COMPLIANCE PROGRAM DESCRIPTION, FY 2022 Program Effectiveness Review and FY 2023 Program WORKPLAN

Approved By	Date
Quality and Compliance Oversight Committee (QOC)	January 3, 2023
Internal Operations Committee (IOC)	January 11, 2023
Board of Directors	January 25, 2023

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I. INTRODUCTION

A. The NMRE is committed to establishing and maintaining an effective compliance program in accordance with the compliance program guidance published by the Office of Inspector General and the U.S. Department of Health and Human Services. The compliance program is about prevention, detection, collaboration and enforcement of the law, requirements from regulatory bodies, contractual obligations and NMRE's policies, procedures, and Standards of Conduct.

B. The Compliance Program:

1. Ensures that the NMRE staff and partners adhere to all pertinent federal, state, and contractual obligations and guidelines.
2. Serves as a mechanism for preventing and reporting any breach of those laws and regulations that fall within specified criteria.
3. Applies the guidelines of the Office of Inspector General (OIG), requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR 438.608, 42 CFR Part 2, 2 CFR 200, and Title 45 CFR.

   An effective compliance program includes the following elements:

   a. Written policies, procedures, and standards of conduct.
   b. Compliance Program oversight.
   c. Effective training and education.

d. Effective lines of communication.

e. Well-publicized disciplinary guidelines.

f. Internal and external monitoring and auditing activities.

g. Prompt response to detected offenses and the development of corrective actions.

II. STRUCTURE OF THE COMPLIANCE PROGRAM

A. The NMRE Board of Directors: The NMRE's Board of Directors is responsible for the review and approval of the Compliance Plan, review of the Annual Compliance Report, and review of matters related to the Compliance Program. The NMRE Board of Directors has the highest level of responsibility for the oversight of the Compliance Program.

B. Compliance Director: The NMRE's Compliance Director has the primary responsibility for ensuring that NMRE maintains an effective Compliance Program. Specifically, the Compliance Director oversees the implementation and effectiveness of the Compliance Plan, Standards of Conduct and other policies and procedures, serves as the Chair of the Quality and Compliance Oversight Committee (QOC), and provides consultative support to the NMRE staff and provider network. The Compliance Director is responsible for the day-to-day operation of the Compliance Program.

C. The Quality and Compliance Oversight Committee (QOC): The NMRE regional Quality and Compliance Committee provides guidance, supervision, and coordination for compliance efforts at the NMRE and its partners. The QOC advises on matters involving compliance with contractual requirements and all related federal and state laws and regulations, including the Office of Inspector General guidelines and 42 CFR 438.608 and 42 CFR Part 2. The QOC is comprised of the NMRE's Chief Executive Officer, Chief Information Officer/Operations Director, Compliance Director, SUD Grant Director, Clinical Director, Customer Service Specialist, Quality Analyst, Business Intelligence Analyst, Provider Network Manager and representatives from all five member

Community Mental Health Services Programs (CMHSPs). The Medical Director is an ad-hoc member of the committee.

III. ELEMENTS

A. Implementing Written Standards, Policies, and Procedures

Written Standards of Conduct and written policies and procedures are a central element of the compliance program. The Standards of Conduct demonstrates the NMRE's ethical attitude and its emphasis on compliance with all applicable laws and regulations. NMRE policies and procedures are living documents and provide guidelines on the day-to-day operations of the organization. Written policies and procedures also ensure good quality of care as well as patient confidentiality and privacy. These compliance standards apply equally to ALL NMRE staff and partners. It is the responsibility of each employee to become familiar with the Standards of Conduct and the written policies and procedures that apply to their job duties.

