Scanned Packet to the committee for review and Joelin will review and follow-up if necessary. c) <u>Review of Compliance Updates/Regulatory Education Needed for Staff</u> – Nothing to review this month. d) <u>Process for Ensuring Implementation of Policy Changes</u> – No other updates to report. e) <u>Updates from CMHAM ED Forum</u> – No updates to report this month.	b) Joelin will review the CMHA Legislative Policy scanned packet and follow-up if necessary.
3.	**<u>Plans, Policies, Procedures, Assessments</u>:** a) Status of Employee Attestations/Time for new ones (end of Summer/early Fall)	a) <u>Employee Attestations</u> – Katie developed a MS form process. This was sent out to staff by Melissa. The paper form still works. The form was much easier to work with.	a) Melissa P. to send the 2026 form to Amy for current language.

#	Topic	Key Discussion Points	Action Steps
4.	**<u>Data/Monitoring/Reports</u>:** 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) Ethics/Recipient Rights/Customer Service Update f) Report on spot checks for compliance for Self Determination g) Corporate Compliance Activity Report – Summary of log **<u>December Reports</u>:** h) Quality Review of Medical Records	a) <u>Phoenix and Gallery Breach Monitoring</u> – Monthly monitoring was completed; there were no security breaches in Phoenix or Gallery for the month of November. b) <u>Exclusion/Debarment</u> – There were no findings to report this month. c) <u>Monitoring for Unsecured PHI Files</u> – A report needs to be set up since Jesse is no longer at BABH. d) <u>Security Officer Update</u> – The phishing emails have gone out. There is no official report to go out. Out of the 263 emails, 9 clicked on the email, not sure how many reported it as a phishing email. There is a security awareness training coming up on December 16th or 18th. The recommendation is that HR and Finance staff attend. Staff are going through the Information Management Strategic Plan, and it will come out in January. e) <u>Ethics/RR/CS Update</u> – Nothing to report this month. f) <u>Report on spot checks for SD</u> – There were 8 sets of notes with minor quality issues regarding TV or non-goal related activities. Education was provided. Five new staff were educated. There was no evidence of over or under utilization. g) <u>Corporate Compliance Activity Report</u> – There were no Fraud and Abuse allegations. There was a large recoupment on MEV last time and another large recoupment this time, but not to that extent. One recoupment was over $10,000 and another one was for over $5000. h) <u>Verification of Medicaid Services</u> – This is reported at the Leadership meeting so it would be redundant to share the results here. The reporting schedule has been adjusted, so the data will be reported at the CCC meeting first, and then at the Leadership meeting if need be starting next month. Nothing new to share this month.	

#	Topic	Key Discussion Points	Action Steps
5.	**<u>Outstanding Items/Other</u>** a)	Nothing to address this month.	
6.	**Adjourn**	**The next meeting is scheduled for Monday, January 12, 2026, from 1:00 - 3:00 pm via MS Teams.**	

CMS Office of Inspector General Work Plan 2026

Medicaid Managed Care Early and Periodic Screening, Diagnostic, and Treatment Behavioral Health Services

Mental health in childhood includes reaching developmental and emotional milestones and learning healthy social skills and coping skills for when problems arise. Medicaid's mandatory early and periodic screening, diagnostic, and treatment (EPSDT) benefit requires that children under age 21 who are enrolled in Medicaid receive all medically necessary services, including behavioral health services, which include services for mental and substance use disorders. Many States include coverage of behavioral health services for children and youth in their Medicaid State plans and through various Medicaid managed care waivers. We will determine the extent to which children enrolled in Medicaid received EPSDT medical screenings and, if diagnosed with a behavioral health condition, whether behavioral health treatment services were provided. We will also review whether States and managed care organizations met Federal and State requirements for providing EPSDT behavioral health services. – Estimated FY for Project Completion – 2027

Medicaid Managed Care Organizations' Denials

The State Medicaid agency and the Federal Government are responsible for the financial risk for the costs of Medicaid services. State Medicaid agencies contract with managed care organizations (MCOs) to ensure that beneficiaries receive covered Medicaid services. The contractual arrangement shifts the financial risk from the State Medicaid agency and the Federal Government to MCOs, which can create an incentive for MCOs to deny beneficiaries' access to covered services. Our audits will determine whether Medicaid MCOs complied with Federal requirements when denying access to requested medical and dental services, behavioral health services, and associated drug prescriptions that required prior authorization. – Estimated FY Completion – 03/2026

BAY ARENAC BEHAVIORAL HEALTH

Activity Report for Corporate Compliance Committee

FY26 Q1 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
12/03/2025	Audit - Scheduled	Fiscal Intermediary	Stuart Wilson	During the scheduled audit, BABHA reviewed 142 Claims, 4 claims were invalid.	H2015	142	4	Multiple	Multiple	$19,755.28	Yes	No	n/a	$99.92	Closed	11/14/2025
12/03/2025	Audit - Scheduled	Community Living Service Provider	MCSI	During the scheduled audit, BABHA reviewed 266 Claims, 1 claims were invalid.	H2015	266	1	1	1	$3,988.66	Yes	No	n/a	$11.96	Closed	11/26/2025
12/03/2025	Audit - Scheduled	Community Living Service Provider	PAO	During the scheduled audit, BABHA reviewed 278 Claims,36 claims were invalid. Funds have been recouped.	H2015	278	36	Multiple	Multiple	$35750.75	Yes	No	1/16/2026	$5,416.98	Closed	11/26/2025
12/03/2025	Audit - Scheduled	Community Living Service Provider	Arnold Center	During the scheduled audit, BABHA reviewed 9 Claims, 4 claims were invalid. Funds have been recouped. No potential fraud/abuse suspected.	H2015	89	4	Multiple	Multiple	$9,489.00	Yes	No	n/a	$447.52	Closed	11/14/2025
12/03/2025	Audit - Scheduled	Community Living Service Provider	Do - All, Inc. - CLS	During the scheduled audit, BABHA reviewed 328 Claims, 1 claims were invalid. Funds have been recouped. No potential fraud/abuse suspected.	H2015	328	1	1	1	$5,046.74	Yes	No	n/a	$73.89	Closed	11/07/2025
11/03/2025	Audit - Scheduled	Community Living Service Provider	New Dimensions	During the scheduled audit, BABHA reviewed 246 Claims, 6 claims were invalid. Funds have been recouped.	H2015	246	6	Multiple	Multiple	$6,116.53	Yes	No	n/a	$101.34	Closed	11/07/2025
10/22/2025	Audit - Scheduled	Behavioral Health/Analyst	Game Changer Pediatric Therapy LLC, Inc - ABA/LIP	During the scheduled audit, BABHA reviewed 109 Claims, 5 claims were invalid. Funds have been recouped.	97155, 97156	109	5	Multiple	Multiple	14,140.41	Yes	No	n/a	$775.00	Closed	10/31/2025
10/22/2025	Audit - Random	Behavioral Health/Analyst	Game Changer Pediatric Therapy Services, LLC - ABA	During the random sample scheduled audit, BABHA reviewed 172 Claims, 5 claims were invalid. Funds have been recouped.	97153, 0373T	172	5	Multiple	Multiple	28,446.01	Yes	No	n/a	$871.48	Closed	10/31/2025
10/01/2025	Audit - Scheduled	Behavioral Health/Analyst	Flourish Therapy	During the scheduled audit, BABHA reviewed 61 Claims, 3 claims were invalid. Funds have been recouped.	97155	61	3	Multiple	Multiple	$12330.00	Yes	No	n/a	$360.00	Closed	10/10/2025
										$44,396.21				$6,914.65		

Corporate Compliance Plan

~~2025~~2026

APPROVALS

Corporate Compliance Committee: 1/15/25
Strategic Leadership Team: 1/28/25
Leadership Team: 2/4/25
Board Corporate Compliance Committee:2/6/25
Full Board Approval Date: 2/20/25

Contents

Statement of Purpose

It is the policy of the Bay Arenac Behavioral Health Authority (BABHA) Board of Directors to have a Corporate Compliance (CC) Plan in effect, as stated in BABHA policy and procedure C13-S02-T18 Corporate Compliance Plan. The CC Plan is in place to guard against fraud and abuse, and to ensure that appropriate ethical and legal business standards and practices are maintained and enforced throughout BABHA[1].