B. Designating Compliance Oversight

1. The NMRE's Compliance Director has the authority and responsibility to administer and manage all tasks related to establishing, monitoring, and updating the Compliance Program. To ensure success of the program, the Compliance Director will:

    a. Have direct access to the Chief Executive Officer and the NMRE Board of Directors. This will ensure that a system of checks and balances is established to effectively achieve the goals of the Compliance Program.

    b. Coordinate and collaborate with NMRE leadership and NMRE partners to assess and mitigate risks, develop, and implement policies and procedures, and develop and implement the Compliance Program. Methods used to ensure an effective Compliance Program include:

        i. Working with the NMRE network providers and other partners to coordinate and implement compliance activities.

ii. Analyzing reports generated as part of the auditing and monitoring initiatives and other processes to identify trends and implement corrective actions.

iii. Analyzing all allegations of abuse, waste, or fraud and reporting requirements/process and providing notifications to MDHHS/Office of Inspector General (OIG), as necessary.

iv. Reviewing and analyzing compliance activities and provider agencies via ongoing and annual contract monitoring processes.

c. Ensure that appropriate screening and evaluation checks are completed to eliminate sanctioned individuals and contractors from participating in the federal or state healthcare programs for the provision of items or services. This will include the following activities:

i. Ensure NMRE complies with all requirements to obtain, maintain, disclose, and furnish required information about ownership and control interest, business transactions, and criminal convictions.

ii. Ensure that all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment, or services provided with federal and state healthcare funds are compliant with applicable federal and state regulations.

iii. Ensure NMRE and its partners comply with 42 USC 1320a-7(b), which imposes penalties for "arranging (by employment or otherwise) with an individual or entity that the person knows, or should know, is excluded from participation in a federal health care program for the provision of items or services for which payment may be made under such a program."

d. Prior to employing or contracting with any individual or provider and monthly thereafter, the NMRE will take appropriate steps to confirm that the individual or provider has not been excluded pursuant to the NMRE Excluded Provider Policy and Procedure.

i. Develop and implement an educational training program for NMRE staff and its partners that furnish services to ensure

understanding of federal and state laws and regulations involving ethical and legal business practices.

ii. Independently and confidentially investigate and act on matters related to compliance and privacy.

2. The NMRE Quality and Compliance Oversight Committee will be responsible to:
   a. Guide the implementation of the Compliance Program.
   b. Assist with the implementation of compliance policies and procedures and the Standards of Conduct.
   c. Encourage employees to raise concerns and report non-compliance issues including suspected fraud, waste, abuse, or inappropriate behavior without fear of retaliation.

C. Conducting Effective Training and Education

Education and training are the first and possibly the most important lines of defense of a compliance program. All NMRE staff and Board Members will receive training and have access to the NMRE Compliance Plan, compliance policies, and Standards of Conduct. Additional training may be required for employees involved in specific areas of risk or as new regulations are issued. Records will be maintained on all formal training and educational activities for 10 years. The Compliance Director will receive training from an entity other than themself. Training is considered a condition of employment and failure to comply will result in disciplinary action up to and including termination. All employees will receive mandatory compliance training during the first 30 days of their employment and annually thereafter.
Educational activities include, but are not limited to, face-to-face training and online training in programs related to:

1. Federal and state regulations and guidelines
2. Contractual obligations
3. Policies, procedures, and the Standards of Conduct
4. Coding and billing requirements

5. False Claims Act implications including fraud, waste, and abuse

The Compliance Director will provide ongoing information and education on matters related to healthcare fraud, waste, and abuse as disseminated by the Office of Inspector General, the Department of Health and Human Services or other regulatory bodies.

It is the responsibility of NMRE staff to maintain licensure and certifications that are specific to their job responsibilities.

The NMRE Provider Network Committee will review and recommend regional training requirements to assure and provide consistent training requirements throughout the provider network. The NMRE will monitor the provider network to ensure adherence to the identified training requirements. When necessary, the NMRE will offer related compliance training and educational materials to the provider network.

D. Developing Effective Lines of Communication

There will be open communication between the Compliance Director, The NMRE Board of Directors, the Quality and Compliance Oversight Committee, and all NMRE staff and partners. With open lines of communication, the potential for fraud, waste, and abuse is substantially reduced. Examples of ways to maintain lines of communication include:

1. Face-to-face with the Compliance Director
2. Compliance Hotline: 866 789 5774 (can be anonymous or identified)
3. Compliance E-mail: Compliancesupport@nmre.org
4. NMRE website: NMRE.org → Compliance → Report Compliance Issue
5. Mail to: 1999 Walden Drive, Gaylord, MI, 49735

Confidentiality and Non-Retaliation policies and procedures are in place and accessible to all employees to encourage the reporting of incidents of potential or suspected fraud, waste, or abuse in a safe environment without fear of retaliation. All reported incidents will be documented and investigated promptly to determine validity.