The BABHA Corporate Compliance Plan ensures the integrity of the system in which BABHA operates and the culture in which it is served is maintained at the highest standards of excellence, with a focus on business and professional standards of conduct compliant with federal, state and local laws, including confidentiality, compliance with reporting obligations to the federal and state government, and promotion of good corporate citizenship, prevention and early detection of misconduct.[2]

The BABHA Corporate Compliance Plan is reviewed and updated annually.

Definitions

Abuse: Practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the payor, or in reimbursement for services that are not medically necessary or failure to meet professionally recognized standards for healthcare.

Contracted Service Provider means an individual who has a contractual agreement with BABHA to provide behavioral health clinical or administrative goods or services to BABHA or its consumers, or an organization with such a contract.

CEO means Chief Executive Officer of Bay-Arenac Behavioral Health Authority.

CC is an abbreviation for Corporate Compliance.

CCO or CC Officer means Corporate Compliance Officer.

Fraud: An intentional deception or misrepresentation by a person that could result in unauthorized benefit to him/herself or some other person. Includes any act that constitutes fraud under applicable Federal or State laws.

Individual Practitioner means a licensed professional engaged with BABHA through either an employment contract or as a Contracted Service Provider, providing health care services for consumers consistent with their licensure.

Privacy Officer means the individual assigned the responsibility for overseeing the ongoing development of privacy related operations.

PHI is an abbreviation for Protected Health Information, which is comprised of several types of confidential consumer treatment information which is defined as protected under the Healthcare Improvement Portability and Accountability Act.

Security Officer means the individual assigned the responsibility for overseeing the ongoing development and management of security related technological operations.

[1] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)
[2] CARF Standards: Section 1 Aspire to Excellence: E Legal Requirements: Standard 1

Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, considered not caused by criminally negligent actions, but rather the misuse of resources.

Policies, Procedures, Standards of Conduct

BABHA has established written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with applicable Federal and State standards, including but not limited to the False Claims Act (31 USC 3729-3733, the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005), the Michigan Whistleblowers Protection Act (PA 469 of 1980) and the federal Whistleblower Protection Act of 1989, 5 U.S.C. 2302(b)(8)-(9).[3]

The policies have been approved by the BABHA Board of Directors in accord with Federal Program Integrity requirements, the MI Dep't of Health and Human Services Medicaid Manual and the Medicaid Managed Specialty Supports and Services Contract.

Regulatory Compliance

BABHA maintains a list of Federal and State laws and regulations, and contractual requirements with which the organization must comply (see attachments). The list is maintained on the BABHA group drive by the CCO. The BABHA Corporate Compliance Committee has a regular monitoring process for review and disposition of new and changing regulatory requirements. The membership of the BABH Corporate Compliance Committee facilitates communications and preparations for compliance with new and revised regulatory and contractual requirements. The Director or Health Care Accountability attends the CMHA Legislative and Regulatory Meeting and updates the Corporate Compliance Committee on legislative proposals that may impact service delivery and operations.

—Agenda items on the Leadership Meeting have been added to include regulatory items to ensure that the full integration of changes are consistently being adopted. Policy and Procedure changes are presented to the staff through Relias and for Providers they are posted on the website. At the Provider Network and Quality Management Committee (PNOQMC) a reminder of the policies that have been updated is included -on the Agenda.

Medical Records

BABHA maintains an electronic record keeping system to ensure documentation of services delivered is maintained in a manner that is consistent with the provisions of the Michigan Medical Services Administration Policy Bulletins and the Michigan Medicaid Manual, and appropriate state and federal statutes. BABHA requires clinical service delivery records to document the quantity, quality, appropriateness and timeliness of services provided. Clinical contracted service providers (including Individual Practitioners) are required to either utilize the BABHA electronic medical record keeping system or establish and maintain a separate comprehensive individual service record system. At a minimum clinical contracted service providers are required to scan key documents into the BABHA electronic health record (EHR).

BABHA policy and procedure C04:S10:T01 Clinical Documentation, C13-S01-T20 Designated Record Set, and C04:S10: T02 Signatures outlines specific BABHA record keeping standards. BABHA policy and procedure C13-S02-T03: Document Retention and Disposal outlines BABHA's strategies to comply with retention schedules in place by the State of Michigan.

[3] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(i)

Prohibited Affiliations[4]

BABHA has an active program to protect the organization from knowingly having a relationship with individuals debarred, suspended or otherwise excluded from participation in Federal procurement activities and healthcare programs such as Medicare.[4] The program also ensures BABHA does not knowingly have relationships with individuals excluded from participation in Medicaid, or any other state healthcare program.

BABHA policy and procedure C13-S02-T11 Prohibited Affiliations and Backgrounds outlines BABHA's monitoring and response program. The program covers BABHA's Board of Directors, CEO and employees, as well as contracted service providers (including Individual Practitioners), as well as selected vendors and suppliers.

Federal exclusion/ debarment registries are checked monthly for BABHA Board of Directors, Officers (i.e., senior managers), employees, individual professionals and clinical contracted service provider organizations, CEO's and key prescribers. BABHA also checks selected non-clinical vendors with significant transactions with BABHA and declared co-owners of contracted service provider organizations as appropriate.

BABHA contracts with a vendor to facilitate reviews of the registries monthly. BABHA requires providers to declare ownership and control interests and monitors these individuals concurrently with the providers and BABHA personnel.

Members of the BABHA Board of Directors, the BABHA CEO and new employees sign attestations of their compliance with these requirements and commit to notifying BABHA of any changes in status including criminal convictions. BABHA also requires employees to complete an annual attestation which confirms they have not acquired a criminal conviction during their employment that has not been reported to Human Resources.

Clinical contracted service provider organizations are required to perform initial and monthly checks for exclusion/debarment and criminal convictions for their employees and relevant subcontractors, if any. BABHA confirms these practices are in place during site reviews of contracted clinical service providers.

Criminal background checks are completed for BABHA employees upon hire and every two years thereafter. Abuse registry checks are completed for BABHA employees serving children. Contracted service providers are required to comply with ~~the criminal~~criminal background checks and abuse registry checks for providers that serve children. Specialized residential providers are further required to obtain fingerprint-based background checks.

Privacy and Security

BABHA has policies and procedures in place to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) for confidentiality of health care records, as well as 42 CFR PART 2 for confidentiality of any substance abuse treatment program records maintained by BABHA, and state laws governing the confidentiality of mental health and substance use disorder (SUD) treatment records and HIV/AIDS information. The policies and procedures cover protected health information (PHI) and substance use disorder treatment information generated, received, maintained, used, disclosed or transmitted by BABHA and selected contracted service providers (including Individual Practitioners).

BABHA's Agency Manual Chapter 9, Information Management, contains the organization's HIPAA Security, Transaction and Code Set Rule compliance strategies. Policies regarding Artificial Intelligence (AI) – transcribing, recording and Generative AI software the agency may utiliz4e are also contained within the Agency Manual within the Information Management Chapter. Privacy and confidentiality strategies are addressed in Chapter 13, Corporate Compliance, Section 1.

[4] Managed Care Rules: 438.610 Prohibited Affiliations

BABHA's policy and procedure C13-S01-T18 Business Associates outlines which types of service providers, including health care service providers, and non-health care vendors and suppliers, who meet the definition of a Business Associate (BA) of BABHA. The BABHA Contract Manager and Finance Assistant work with the Privacy Officer to ensure BA Agreements are in place where required.

Standards of Conduct[5]/ Operating Philosophy and Ethical Guidelines

BABHA has written Standards of Conduct and Operating Philosophies/Ethical Guidelines for employees and Individual Practitioners to clearly delineate BABHA's institutional philosophy and values concerning compliance with the law, government guidelines and ethical standards applicable to the delivery of behavioral health care.

The BABHA Director of Human Resources prepares and reviews/ revises the Standards of Conduct/ Operating Philosophy and Ethical Guidelines, as appropriate. The Standards of Conduct/Operating Philosophy and Ethical Guidelines are submitted to the Strategic Leadership Team, CEO and BABHA Board for consideration and approval.

A copy of the Standards of Conduct/Operating Philosophy and Ethical Guidelines is distributed to all employees as part of the new employee orientation process and is also available to staff on the BABHA intranet site. It is posted for contracted service providers through the provider section of the BABHA website. Changes to the Standards are communicated to all staff via the policy/ procedure/ plan educational system.