Communication System

The compliance program's system for effective communication will include the following:

1. Requirement that all staff must report suspected misconduct, that a reasonable person acting in good faith would have believed to be misconduct, without fear of retaliation.
2. Creation of a user-friendly process, such as the compliance hotline; where staff can anonymously and promptly report fraudulent, unethical, or erroneous conduct.
3. Policy and procedure provision that states a failure to report fraudulent, unethical, or erroneous conduct is a violation of the Compliance Program.
4. Implementation of a simple and readily accessible procedure to investigate reports of fraudulent, unethical, or erroneous conduct.
5. Implementation a process that maintains the confidentiality of the persons involved in alleged fraudulent, unethical, or erroneous conduct and the person making the allegation.
6. Policy and procedure provision to indicate non-retribution for reporting conduct that a reasonable person, acting in good faith, would believe to be fraudulent, unethical, or erroneous.

E. Enforcing Standards through Well-Publicized Disciplinary Guidelines

The Standards of Conduct and NMRE policies and procedures apply to employees at all levels and NMRE partners. Enforcement applies regardless of the employee's position or years of service. Failure by any employee to comply with applicable regulations, NMRE's Standards of Conduct, or policies and procedures will subject the employee and the supervisor who ignored or failed to detect misconduct, or who has knowledge of the misconduct and failed to correct it, to disciplinary action that could range from verbal warnings to suspension, privilege revocation, or termination from employment, based on the seriousness and type of violation. The NMRE's Sanctions Policy and Procedure sets forth the degree of disciplinary action that may be imposed

on employees for failing to abide by the Compliance Program.

F. Conducting Internal and External Monitoring and Auditing Activities

Auditing and monitoring activities are critical to a successful compliance program and should be an ongoing activity under the direction of the Compliance Director. Auditing and monitoring will remain a key feature in any annual review of the effectiveness of the Compliance Program. The auditing activities will focus on compliance with specific regulations and policies that have been identified by CMS, OIG, and MDHHS-PIHP contractual obligations. The NMRE utilizes a variety of monitoring and auditing techniques including:

1. Periodic questionnaires, surveys, and interviews with staff within the NMRE, its member CMHSPS, and subcontracted providers regarding their perceived levels of compliance and the effectiveness of training/education within their departments and areas of responsibilities.

2. Periodic audits that comply with federal and state regulations, MDHHS-PIHP contractual obligations, and other guidelines.

3. Service verification audits.

4. Input from regional Compliance Officers.

5. Internal/external audit results for specific compliance guidelines.

6. Information from past investigations of noncompliance.

7. Information from exit interviews.

Quarterly Submissions to the OIG:

1. Grievance report

2. Data mining and analysis of paid claims

3. Audits performed

4. Overpayments collected
5. Identification and investigations of fraud, waste, and abuse
6. Corrective action plans implemented
7. Provider disenrollment
8. Contract termination

Reporting/Reviewing Compliance Data:

1. Quarterly reports of issues
2. Quarterly results of Medicaid service verification audits
3. Annual reviews of the Compliance Plan
4. Annual summaries of compliance activities, including number of investigations, summaries of results of investigations, and summaries of disciplinary actions
5. Trend analysis that identifies deviations (positive or negative) in specific risk areas over a given period
6. Annual reports of Medicaid Encounter Verification (MEV)
7. Annual reports to MDHHS of MEV results
8. Annual reports to MDHHS of compliance with annual trainings on the Deficit Reduction Act (DRA) from all network providers
9. Annual reports to the OIG of any non-compliance communication resulting in OIG involvement.