Ethics Committee

BABHA operates an Ethics Committee chaired by the Recipient Rights/Customer Service Manager, which is a sub-committee of the BABHA Corporate Compliance Committee. The Ethics Committee is responsible for serving as a forum for the review and analysis of ethical dilemmas. The Committee also oversees BABHA standards for ethical conduct, including establishing policies and procedures to enhance the organization's responsiveness to internal and external customers with respect to the ethical dimensions of managing, coordinating, and providing community-based behavioral health services. The Ethics Committee is responsible for promoting staff understanding of ethical concerns in contemporary behavioral health care, including ongoing education.

The Ethics Committee is comprised of representatives from the major departments and programs of BABHA, as well as subject matter experts, internal and external to the organization. The Ethics Committee reports through the Corporate Compliance Committee. The Recipient Rights/Customer Service Manager has direct access to the CEO to address issues that overlap with personnel management and the Corporate Compliance Officer in the event of ethics issues that coincide with corporate compliance concerns.

The Ethics Committee meets twice per year, with additional meetings called on an ad hoc basis as needed for case review. Employees can submit an ethical question for consideration by the Committee. An Ethicist from a local university is on contract for consultation with the Committee as needed.

Duties of the Committee include but are not limited to:

- Assisting with annual updates of the BABHA Standards of Conduct/Operation Philosophy and Ethical Guidelines as appropriate.
- Concerns raised by staff and leadership of BABHA that are not determined to involve regulatory compliance will typically involve a conflict of interest or ethical dilemma. The Ethics Committee is responsible for serving as a forum for review and analysis of ethical dilemmas. The Committee analyzes

[5] Managed Care Rules: 438.608 (a)(1)(i) Program Integrity Requirements

ethical dilemmas, consults with an Ethicist as necessary, and provides feedback/ recommendations to the individual who submitted the issue for consideration.

- Assisting the Director of Human Resources with overseeing BABHA standards for ethical conduct, including establishing policies and procedures to enhance the organization's responsiveness to internal and external customers with respect to the ethical dimensions of managing, coordinating, and providing community-based behavioral health services.
- The Ethics Committee is responsible for promoting staff understanding of ethical concerns in contemporary behavioral health care, including ongoing education.

Program Integrity Requirements for Clinical Contracted Service Provider Organizations

BABHA requires clinical contracted service providers to adhere to Federal and State requirements regarding guarding against fraud and abuse, and complying with applicable regulatory requirements and standards, as outlined in BABHA policy and procedure C13-S02-T16 False Claims.

Clinical contracted service provider organizations are required to implement and maintain written policies, procedures and standards of conduct, appropriate to the type and scale of the Provider agency, that articulate the organization's commitment to comply with federal and state program integrity requirements, including provisions for monitoring for exclusion and debarment from participation in state and federal health care programs.[6]

The required program integrity elements are communicated to the providers through contractual requirements. Compliance by contracted service providers is monitored by BABHA during site reviews.

Compliance Officer and Compliance Committees

The BABHA CEO has designated a Compliance Officer[7]. The BABHA Board of Directors has established a regulatory Compliance Committee and the CEO has a regulatory Compliance Committee at the senior management level.[8]

Corporate Compliance Officer

The CEO appoints the Corporate Compliance Officer. The CC Officer has the authority to address compliance concerns directly with the Chair of the BABHA Board of Directors, and the ~~Health Care Improvement and~~Corporate Compliance Committee of the Board of Directors. The CC Officer has direct access to the BABHA Chief Financial Officer for consultation, as well as to specialized legal counsel of BABHA.

The CC Officer is responsible for the following:

- Developing and operating the CC Program; reviewing/ revising the CC Plan annually as necessary to meet changes in the regulatory and business environment;
- Reviewing and revising as necessary BABHA policies, procedures and practices governing corporate compliance, privacy and confidentiality; and ensuring the Security Officer reviews and revises as necessary BABHA policies and procedures governing security;
- Chairing the CC Committee or appointing a designee; and maintaining meeting records;

[6] Managed Care Rules: 438.608(a)(6)
[7] Managed Care Rules: 438.608(a)(1)(ii)
[8] Managed Care Rules: 438.608(a)(1)(iii)

- In consultation with the CC Committees as needed, preparing and implementing an education plan, to include Board members, senior management, all other employees and contracted service providers (including Individual Practitioners), as appropriate; including performance of new employee orientation;
- Identifying new Federal and State Acts, Regulations or Advisories relative to corporate compliance, fraud and abuse prevention, privacy, security and identity theft for which BABHA must comply; monitoring the environment to identify other regulatory requirements that may impact BABHA; reviewing, analyzing and assisting with the development of strategies to comply.
- Maintaining effective lines of communication, including monitoring and responding to calls received on the Corporate Compliance Hot-Line or via other methods of communication;
- In conjunction with the CC Committee, establishing a system and schedule of routine monitoring activities (see Attachments for Monitoring Plan) and ensuring follow-up activities are completed;
- In conjunction with the CC Committee, ensuring HIPAA Security and Fraud/ Abuse compliance risk assessments are conducted in accord with the monitoring plan and findings are addressed;
- In conjunction with the CC Committee, complete an evaluation of the effectiveness of the compliance program;
- Promptly investigating potential compliance and privacy issues discovered through monitoring/auditing activities and disclosures by employees and contracted service providers (including Individual Practitioners); includes mitigation and remediation; maintaining investigative files; in conjunction with the Corporate Compliance Committee, determining if root causes analyses are warranted; ensuring the Security Officer promptly investigates, mitigates, remediates and reports as required any security incidents;
- Working with the CFO to ensure prompt repayment of any overpayments identified through the corporate compliance program, including suspension of payments;
- Communicating reportable fraud/ abuse issues to payers, and federal and state authorities prior to investigation as required; act as liaison to payers and state authorities for compliance and privacy issues, and oversee the activities of the Security Officer in doing the same for security issues;
- Maintaining a log of compliance issues, whether substantiated, and remedial actions;
- Maintaining breach logs and reporting to HHS and regional/state payers as required on an annual basis;
- Working with legal advisers as necessary to develop and issue HIPAA Privacy Notices for use by BABHA Clinical programs and contractors;
- Working with legal advisers (as necessary) and BABHA contract management to develop and issue Business Associate Agreements;
- Ensuring disclosures of protected health information are logged by Medical Records staff as required by HIPAA; and
- Prepare and complete reports to the CEO, BABHA Board of Directors, Mid-State Health Network, and Corporate Compliance Committee on the activities of the CC Program.

Corporate Compliance Committees[9]

The BABHA Board of Directors Corporate Compliance Committee (BCCC) is the compliance committee of the Board. BCCC's duties include overseeing the BABHA Corporate Compliance Program by reviewing and approving the BABHA Corporate Compliance Plan and receiving regular reports of organizational activities to guard against fraud and abuse. The Corporate Compliance Officer formally reports on Corporate Compliance Program

[9] Managed Care Rules: 438.608(a)(1)(iii)

activities to the BABHA Board of Directors at least once per year with quarterly updates provided at each meeting.

The BABHA Board of Directors also has an Audit Committee, which helps ensure the fiscal integrity of the organization through internal controls and practice up to and including inspection of disbursements, paid health care claims and financial statements. The Committee also arranges for an independent audit, review the Financial Statement and Compliance Audits and recommend appropriate actions.

In addition to the Board Committees and the Ethics Committee, BABHA operates an internal Corporate Compliance Committee (CCC) comprised of members of senior management and key subject matter experts. The Committee is chaired by the Corporate Compliance Officer. The BABHA Finance Manager backs up the CC Officer as Chair of the CCC if needed. The Corporate Compliance Committee is responsible for all matters related to the legal and regulatory requirements of BABHA operations as it relates to contractual compliance, HIPAA privacy and security, and guarding against fraud and abuse of state and federal healthcare funds.