HIPAA Privacy and Information Security audits, such as:

1. Use and disclosure of protected health information (PHI),
2. Employee access to protected information

3. Validation and reliability of data,
4. Information security risk assessment,
5. Electronic and physical safeguards.

Clinical/Quality of Care, review of:

1. Performance indicators
2. Peer reviews
3. Chart reviews
4. Scope of work and qualification

Consumer rights review of:

1. Rights complaints and concerns
2. Consumer satisfaction survey
3. Rights Officers' responsibilities
4. Risk Events and Critical Incidents
5. Sentinel Events and Root Cause Analyses (RCA)

G. Responding to Detected Offenses, Developing Corrective Actions and Prevention.

According to the OIG, one of the seven essential elements for an effective compliance program is the investigation and remediation of identified systemic problems. If there should ever be a reason to believe that misconduct or wrongdoing has occurred, the organization must respond appropriately. The OIG notes that violations of the compliance program and other types of misconduct threaten an organization's status as a credible, honest, and trustworthy provider capable of participating in federal healthcare programs. Detected but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the NMRE. The OIG calls for prompt reporting of misconduct to the appropriate authority within a reasonable period, but not more than 60 days after determination

that credible evidence of a violation exists, and not more than 30 days to avoid stricter fines.

Audit and review follow-up are important parts of good management and evidence of an effective compliance program. To ensure that identified problems and/or weaknesses do not recur, it is essential that corrective action is taken.

Approval Signature

NMRE Chief Executive Officer

2/8/23

Date

IV. 2022 COMPLIANCE PROGRAM EVALUATION SUMMARY REPORT

A. Compliance Activities:

1. Policies, procedures, and compliance documents: The following documents, policies, and procedures were created/updated, approved, and implemented in 2022:

    a. Behavior Treatment Plan Review Policy

    b. Customer Handbook

    c. SUD Recipient Rights Policy

    d. Member Information Booklet

    e. LEP/Accessibility Policy

    f. Recipient Rights Beneficiary Grievance and Appeal Policy

    g. Customer Services Beneficiary Grievance and Appeal Policy

    h. Notification of Provider Termination Policy

    i. Satisfaction Survey Policy

2. Consumer Material: The following information was created/updated and disseminated to providers:

    a. NMRE Newsletters: 1 annual publication: October 2022.

    b. Limited English Proficiency (LEP) Materials including Braille, large print versions of the Guide to Services and other materials, Spanish version of the Guide to Services, taglines, website information in machine readable format, American Sign Language (ASL) Interpreter information, language line information

    c. Guide to Services: approximately 10,000 copies distributed to providers, bi-annual updates

    d. Informational posters

    e. SUD brochures

    f. Advance Directive brochures

    g. Notice of Privacy Practice brochures

    h. Grievance, Appeal, and Second Opinion brochures

    i. Rights Information

B. Compliance Oversight

Current compliance oversight activities include:

1. Exclusion/sanctions verifications

    a. The NMRE completed exclusion checks for all NMRE employees, contractors, contract entities/providers, and Board Members upon hire or extending a contract and monthly thereafter.

    b. The NMRE completed monthly checks for SUD Providers. The databases that were searched included:

        - MI_SPL – Michigan Medicaid List of Sanctioned Providers
        - OIG – Office of Inspector General – List of Excluded Individuals/Entities
        - OIG_Most_Wanted – Office of Inspector General – Most Wanted Fugitives
        - SAM System for Award Management: Excluded Parties
        - SDN – Office of Foreign Assets Control – Specially Designated Nationals
        - NPDB – National Practioner Data Bank

2. Grievances, Appeals, and Right Complaints.

    a. Grievances

    This report shows the results of an analysis of reported grievances, and rights complaints by CMHSPs and SUD providers in Region 2 during FY22. The collected data included the grievance category, dates of receipt and closure, determination, and intervention. This data was utilized to identify grievance trends and pinpoint areas where corrective action was necessary to improve services as well as identify providers who were not adhering to state-mandated timelines for grievance resolution. The total number of reported Member's Served was 19,553, a decrease of 4.4% (20,459) from last year (FY21).