Duties of the Committee include but are not limited to the following:

- Assist the CC Officer in the ongoing development and operation of the CC Program,
- Perform fraud and abuse risk assessments and compliance program evaluations, identify focus areas, conduct any necessary audits and self-review, and develop compliance program improvement priorities,
- Assess existing policies and procedures in the identified risk areas for incorporation into the CC Program and develop new policies and procedures as needed,
- Assist the CC Officer with systems level remediation and mitigation of substantiated compliance issues, where appropriate, including performing informal root cause analyses where warranted,
- Assist in the monitoring of new laws and regulations and the development of strategies to comply,
- Assist with the review of internal and external monitoring and auditing activities to ensure that efforts are appropriate to provide assurance of compliance,
- Ensure routine monitoring occurs as scheduled and findings are responded to, as assigned to the Committee via the Corporate Compliance Plan.

Committee membership is comprised of the following staff roles within the organization:

- HIPAA: Security and Privacy Officers
- Finance (including Claims) Management: Chief Financial Officer, and Finance Manager (who also acts as the back-up the CCC Chair)
- Regulatory Compliance and Accreditation: Corporate Compliance Officer, Quality Manager, Medical Records Associate(s) (ad-hoc member(s)), Quality/Compliance Coordinator(s) (ad-hoc member(s)) and Secretary (Committee Recorder)
- Contracting: Contract Manager
- Clinical Practices: Directors of Integrated Care, Clinical Practice Manager (ad-hoc member)
- Ethics and Personnel: Director of Human Resources
- Recipient Rights: ~~Customer Service/~~ Recipient Rights/Customer Service Manager

The Committee reports through the BABHA Corporate Compliance Officer to the Medical Director and CEO. The CC Committee meets 10-12 times per year. Meeting records are maintained by the Secretary member of the Committee.

Training and Education

BABHA has established an effective training and education program for its Board of Directors, senior managers, Compliance and HIPAA officers, employees, and clinical contracted service providers (including Individual Practitioners)[10]. All training is documented via employee training records, various meeting records and Corporate Compliance Activity Reports. The current BABHA Corporate Compliance Education Plan is attached to this document. The Corporate Compliance Officer maintains a Corporate Compliance Education Log, which is also attached.

Training of personnel and contracted service providers is required under the Deficit Reduction Act of 2005 Section 6032: Employee Education About False Claims Recovery. BABHA is required to attest to the State each year that training has been completed.

Board of Directors

The Board of Directors receives education on corporate compliance requirements annually, including information about fraud and abuse, conflict of interest, and how to report compliance concerns. The Board of Directors does review and approves the Corporate Compliance Plan each year. Contemporary compliance issues, such as new Medicaid and Medicare regulations, Office of Inspector General work plans, and federal/state compliance program standards are included on the Board of Directors Corporate -Compliance Committee agendas as warranted to keep the members abreast of changes in the compliance environment.

Employees[11]

New employees are oriented to the compliance program and privacy/ confidentiality requirements within 30 days of hire. All employees receive an annual corporate compliance and privacy/ confidentiality training update. Training content includes Standards of Conduct/Operating Philosophy and Ethical Guidelines and appropriate reporting mechanisms (e.g., the Corporate Compliance "Hot-line", etc.). Employee orientation and training updates also cover the False Claims Act (31 USC 3729-3733), the elimination of fraud and abuse in Medicaid provisions of the Deficit Reduction Act of 2005; and the Michigan Medicaid False Claims Act (PA 72 of 1977, as amended by PA 337 of 2005), the federal False Claims Act (31 U.S.C. §§ 3729–3733) and the Michigan Whistleblowers Protection Act (PA 469 of 1980). Training content is updated regularly to reflect relevant content from the BABHA Corporate Compliance Plan, and any systems issues identified during fraud, abuse and privacy investigations.[12] The Security Officer likewise incorporates security related findings into the annual BABHA Information Management Strategic and Operational Plan.

As compliance or privacy/ confidentiality concerns arise throughout the year or as they are identified as through priorities defined in the BABHA CC Plan, educational communications are issued to employees. This includes intranet site announcements, and discussion of topics at Strategic Leadership Team meetings, or Agency Leadership Meetings.

Supervisors

BABHA has determined the compliance program would be strengthened by providing specialized program integrity training for supervisors and managers. This training is in addition to the standard employee orientation and training. New Supervisiors are trained by the Director of Health Care Accountability to outline their role in

[10] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(iv)
[11] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7
[12] CARF Section1: Aspire to Excellence; Section A Leadership; Standard 7 (requires training of personnel on the corporate compliance plan)

compliance. In addition, periodic training for supervisors has been sent out via email throughout the year and the CC Officer has met in person with new Supervisors when they are hired. The training focus is on what supervisors should be watching for as indicators of the presence of potential fraud or abuse, and the importance of monitoring processes for regulatory compliance.

Regulatory compliance has also been added to BABHA Leadership meeting agendas to ensure supervisors and managers are kept up to date on compliance issues and regulatory changes.

Contracted Service Providers[13]

Individuals (including Individual Practitioners) who are contracted with BABHA to provide clinical services receive an orientation to the BABHA Compliance Program and the Operating Philosophy and Ethical Guidelines. They sign an attestation to the completion of the orientation.

Clinical contracted service provider organizations are kept abreast of relevant current risk areas and trends as necessary via email communications and discussion during periodic primary, Community Living Support (CLS)/residential, autism provider, and vocational provider meetings. An annual training is completed by the BABHA Corporate Compliance Officer for primary clinical contractors, vocational, autism and CLS/residential service providers.

The following training and resource materials on Corporate Compliance, Privacy/Security and other topics, as well relevant BABHA policies and procedures are posted to the BABHA website in a Provider section for access by contracted service providers:

- Corporate Compliance Plan
- Compliance Hotline Poster for Providers
- Operating Philosophy and Ethical Guidelines
- Corporate Compliance, Privacy and Security Policies and Procedures
- Provider Training on Corporate Compliance for Subcontracted Mental Health Service Providers
- Provider Training on Privacy and Security for Subcontracted Mental Health Service Providers
- Documentation Requirements Guide

Corporate Compliance Officer, Security Officer, Privacy Officer, CC Committee

The Corporate Compliance Officer, HIPAA Officers and various other senior managers and key staff of BABHA subscribe to Federal and State list-serves which provide alerts regarding emerging regulatory requirements. BABHA also takes advantage of available governmental guidance and technical websites for the operation of Medicaid and Medicare program integrity programs and maintenance of HIPAA regulatory compliance.

BABHA contracts with legal counsel with extensive healthcare experience and seeks opinions and other educational guidance regarding general compliance and privacy issues.

BABHA is a member of the Health Care Compliance Association and receives the newsletters and magazine. The Officers attend conferences and webinars on compliance, security, and privacy concerns as available and if cost effective. BABHA has identified the following training opportunities:

- US Dep't of Health and Human Services Office of Inspector General Compliance Resource Portal Provider Compliance Resources and Training materials
- Health Care Compliance Association web and regional conferences
- The Community Mental Health Association of MI, Improving Outcomes Conference sessions

[13] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 6

BABHA is a member of the Regional Compliance Officers group for MSHN which offers a venue for communication of MI Office of Health Services Inspector General guidance regarding preventing and detecting fraud and abuse.

The Corporate Compliance Committee stays informed by reviewing changes to program integrity regulations for Medicaid, Medicare and other state health care programs, federal Office of Inspector General's Compliance Work Plans and federal program integrity guidance materials.

Lines of Communication

Effective lines of communication are in place between the compliance officer and the organization's employees[14]. BABHA operates a hot-line for consumer, employee, provider and contracted service provider reporting of compliance and privacy/ security concerns. BABHA's policy and procedure C13-S02-T01 Internal Reporting (Hot-LINE) describes the purpose and procedure for the hot-line and other reporting provisions.

The main BABHA Corporate Compliance Hot-Line Poster is attached to this plan. A customizable version is available for contracted service providers. The poster includes Mid-State Health Network and state MDHHS Office of Inspector General (MIOHSIG) contact information as required. The poster is displayed in all BABHA waiting, conference and break rooms

Employees and contracted service providers (including Individual Practitioners) have direct access to the BABHA Corporate Compliance Officer via phone, email and in person, both for consultation regarding compliance strategies and for reporting of suspected fraud and abuse, or privacy and security concerns.

In 2020, BABHA added an annual employee attestation, where they indicate whether or not they are aware of potential fraud or abuse, and whether they had any criminal convictions. Employees are further asked if they have reported these issues in accordance with BABHA policies. This includes Individual Practitioners.