Grievance Category	# of Cases Closed	# of Cases Per 100 Members	# of Cases Substantiated	# of Interventions	# of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution *
QUALITY OF CARE	91	0.74	71	101	91	6
ACCESS AND AVAILABILITY	48	0.39	20	57	48	10
INTERACTION WITH PROVIDER OR PLAN	68	0.55	36	113	68	6
MEMBER RIGHTS	31	0.25	22	33	31	9
TRANSPORTATION	0	0.00	0	0	0	0
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0	0	0
FINANCIAL OR BILLING MATTERS	2	0.02	0	2	2	2
SAFETY/RISK MANAGEMENT	2	0.02	2	3	2	3
SERVICE ENVIRONMENT	9	0.07	3	9	9	7
OTHER	24	0.20	12	35	24	10
Total	**275**	**2.24**	**166**	**353**	**275**	**7**

Closed grievances were down by 17% in 2022. Out of 275 closed cases reported, 166 were substantiated and required corrective action. 30% of these cases were in connection with perceived quality of care. Member rights violation increased from 22 in 2021 to 31 in 2022. Of the 31 reported rights violations, 22 were substantiated and required corrective action. All 275 closed cases were completed, and notice was sent to interested parties within 90 calendar days. The Quality and Compliance Oversight Committee utilized this data to identify trends and pinpoint areas that may require additional monitoring.

b. Appeals

The collected data included the type of appeal (standard or expedited), a description of the service being appealed, dates of receipt, notice of resolution, determination, and reason for the adverse decision. The Quality

and Compliance Oversight Committee utilized this data to identify appeal trends and pinpoint areas where corrective action was necessary to improve services as well as identify providers who were not adhering to state-mandated timelines for standard or expedited appeal resolution.

	Count	Percentage
Appeals	51	
Appeals Upheld	34	66.67%
Appeals Overturned	15	29.41%
Appeals Partially Upheld/Overturned	3	5.88%

Most cases involved clients appealing the decision to deny services based on lack of medical necessity (55%). Of 51 appeals, 34 (66.67%) were upheld while 15 (29%) were overturned. 94% of appeals were completed within the 90 calendar days allowed timeframe. This showed good improvement from 88% in 2021.

Reason for Adverse Decision on Appeal	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited	Percent Timely-All Cases	Percent Untimely-All Cases
MEDICAL NECESSITY CRITERIA NOT MET	23	0.19	22	0	1	0	100%	0%
NOT A PIHP-COVERED BENEFIT	4	0.03	4	0	0	0	100%	0%
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	0%	0%
TREATMENT/SERVICE PLAN GOALS MET	0	0.00	0	0	0	0	0%	0%
MEMBER NOT ELIGIBLE FOR SERVICES	5	0.04	5	0	0	0	100%	0%
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	4	0.03	4	0	0	0	100%	0%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	0%	0%
OTHER	7	0.06	6	1	0	0	86%	14%
NOT APPLICABLE	8	0.07	6	1	0	0	75%	13%
Total	**51**	**0.42**	**47**	**2**	**1**	**0**	**94%**	**4%**

c. Denials

In 2022 there were 1,502 service denials. 86% of these denial decisions were made timely. Most denials were a result of eligibility. Out of 1,164 eligibility denials, 857 were because clinical eligibility criteria were not met; the next was the fact that other resources were available which made the beneficiary ineligible. Only 9% of the total denials were due to medical necessity.