Compliance activity is reported to the BABHA Board of Directors, as well as the Corporate Compliance Committee, which includes representatives from senior management, finance, contracts, medical records, quality, information management, human resources, and clinical programs. The BABHA Corporate Compliance Officer attends Agency Leadership and contracted service provider meetings (vocational, residential/CLS, primary, and Autism providers) to receive and respond to compliance related issues.

Information regarding the Corporate Compliance Hot-Line and how to contact the BABHA Privacy Officer, MSHN Privacy Officer and MIOHSIG are included in the handbook provided to individuals receiving BABHA services. An interpreter is made available to individuals with limited English proficiency as requested.

BABHA policy and procedure C13-S02-T02 Non-Retaliation reflects BABHA's commitment to ensuring individuals reporting fraud/abuse or privacy/ security concerns are not subject to retaliation or retribution.

Disciplinary Guidelines

BABHA's corporate compliance related standards are communicated to staff and clinical contracted service providers (including Individual Practitioners) through the Corporate Compliance education program outlined in this plan, including disciplinary guidelines and provisions for adverse contract action[15].

[14] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(v)
[15] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(vi)

Employees

In addition to the corporate compliance and privacy/ confidentiality education afforded new and existing employees, employees are informed of expectations for their compliance with regulatory requirements and standards via document-specific education on new and revised BABHA plans, policies, and procedures. This includes education on the Corporate Compliance Plan, corporate compliance policies and procedures, and privacy and security policies and procedures.

Employees are educated at least annually regarding BABHA compliance, privacy and security related requirements, which include the obligation to report suspected fraud, waste, abuse and privacy/security violations, to report criminal convictions, as well as the protections available to individuals who are whistleblowers.

Employees directly responsible for fraud, abuse, and privacy/security violations, as well as those who assisted, facilitated or ignored a violation, are subject to disciplinary action. Disciplinary action is commensurate with the severity of the offense and occurs at the discretion of the CEO in consultation with the Director of Human Resources and the involved supervisor. All disciplinary action is applied in accordance w/ BABHA human resources policies/ procedures.

The following are examples of the types of potential disciplinary action, which are communicated to staff:

- Employees may be suspended with or without pay during an investigation
- For minor violations employees may be subject to verbal/written warnings
- For more severe violations employees may be subject to significant disciplinary action including suspension and/or termination of employment
- Considerations may include:
    - Inaccurate or incomplete documentation
    - Unsigned or missing documentation
    - Deliberately fraudulent service documentation
    - Failure to maintain continuous licensure, registration, or certification
    - Falsification of licensure or certification
    - Failure to adhere to BABH policies and procedures
    - Intent to defraud
- Discipline may also be applied to employees who assisted, facilitated, or ignored a fraud and abuse, including supervisory and management staff

Provisions for disciplinary action are outlined in the BABHA Agency Manual and the BABHA Employee Handbook. Each employee receives a copy of the Employee Handbook at the time of hire. The handbook and all agency policies, procedures and plans are posted on the agency intranet site, accessible by all employees. Standards of conduct and disciplinary guidelines are covered in employee compliance and privacy/security related trainings.

See the section on External Reporting for discussion of potential additional adverse action against licensed and registered professionals.

Contracted Service Providers

The contract boilerplate language outlines contract remedies for failure to comply with the terms of the contract, such as substantiated privacy/confidentiality or security violations, and fraud or abuse involving state or federal healthcare funds, as follows:

- Require a plan of correction together with status reports and/or additional oversight by BABHA;
- Recoupment of payments;
- Suspension or reduction of payments;[16] or
- Termination of the contractual agreement.

Provider trainings on these topics address adverse contract action that may be taken. Individual Practitioner and Organizational Provider re-credentialing includes consideration of past fraud, abuse, privacy and security related investigations.

For purposes of example only, the following is a non-exhaustive list of compliance or performance issues for which BABHA may take remedial action to address repeated or substantial breaches, or patterns of non-compliance or substantial poor performance:

- Reporting timeliness, quality and accuracy;
- Performance indicator standards;
- Repeated site review non-compliance (repeated failure on same item);
- Failure to complete or achieve contractual performance objectives;
- Substantial inappropriate denial of services or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume, but severe impact;
- Repeated failure to honor appeals/grievance assurances;
- Substantial or repeated health and/or safety violations;
- Failure to adhere to training requirements and timelines for completion;
- Failure to complete required documentation for each service provided; and/or
- Failure to comply with prohibitions regarding exclusion, suspension or debarment from state and/or federal health care programs.

Adverse contract action is documented in contract files for each provider by the Finance Department. See the section on External Reporting for discussion of potential additional adverse action against contracted licensed and registered professionals and organizations, including reporting to Medicaid payers and the MI Dep't of Licensing and Regulatory Affairs (LARA).

Monitoring and Auditing[17]

BABHA has an active internal prevention, monitoring and auditing program[18]. The Attachments to this Plan include the current BABHA Compliance Committee Data Monitoring Plan, which define monitoring BABHA's activities. The Monitoring Plan changes frequently based upon reporting timelines, results of ongoing environmental assessment activity and periodic risk assessments, and the availability of information.

BABHA's monitoring program includes methods to verify, by sampling or other methods, whether services that have been represented to have been delivered were received by the individuals whom BABHA intends to serve.[19] BABHA applies the verification process on a regular basis (see BABHA policy and procedure C13:A02:T20 Service Event Verification and Restitution) and participates in twice yearly verification activities by its regional payer. Monitoring activities include but are not limited to:

1. Privacy and Security

[16] Managed Care Rules: 438.608(a)(8)
[17] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7
[18] Managed Care Rules: 438.608 Program Integrity Requirements (a)(1)(vii)
[19] Managed Care Rules: 438.608(a)(5)

a. Electronic Health Record monitoring for use of "break the glass" feature in the role-based security system
b. Security risk assessment (annual)
c. Scan of shared/ group network drives for exposure of PHI
d. Monitoring for security breaches
e. Email phishing drills

2. Fraud and Abuse
    a. Fraud and abuse risk assessment (Triennial)
    b. Annual financial compliance audits
    c. Retrospective record reviews to verify Medicaid service claims, concurrent checks of high risk services, (specifically self-determined community living support services), and continuing stay reviews of psychiatric inpatient bed days.
    d. Checks for sanctioned, excluded, or debarred employees, directors/ officers, contracted service provider CEO's or their owners, and selected vendors
    e. Verification of specialized residential provider Adult Foster Care Licensure
3. General Compliance
    a. On-site reviews of organizational contracted service providers against contract requirements per a defined annual schedule, including record reviews (see BABHA policy and procedure C04-S12-T35 Site Reviews.)
    b. Quality Record reviews for direct operated programs, including verification of:
        i. Documentation of medical necessity including diagnostics and clinical assessments;
        ii. Completion of annual ability to pay assessments;
        iii. Proper qualification of clinical staff for services rendered; and
        iv. The presence of physician orders for Medicaid services for which orders are required.

BABHA compliance staff run routine compliance monitoring reports for clinical supervisors and team leader self-review. (See the attached Data Monitoring Plan and Supplemental Compliance Reports). Record reviews and corrections to documentation are completed as needed. Supervisors also receive a list of the service encounters generated by their program each month. Supervisors are required to attest that the encounters have face validity, and they refer suspicious encounters to compliance staff for review. System barriers to compliance identified are addressed by quality and compliance staff in conjunction with clinical leadership. If compliance errors (not due to system errors) are not resolved within a reasonable timeframe, the Supervisor develops a corrective action plan.

Fraud/abuse risk areas for routine monitoring are identified by the Corporate Compliance Officer in collaboration with the BABHA Corporate Compliance Committee based on previous compliance concerns, state and federal priorities and identified risk areas. Monitoring reports are received by the CC Committee and corrective action taken, as necessary.

BABHA limits the service codes which can be used by employees and contracted service providers (including Individual Practitioners) to those which are relevant to their scope of work and credentials, as applicable. The electronic health record and its billing engine include extensive business rules which work to preclude as many billing errors as possible. Service authorization parameters and packages or bundles are employed to minimize the risk of abuse as much as feasible without adversely impacting person-centered planning by consumers served. Further information regarding BABHA claims management controls is outlined in the C08 Fiscal Management, Section 7 – Claims, of the BABHA policy and procedure manual.