ABD Reason	ABD Sub-Reason	Number of Services Denied	Number of Services Denied Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
ELIGIBILITY		**1164**	**9.50**	**1024**	**125**	**15**	**0**
	CLINICAL ELIGIBILITY CRITERIA NOT MET	857	6.99	750	94	13	0
	MEDICAID ELIGIBILITY CRITERIA FOR SMI, IDD, SED, OR SUD NOT MET	105	0.86	87	18	0	0
	MHP RESPONSIBLE FOR SERVICE	2	0.02	2	0	0	0
	OTHER RESOURCES ARE AVAILABLE	168	1.37	151	13	3	1
	MEMBER LIVES OUTSIDE OF PIHP SERVICE AREA	14	0.11	13	1	0	0
	MEMBER RESIDING IN AN INSTITUTION	16	0.13	16	0	0	0
	OTHER	3	0.02	13	0	0	0
DELAY		**160**	**1.31**	**160**	**0**	**0**	**0**
	AUTHORIZATION DECISION NOT MADE WITHIN REQUIRED TIMEFRAME	58	0.47	58	0	0	0
	OTHER	2	0.02	2	0	0	0
MEDICAL NECESSITY		**141**	**1.15**	**128**	**9**	**3**	**1**
	CLINICAL DOCUMENTATION PROVIDED DOES NOT ESTABLISH MEDICAL NECESSITY	124	1.01	114	8	2	0
	OTHER	3	0.02	3	0	0	0
OTHER		**37**	**0.30**	**34**	**3**	**0**	**0**
	SERVICE(S) IS NOT COVERED BY MEDICAID	3	0.02	3	0	0	0
	OTHER	25	0.20	23	2	0	0
Total	**Total**	**1502**	**12.25**	**1346**	**137**	**18**	**1**

C. Training and Education (Focused and General) for Providers

1. The NMRE provided the following trainings to providers:
    a. Habilitation Support Waiver (HSW) goal and objective writing to CMH Case Mangers
    b. Home and Community Based Services (HCBS) Policy update training to CMH Case Managers
    c. Grievances, Appeals, Rights, LEP, Denials, Adverse Benefit Determinations (ABDs), notice requirements, and MDHHS reporting requirements
    d. Provider RECON training
2. NMRE Staff received the following trainings:
    a. Code of Ethics training
    b. Annual Compliance training
    c. Non-Retaliation Policy training
    d. HIPAA and Information Security and Awareness training
    e. Grievance and Appeals training.

D. Lines of Communication

The Compliance program provides the following lines of communication:

1. Internal: There are several ways that employees can voice their concerns:
    a. The compliance hotline is fully functional, and the number is available on the NMRE website. Employees can raise their concerns openly or anonymously.
    b. The NMRE has a compliance email account where concerns can be exoressed.
    c. The NMRE has an open-door policy where employees can raise their concern to management without any fear of retaliation.
    d. Employees can also approach the Compliance Officer to express their concerns.
2. External: There are two ways that clients can voice their concerns:
    a. The Compliance hotline is fully functional, and the number is available on the NMRE website.
    b. Clients can use the compliance email account to share their concerns.

E. Auditing and Monitoring

1. Medicaid Encounter Verification

   Medicaid Encounter Verification audits were conducted quarterly. This process allows the NMRE to ensure that all claims for services are properly documented and that services were provided prior to payment. This audit was completed quarterly, and the results were shared with the providers. If an audited sample yielded less than 95% accuracy, a Plan of Correction was required. If an audited population fell below 90% accuracy during a 12-month period, a stratified sample was pulled, and a plan of correction required.

   - CMHSP Direct Provided Services Population (5 Providers Total)
     - ✓ 40 Services per year, 10 per Quarter
   - CMHSP Subcontractors Provided Services Population (5 Providers Total)
     - ✓ 40 Services per year, 10 per Quarter
   - SUD Provider Population (1 Provider Total)
     - ✓ 60 Services per year, 15 per Quarter
   - Financially Significant Population (3 SUD, 0 CMHSP)
     - ✓ 40 Services per year, 10 per Quarter
     - ✓ Any single provider that accounts for more than 10% of the total MH or SUD budgets accordingly.
   - Stratified Population-if review yields less than 90% accuracy

   Five (5) CMHSP Review Summary- see attachment for detailed report. For details on the population of providers, see sampling methodology above.

   a. Five providers were audited (CMH Contracted Services and CMH Direct Services)

   b. $146,890.56 dollars were audited, with $146,509.64 dollars validated.

   c. 400 encounters were audited and 198 were valid.

   d. $380.92 dollars were invalid

   e. 99.5% of encounters were compliant

   Ten (10) SUD Provider Review Summary- see attachment for detailed report. For details on the population of providers, see sampling methodology above.

   a. Ten providers total were audited

   b. $58,837.10 dollars were audited, with $5,890.72 dollars validated.

c. 180 encounters were audited and 153 were valid.

d. $2,946.38 dollars were invalid

e. 85% of encounters were compliant

The Medicaid Encounter Verification Audit for FY22 resulted in a few plans of correction which were due to the NMRE 30 days after the final MEV report was received by the providers. It was noted that many providers struggled with the following issues:

- Staff shortage, especially with the SUD providers. As a result of this, staff were stretched too thin which caused them to miss certain steps at the job.
- High turnover also played a major factor; when staff leave, they take away knowledge and new staff need to be trained all over again. During the training period, certain processes were missed as new staff were already on board.

Grand totals for the NMRE's FY22 MEV audit were as follows:

a. For details on the population of providers, see sampling methodology above.

b. 15 Providers in total were audited

c. $205,727.66 dollars was audited, with $202,400.36 dollars validated resulting in a compliance rate of 95%.

d. 580 encounters were audited, with 551 encounters validated.

e. $3,327.03 dollars and 29 encounters were found to be invalid

Persistent challenges such as the pandemic, high staff turnover, and staff shortage, caused a 1% decrease in MEV results in 2022 compared to 2021.

2. Prevention Program

The NMRE contracts with four prevention providers to deliver evidence-based programs with fidelity standards as well as other services to prevent youth drinking, marijuana misuse, drug misuse, and youth tobacco sales within the 21-county region. The annual audit involves a random sample method that includes program monitoring, staff verifications, and Michigan Prevention Data System (MPDS) verifications and is conducted through site visits (if applicable), desk review, and concludes with an exit interview. The Prevention Monitoring tool breaks down each section in detail to compile the results, see explanations below.

Provider	Program Monitoring	Staff	MPDS	Synar Complete	Total	Records Audited
Catholic Human Services	90%	100%	73%		81%	19
Centra Wellness CMH	59%	100%	86%		82%	13
District Health Dept #10	100%	100%	100%		100%	10
Health Department Northwest Mich.	98%	100%	100%		99%	14
District Health Dept #2						
NMRE Grand Total	**87%**	**100%**	**90%**		**91%**	**56**

Definitions/Explanations*

Program Monitoring- Review assessments, meeting minutes, publication samples/approvals, Prevention Plans, Cultural Competency, and reporting

Staff Verification- Credentials, background checks, and trainings

MPDS- Direct services are entered into this state system within 30 days of service. Contracted providers deliver supporting documentation that this activity occurred as billed.

Synar checks- In accordance with the Federal Youth Tobacco Act, the NMRE Contracts with Designated Youth Tobacco Use Representative (DYTUR) to ensure retailers do not sell tobacco or Electronic Nicotine Delivery Systems (ENDS) to underage persons.

F. Customer Service Calls

Calls for assistance came in via the customer services direct telephone line. Requests were also submitted by providers or consumers using the online NMRE ticket system. The most common reasons for calls received in 2022 from consumers were:

1. Did not understand the ABD they received
2. Request for local resources
3. Not getting the assistance from the CMH they feel they should receive
4. SUD Grievances

The most common categories of calls received in 2022 from non-consumers were:

1. Provider request for information
2. Grievance, Appeal, or Rights processes

3. Materials requests
4. Case Consultations

G. Day of Recovery Education

The NMRE hosted the Day of Mental Health Education at Treetops Resort on May 20, 2022. Out of 112 individuals who registered, 109 attended. The day consisted of break-out sessions in the morning, lunch with entertainment, and the keynote session following. 15 door prizes (gift baskets) were given out via drawings throughout the day. Several gifts were available for attendees which included t-shirts, stress balls, pens, buttons and pins, water bottles, chap stick, lunch bags, hand sanitizer, and a variety of other items as well as abundant informational flyers and brochures.

A survey was completed by approximately 70 attendees who rated the event. Below is the feedback.