Environmental and Risk Assessments[20]

The CC Officer, with assistance of the CC Committee, reviews the risk or focus areas identified in the Office of Inspector General (OIG) for the United States Department of Health and Human Services Work Plan, the Michigan Office of Health Services Inspector General (MIOHSIG) Recovery Audit Contractor Approved Scenarios, if any, as well as any other priority compliance or risk areas communicated by the Michigan Office of Health Services Inspector General or the Mid-State Health Network.

In addition, BABHA identifies themes in the results of its data/monitoring activities for reimbursement trends, prior audit findings, and internal record reviews to identify other areas of potential risk.

A security risk assessment is completed which reviews existing BABHA technological, administrative, and other safeguards to ensure compliance with HIPAA requirements.

In 2019 BABHA adopted the US Dep't of Justice Corporate Compliance Program Evaluation as a program evaluation tool. The evaluation is used by US attorneys when investigating Medicare fraud and abuse to determine the effectiveness of compliance programs. The presence of an effective program is a consideration when the DOJ assesses intent and determines fines/penalties. Findings being actioned are included in the list of areas warranting attention below. The evaluation is completed every three years, alternating with the BABHA Fraud/Abuse Risk Assessment.

The BABHA fraud and abuse Risk Assessment is also completed by the Corporate Compliance Committee every three years, and involves tracing BABHA's workflows for generation of service claims from contact with the person served to the submission of claims file to payers to assess and mitigate weaknesses in fraud/abuse protections. The Risk Assessment evaluates the likelihood of fraud and abuse occurring and potential impact on the organization should it occur. Workflows for both direct operated and contracted services are evaluated.

These activities result in corrective action planning to reduce risk and response to changing expectations in the external compliance environment. The BABHA Fraud and Abuse Risk Assessment template is attached to this plan.

The results of such reviews, on-site audits and CC data/monitoring activities are incorporated into BABHA policies, procedures and practices as necessary, and/or added to the CC data/ monitoring schedule for further oversight by the CC Committee. Findings from the compliance program evaluation and risk assessments are also included in the Corporate Compliance Plan evaluation of plan effectiveness and priorities.

Response and Corrective Action

BABHA has policies and procedures which provide for prompt response to compliance issues, including investigation of potential compliance problems as identified during self-evaluation and audits, correction of such problems promptly and thoroughly (including any required coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence and ongoing compliance with requirements.[21]

Investigations

BABHA policy and procedure C13-S02-T22 Complaint Investigations provides detail regarding BABHA investigation strategies. Both the BABHA Corporate Compliance Fraud/Abuse Record and Privacy/Security Record templates are attached to this plan.

[20] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7
[21] Managed Care Rules: 438.608(b)(7) Program Integrity Requirements

In general terms, the CC Officer oversees the prompt and thorough investigation of any report of potential fraud or abuse, in coordination with the HR Department and/or management structure as appropriate. Similarly, the Privacy Officer conducts investigations of HIPAA privacy violations and breaches.

Record reviews are performed by the Quality and Compliance Coordinator under the oversight of the CC Officer. Suspected fraud and abuse of Medicaid funds is reported prior to investigation to the Mid-State Health Network, Michigan Department of ~~Community~~ Health and Human Services, and the Michigan Office of Health Services Inspector General per contract requirements.

Each investigation includes the gathering and preservation of relevant documents and identification and interviewing of employees, recipients of services and/or contracted service providers (including Individual Practitioners) who may be able to provide pertinent information, as warranted. However, any investigation which overlaps with potential Recipient Rights violations, particularly confidentiality investigations, are coordinated with the relevant officials within BABHA. The BABHA CC Officer may use reports and interviews from those functions as a basis for determination of whether a privacy/ security concern will be substantiated, to minimize the impact of investigations on the involved parties.

Payments to contracted service providers may be suspended during investigations in accordance with BABHA policies. New referrals may also be suspended.

The BABHA CC Officer maintains a compliance log (and documentation files where warranted) of CC related issues and their disposition, including privacy, security, fraud, and abuse concerns.

BABHA and the provider network will cooperate fully with investigations or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Cooperation must include providing upon request, information, access to records, and access to interview employees and consultants including but not limited to those with expertise in administration of the program and/or in any matter related to an investigation or prosecution.

Corrective Action

Each investigation is documented, including information about the issue or incident, conclusions reached and the recommended corrective action, where such action is necessary. The CC Officer, Privacy Officer, or appropriate management personnel responds to the reporting party, as appropriate and to the extent reasonably possible, regarding the status of the investigation and any corrective action taken.

Corrective actions are geared to mitigate the impact of the issue or incident, remediate the error(s), and prevent future occurrence if possible. Steps taken range from employee education or training, consultation with contracted service providers, revision of policies, procedures, or contract boilerplate, revision of electronic health record functionality, service claim recall, reporting and reporting recoupment of over-payments, disciplinary action against employees and adverse contract action against contracted service providers (including Individual Practitioners), as previously described in this Plan. Training programs are also updated frequently to address current patterns of fraud/abuse or privacy violations.

BABHA has added to it's investigative process a checkpoint to determine whether a root cause analysis is warranted to identify the variables that contributed to the occurrence and possible remediation.

Claims/Over-Payment Recoupment and Voiding of Encounters

BABHA's policy and procedure C08:S03:T13 Third Party Revenue Collection and Repayments outlines steps for prompt reporting and recoupment of all Medicaid and Medicare overpayments identified. Finance policies and procedures also address suspension of payments as necessary.

Recoupment of Medicaid, Medicare and other state/federal healthcare related over-payments for fraudulent or erroneous service claims from contracted service providers (including Licensed Independent Practitioners) are handled by the BABHA Finance Manager. This includes the voiding of encounters and any cost write-off or repayment that may be required for substantiated fraud or abuse by BABHA employees which may have resulted in an excessive or erroneous service claim. Recoupments are tracked on the BABHA Corporate Compliance Log by the CC Officer.

Providers are required to agree to a repayment strategy for larger recoupments, to the satisfaction of the CFO. The CFO, in consultation with the CEO as necessary, determines whether contracted service providers (including Individual Practitioners) will be subject to additional action, such as being turned over to collection agencies, if they fail to meet repayment obligations.

Other Corrective Action and Enforcement

BABHA works with the Michigan Office of Health Services Inspector General, and other governmental entities at the state and federal level which hold civil and criminal enforcement authority under Medicaid, Medicare, and other state/federal healthcare program integrity related statutes. Corrective action plans are also coordinated with the Michigan Department of Health and Human Services, the Michigan Department of Licensing and Regulatory Affairs, and Mid-State Health Network in accord with contract requirements.

Compliance Reporting

BABHA requires employees and providers to report to the CC Program and the CC Program must submit required information to its payers. The CC Program endeavors to be accessible and consultative to stakeholders.

Employee/ Contracted Service Provider Guidance and Reporting[22]

BABHA employees are required to report to the CC Officer and their Supervisor any suspected fraud/ abuse or privacy/security violation, and any criminal conviction that may result in their exclusion/debarment from Medicaid/Medicare programs. BABHA policy and procedure C13-S02-T01 Internal Reporting (Hotline) provides more information about such provisions. New employees are advised of this requirement during their orientation and other employees are reminded during annual training updates. Reporting obligations are cited in the contract boilerplate for contracted service providers (including Individual Practitioners).

Board members sign an attestation indicating they agree to report any criminal charge or conviction related to Medicaid, Medicare and any other Federal/State Healthcare Program, as well any other crime involving the delivery of a healthcare item or service. Employees sign a similar attestation annually.

Through the contractual agreement, provider agencies and Individual Practitioners agree to report to BABHA any suspicion or knowledge of fraud or abuse and to fully cooperate with investigations. Providers are required to immediately report to BABHA any invalid claims and/or overpayments for correction. Also, providers agree to immediately notify BABHA with respect to any inquiry, investigation, sanction or otherwise from the Office of Inspector General (OIG), as well as criminal convictions that may result in their exclusion or debarment from participation in Federal and State health care programs.

Employees and contracted service providers (including Individual Practitioners) are encouraged to utilize the CC Program as a source of consultation and guidance regarding compliance related questions. Technical assistance is offered by the CC, Privacy and Security Officers to the maximum extent possible as questions arise and when

[22] CARF Standards: Section 1 Aspire to Excellence: A Leadership: Standard 7

investigations occur. The CC Officer meets face-to-face with each new employee during new employee orientation and participates in face-to-face meetings with key contracted service providers.