- Location: 69/70 Strongly Liked
- Food: 64/70 Liked
- Keynote Joseph Reid: 70/70 Strongly Liked
- Sharing Circle: Tom Melnik: Strongly Liked
- Living With DID: Catherine Rubino: Strongly Liked
- Peer Support and Advocacy: Josette Hoch: Strongly Liked
- Supporting People With MI: Barb Murphy and Eileen Tank: Strongly Liked

Though attendance was lower than normal due to COVID outbreaks and transportation issues, the event was well-attended. Attendee feedback also shared a couple of opportunities for improvement such as, lunch and breakfast selections. Other organizational issues that the NMRE will address with the CMHSPs include transportation and dissemination of information.

H. Home and Community Based Services (HCBS)

1. Non-responsive Setting Remediation/Validation
    a. The NMRE worked with the CMHSPs and their providers to remediate issues involving sites with issues of compliance with the HCBS rules that are going into effect in March of 2023.

2. Current Project
    a. The NMRE is currently working with the CMHSPs through the four transition paths for individuals who are in settings that are considered noncompliant with the HCBS final rule.
3. Surveys
    a. CMHSPs continue to work with the NMRE to complete provisional HCBS surveys.
    b. Preparations are being made to administer new surveys to settings that received provisional surveys after September 4, 2021, and to individuals who are on the Heighten Scrutiny list.
4. Compliant Settings
    a. The NMRE is working with MDHHS to identify compliant settings to share with the CMHSPs, clients, and guardians.

I. DocuSign

A feature that NMRE had planned to implement for FY2022 is DocuSign. DocuSign has been implemented and has been a success in decreasing the processing time in the contract process, securing any PHI in the contract process, and assisted in organizing the status of various agreements (as organized by funding type, what has held up the execution of agreements, ensuring agreements are not lost in email or other secure folder mishandling, etc.)

The NMRE's Compliance Program document is reviewed and updated annually with input from various stakeholders and approved by the Governing Board. The NMRE's Governing Board, and the Internal Operations Committee are responsible for the evaluation of the effectiveness of the Compliance Program. Information on the effectiveness of the Compliance Program will be provided to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS annually and no later than February 28.

The NMRE publishes its Compliance Program effectiveness Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing desired outcomes. This report is shared with the NMRE Board of Directors, Provider Network, Regional Consumer Council, and other interested stakeholders.

The NMRE posts this document on the website https://www.nmre.org. Copies of this document can be made available to stakeholders upon request.

V. 2023 COMPLIANCE PROGRAM WORKPLAN

Goal 1: Transition Substance Use Disorder (SUD) exclusion check activities from the NMRE to the SUD Providers. (The NMRE will continue to run exclusion checks for the SUD providers until the transition is complete.)

Objective 1: Review Exclusion Check policy with SUD providers and update, if necessary.

Objective 2: Share the Exclusion Checks Policy with providers and receive feedback to make sure everyone is on the same page.

Objective 3: Provide necessary information and assistance to ensure a smooth transition.

Goal 2: Improve Medicaid Encounter Verification (MEV) reporting capability by transitioning into Power BI.

Objective 1: Continue to work with IT to provide details on the current flow and the expected outcome.

Objective 2: Collaborate with IT to work through the design and the testing of the new Power BI reporting functionality.

Objective 3: Validate reports in the new system.

Goal 3: Strengthen the Medicaid Encounter Verification (MEV) review process.

Objective 1: Identify areas that need improvement, potentially adding other areas for review (such as modifiers).

Objective 2: Collaborate with other PIHPs to find out how MEV is completed at their agency and see what new ideas can be incorporated.

Objective 3: Collaborate with Internal Operations Committee (IOC) to identify what other changes can be incorporated.

Objective 4: Work internally to incorporate changes.

Goal 4: Update training material.

Objective 1: Update the Compliance and Ethics training and the HIPAA Information Security and Awareness training material to include recommendation from HSAG during the 2022 Compliance review.

Objective 2: Provide training to staff on the updated material.

Objective 3: Obtain attestation that training was complete.

Goal 5: Update some existing policies and create new policies and procedures. These policies are required to ensure the effectiveness of the Compliance Program.

Objective 1: Create new policies and update some existing policies and procedures to include recommendation from HSAG during the 2022 Compliance review.

Objective 2: Provide training to staff on the new and updated material.

Objective 3: Obtain attestation that training was complete.