CC and other agency policies, procedures and documents are designed to encourage and facilitate regulatory compliance. As an example, the business rules embedded in the electronic health record are narrow, limiting an employee's ability to make wrong choices. BABHA has dedicated staff to verify service claims and communicates regularly with contracted service providers (including Individual Practitioners) regarding questionable or erroneous claims.

External Reporting

BABHA is required to report potential fraud and abuse occurrences which warrant investigation to Mid-State Health Network, and ultimately to the Michigan Department of Community Health and the Michigan Office of Health Services Inspector General.[23]

BABHA submits a quarterly report to the MI Office of Health Services Inspector General (MIOHSIG) through MSHN regarding the number of complaints of fraud and abuse that warranted preliminary investigation throughout the year. Annually a summary is also provided directly to MDHHS by BABHA. Additional requirements for reporting of contracted service provider information were added by MIOHSIG, including new and terminated providers. In August of 2025 MSHN launched the use of Healthicity to log fraud and abuse investigations. Healthnicity is a healthcare technology company providing compliance, auditing, and revenue cycle software and services. This reporting mechanism allows MSHN to compile the annual reporting to MDHHS as the PIHP.

BABHA is also required under state law to report licensed or registered professionals and organizations to the Michigan Department of Licensing and Regulatory Affairs (LARA) for potential investigation and possible adverse action.

As a covered entity under HIPAA, BABHA must also report security breaches to the Federal government on an annual basis. BABHA also has mandatory State reporting obligations as an employer.

Reporting of Overpayments[24]

BABHA reports overpayments to regional and state payers, and federal and state offices of inspector generals as required by law and contractual obligations. In accord with regulatory requirements, BABHA specifies the reason for overpayments, including if due to potential fraud.[25] As of August of 2025 BABHA began documenting MEV auditing results of overpayments and recoupments within Healthnicity.

Medicaid Eligibility

If BABHA becomes aware of changes in a Medicaid enrollee's circumstances that, to the best of its knowledge, may affect the enrollee's eligibility for Medicaid, BABHA notifies a representative of the local office of the Michigan Department of Human Services, which is responsible for managing Medicaid eligibility determinations. As a Community Mental Health Services Program, BABHA is also responsible for reporting to the State of Michigan the death of an individual receiving services. [26]

[23] Managed Care Rules: 438.608(a)(7)
[24] 42 CFR 401Reporting and Returning of Overpayments (for Medicare) and Section 1128J(d) of the Affordable Care Act for Medicaid overpayments
[25] Managed Care Rules: 438.608(a)(2)
[26] Managed Care Rules: 438.608(a)(3)

Provider Disenrollment

BABHA notifies regional and state payers when information is received about changes in a contracted service provider's circumstances that, to the best of BABHA's knowledge, may affect the provider's eligibility to participate in a managed care program as a Medicaid provider. [27]

Contracted service providers who leave or who are removed from the BABHA provider network are reported to MIOHSIG, MDHHS and MSHN for purposes of MDHHS monitoring of Medicaid provider enrollment.

Evaluation of Program Effectiveness and Program Priorities

The BABHA Corporate Compliance Program remains largely effective. The program's quality and effectiveness is evaluated every three years by the Corporate Compliance Committee, Corporate Compliance Officer and the Chief Executive Officer. BABHA created an evaluation tool using the U.S. Department of Justice Criminal Division, Evaluation of Corporate Compliance Programs template (see attachments). The lowest scoring items are actioned.

Throughout the course of the past year and/or through the DOJ evaluation process, the following areas were identified for improvement:

Planned Improvement	Target Date	Actions Taken	**Status** New; Continue; Discontinue; Completed
1) The Privacy Notice revisions to address changes in access to Medicaid claims data for coordination of care	3/1/25	Still in process; regulations have continued to change. The Privacy Policy and Procedure needs to be updated and the Privacy Notice needs to reflect new requirements.	~~Continue~~Completed
2) Add: Develop a system to track education of Fraud, Abuse, waste and compliance to Consumers and begin reporting quarterly to MIOHSIG/MSHN.	3/1/25 and ongoing	The MSHN quarterly report has been modified to include consumer education. The identified population are those individuals in Self D and those that are sent the EOB's annually. MSHN implemented the use of Healthnicity for the recording/tracking/reporting of these activities.	Continue
3) Continue to expand supervisor skills relative to program integrity and corporate compliance, beyond the traditional audit compliance.	4/1/25	Have completed a training for supervisors and have sent out emails and intranet postings on topical items related to Fraud, Abuse, waste and compliance.	Continue

[27] Managed Care Rules: 438.608(a)(4)

4) Increase follow-through with line staff regarding how policy/procedure changes should impact their day-to-day work.	4/1/25		Continue
5) ~~Add:~~ Provide education when appropriate for Fraud, Abuse and waste substantiations and record on the Fraud and Abuse log. This will be reported quarterly to MSHN and MIOHSIG.	4/1/25		Continue
6) ~~Add:~~ Review, educate staff and revise policies and procedures as needed to comply with the revisions to 42 CFR, part 2.	4/1/25		Continue
7) Add: Implement a process to identify and manage emerging internal and external risks related to the use of AI and other new technologies	06/01/2026		New
8) Add: Implement a procedure for approving, introducing, using AI as well as an ongoing monitoring and auditing process for ensuring accuracy/error rate/bias, and outcomes for persons served.	06/01/2026		New

Compliance Risk Overview

This section provides an overview of major compliance risks for FY2026, including their descriptions, potential impact, likelihood, and mitigation strategies.

Risk Category	Description	Potential Impact	Likelihood	Mitigation Strategy
Regulatory	Non-compliance with MDHHS guidelines, HCBS rules, or Mental Health Framework.	Loss of funding, penalties, reputational damage.	Medium	Regular audits, staff training, policy updates.
Financial	Incorrect billing or cost reporting.	Financial penalties, repayment obligations.	Medium	Internal financial audits, billing accuracy checks.
Operational	Failure to meet reporting deadlines (FSR,	Contract non-compliance, service disruption.	High	Automated reminders, compliance calendar, dedicated reporting team.

	BH-TEDS, CHAMPS).			
Clinical	Improper use of standardized assessments (MichiCANS, LOCUS).	Incorrect care planning, payer misalignment.	Medium	Staff certification, periodic competency reviews.
Data Privacy	HIPAA violations or data breaches.	Legal liability, client trust loss.	Low	Encryption, access controls, regular security audits.

Attachments:

Law-Regulation Log/Compliance Education Log
Corporate Compliance Education Schedule
Compliance Committee Data Monitoring Plan
Data Monitoring Plan: Supplemental Compliance Reports
Corporate Compliance Log
BABHA Fraud and Abuse Risk Assessment with Action Plan
Evaluation of Compliance Report
Corporate Compliance Fraud/Abuse Record
Corporate Compliance Privacy/Breach Record
Hotline Poster

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	BABHA staff conducted performance improvement reviews for List, Saginaw Psychological, MPA, and BABHA direct-operated primary services for services provided in FY25Q4. Common findings included back-to-back interim plans, late completion of periodic reviews, and unsigned documentation. Five Applied Behavioral Analysis (ABA) regional reviews were also completed during FY26Q1.
Record Reviews	Improved	Fair	During FY26Q1, BABH completed 85 quality of care record reviews, resulting in an 84% compliance rate. The most common areas of concern identified were incomplete sections within the assessment and plan of service.
Verification of Medicaid services provided for direct operated programs & contracted service providers	Good	Good	The BABHA Quality Improvement staff have completed FY26Q1 MEV reviews for: • APS – 100% • BHS – 100% • MCSI – 100% • BABHA CLS – 100% • Carebuilders – 99% • PAO – 87% • Stuart Wilson (FI) – 99% • Arnold Center – 96% • North Bay – 100% • Do-All – 99.7% • New Dimensions – 98% • AOI – 100% • Autism Systems – (LIP) 100% (ABA) 95% • Mercy Plus PDN – 100% • Maxim PDN – 100% • MPA – 95% • SPSI – 94% • BABHA – 98% The services reviewed were $456,788.58 of claims with a recoupment amount of $7857.38. However, some still have not had a finalized amount of recoupment, so this may be slightly higher. The 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	Triennially	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 in the Relias System.
Fraud/Abuse Risk Assessment	Triennially	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.
Security Risk Assessment	Annually	Completed August 2025	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. BABH is compliant with 121 of the 126 questions within the DHHS SRA tool. Remediation plan is being addressed in this upcoming year.

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

EDUCATION		
Persons Served	**Frequency**	**Status**
Consumer Council-Bay Consumer Council-Arenac	Annually/ PRN	Website contains Fraud Abuse and Privacy education. Consumer Council was educated on 09/24/2025 and 10/01/2025.
Self-Determination	As Needed	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	Annually	Completed June 19, 2025
Additional compliance information provided for Board of Directors: Date Audience Topic		

EDUCATION		
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	Annually	Developed initial training and provided training via email to Supervisors.

Additional Educational Activities for Supervisors:

Date	Audience	Topic	Type
None			
12/16/2025	All BABHA Supervisors/Directors	Cyber Threat Awareness Training – completed by Brandon Smith – Cybersecurity Intelligence Analyst with MSP	In-Person

Employees	Frequency	Status
New employee orientation to corporate compliance, privacy and confidentiality	Monthly	Completed every month.
Corporate compliance training	Annually	Completed 06/2025 – Annually for all employees during Staff Development Days
Privacy/security/confidentiality training	Annually	Completed 06/2025 – Annually for all employees during Staff Development Days
Corporate Compliance Plan in-service	Annually	2026 Corporate Compliance Plan being updated now
Email security drills (by Security Officer)	Quarterly	In November 2025, Hook Security Phishing drill emails were sent out to all staff with 122 staff opening the email, 9 clicked on the link, and 50 staff reported it as a suspicious email. This means that 3.53% of employees clicked on the link within the test email which is better than the industry standards, and 19.6% of staff reported this as a phishing email. In January 2026 Hook Security Phishing drill emails were sent out to all staff with 102 staff opening the email, 12 clicked on the link, and 40 staff reported it as a suspicious email. This means that 4.72% of employees clicked on the link within the test email which is better than the industry standards, and 15.75% of staff reported this as a phishing email. Any staff who clicked on the link are provided immediate education by clicking on the link as a pop up is triggered by clicking on the link. Any staff that have clicked on

Employees	Frequency	Status
		phishing emails three times are provided individual training by the IT department.

Additional Educational Activities for Personnel:

Date	Audience	Topic	Type
01/08/2026	PNOQMC – Primary Providers	Documentation requirements for Medicaid, BABHA Contract, and BABHA Policy and Recoupment Requirements	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 09/2025
Corporate Compliance Training for Primary Providers	Annual	Completed 11/2025
Corporate Compliance Training for Autism Providers	Annual	Completed 4/8/25

Additional Educational Activities for Contracted Service Providers:

Date	Audience	Topic	Type

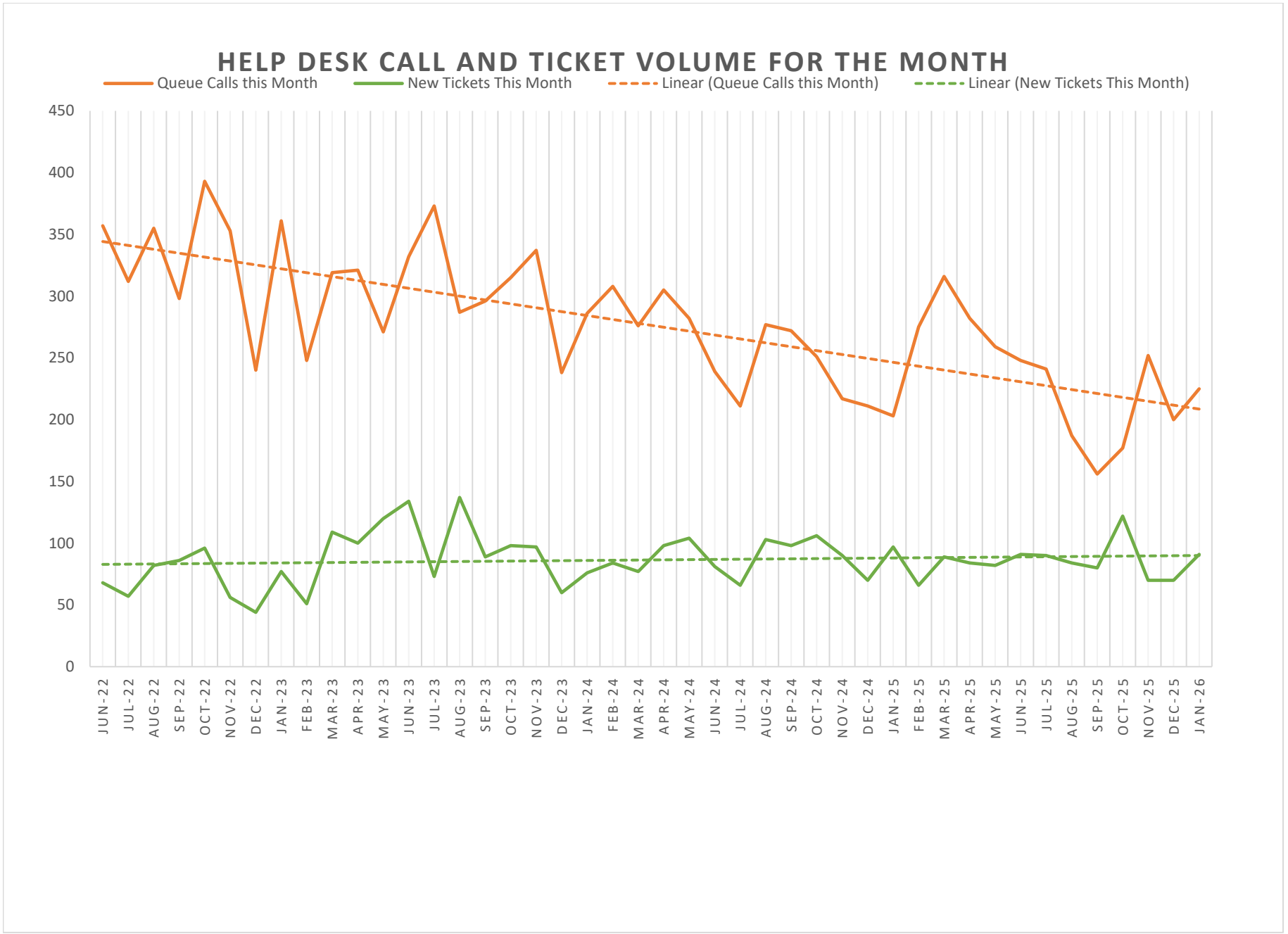
Corporate Compliance Staff & Leadership	Frequency	Status
Review of Regulatory Changes	Monthly	In process
Review of Medicaid and General Fund Contract Boilerplate and Attachments	Yearly	In process
Review of CMS Office of Inspector General [Regulatory Compliance] Work Plan	Yearly	In process

Educational activities for compliance leadership:

Date	Audience	Topics	Type
10/21/2025	Melissa Prusi	Behavioral Health Compliance Conference	Webinar
11/20/2025	Melissa Prusi	Artificial Intelligence Series – Part I	Webinar

Report Prepared by:
Melissa Prusi, LMSW
Director of Healthcare Accountability

Date: January 8, 2026


HELP DESK CALL AND TICKET VOLUME FOR THE MONTH
Queue Calls this Month
New Tickets This Month
Linear (Queue Calls this Month)
Linear (New Tickets This Month)
450
400
350
300
250
200
150
100
50
0
JUN-22
JUL-22
AUG-22
SEP-22
OCT-22
NOV-22
DEC-22
JAN-23
FEB-23
MAR-23
APR-23
MAY-23
JUN-23
JUL-23
AUG-23
SEP-23
OCT-23
NOV-23
DEC-23
JAN-24
FEB-24
MAR-24
APR-24
MAY-24
JUN-24
JUL-24
AUG-24
SEP-24
OCT-24
NOV-24
DEC-24
JAN-25
FEB-25
MAR-25
APR-25
MAY-25
JUN-25
JUL-25
AUG-25
SEP-25
OCT-25
NOV-25
DEC-25
JAN-26