Michigan Department of Health and Human Services

Behavioral Health and Developmental Disabilities Administration

State Fiscal Year 2021 Compliance Review *for* Prepaid Inpatient Health Plans

Region 5—Mid-State Health Network

October 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the state, an agent that is not a Medicaid prepaid inpatient health plan (PIHP), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114 and the quality assessment and performance improvement requirements described in §438.330.

To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct compliance reviews of its contracted PIHPs responsible for the delivery of Medicaid waiver benefits for people with intellectual and developmental disabilities (IDD), serious mental illness (SMI), and serious emotional disturbance (SED), and prevention and treatment services for substance use disorders (SUDs).[1-1]

Description of the Compliance Review

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The state fiscal year (SFY) 2021 compliance review commenced a new three-year cycle of compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable State contract requirements. The compliance reviews in Michigan consist of 13 standards or program areas. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021). The remaining seven standards will be reviewed in Year Two (SFY 2022). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews. Table 1-1 outlines the standards reviewed over the new three-year review cycle.

[1-1] The PIHPs serve Medicaid members who require the Medicaid services included under the following: the 1115 Demonstration Waiver, 1915(i); those eligible for the 1115 Healthy Michigan Plan (HMP), the Flint 1115 Waiver, or Community Block Grant, who are enrolled in the 1915(c) Habilitation Supports Waiver (HSW); those eligible for the 1915(c) Children Waivers (Serious Emotional Disturbance Waiver [SEDW] and Children's Waiver Program [CWP]), who are enrolled in program; or those whom the PIHP has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHPs also serve individuals covered under the SUD Community Grant.

Table 1-1—Three-Year Cycle of Compliance Reviews

Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	✓		Review of PIHP implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Emergency and Poststabilization Services	✓		
Standard III—Availability of Services	✓		
Standard IV—Assurances of Adequate Capacity and Services	✓		
Standard V—Coordination and Continuity of Care	✓		
Standard VI—Coverage and Authorization of Services	✓		
Standard VII—Provider Selection		✓	
Standard VIII—Confidentiality		✓	
Standard IX—Grievance and Appeal Systems		✓	
Standard X—Subcontractual Relationships and Delegation		✓	
Standard XI—Practice Guidelines		✓	
Standard XII—Health Information Systems		✓	
Standard XIII—Quality Assessment and Performance Improvement Program		✓	

Overview of Findings

Review of Standards

From a review of documents, observations, and interviews with key **Mid-State Health Network** staff members as well as file reviews conducted during the desk review and virtual interviews, the reviewers assigned **Mid-State Health Network** a score for each element and an aggregate score for each standard. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2—Methodology. If a requirement was not applicable to **Mid-State Health Network** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all six standards. Table 1-2 presents a summary of **Mid-State Health Network**'s performance results.

Table 1-2—Summary of Standard Compliance Scores

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	5	2	0	**71%**
IV	Assurances of Adequate Capacity and Services	4	4	1	3	0	**25%**
V	Coordination and Continuity of Care	14	14	13	1	0	**93%**
VI	Coverage and Authorization of Services	11	11	10	1	0	**91%**
Total		**65**	**65**	**55**	**10**	**0**	**85%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

*Performance in Standard II should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Mid-State Health Network demonstrated compliance in 55 of 65 elements, with an overall compliance score of 85 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Detailed findings, including recommendations for program enhancements, are documented in Appendix A—Compliance Review Tool.

Corrective Action Process

For any elements scored *Not Met*, **Mid-State Health Network** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP and the criteria used to evaluate the sufficiency of the CAP are described in Section 3.

2. Methodology

Introduction

The following description of the way HSAG conducted—in accordance with 42 CFR §438.358—the external quality review (EQR) of compliance with standards for the Michigan Medicaid managed care program addresses HSAG's:

- Objective of conducting the review of compliance with standards.
- Compliance review activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG followed standardized processes in conducting the review of the PIHP's performance.

Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to MDHHS and the PIHP regarding compliance with the State and federal requirements. HSAG assembled a team to:

- Collaborate with MDHHS to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, virtual review[2-1] activity schedules, and virtual review agenda.
- Collect and review data and documents before and during the virtual review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective, and based on the results of collaborative planning with MDHHS, HSAG developed and used a data collection tool to assess and document the PIHP's compliance with certain federal Medicaid managed care regulations, State rules, and the associated MDHHS contractual requirements. Beginning in SFY 2021, MDHHS requested that HSAG conduct compliance reviews over a three-year cycle with one-half of the standards being reviewed in Year One, the remaining standards in Year Two, and a comprehensive review of each element scored as *Not Met* during Year One (SFY 2021) and Year Two (SFY 2022) during Year Three (SFY 2023). The division of standards over the three years can be found in Table 1-1. The review tool developed for this year's review (SFY 2021) included requirements that addressed the following performance areas:

- Standard I—Member Rights and Member Information

[2-1] Due to the current pandemic, the on-site review component of the compliance activity was held virtually via Webex.

- Standard II—Emergency and Poststabilization Services
- Standard III—Availability of Services
- Standard IV—Assurances of Adequate Capacity and Services
- Standard V—Coordination and Continuity of Care
- Standard VI—Coverage and Authorization of Services

MDHHS and the PIHP will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between MDHHS and the PIHP as they related to the scope of the review. HSAG also followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[2-2] for the following activities:

Pre-Review Activities

Pre-review activities included:

- Scheduling the virtual reviews.
- Developing the compliance review tools.
- Preparing and forwarding to the PIHP an information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a preparation session with the PIHP.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from MDHHS, and of documents the PIHP submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PIHP's operations, identify areas needing clarification, and begin compiling information before the virtual review.

[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 16, 2021.

- Generating a list of 10 sample records for service authorization denials from the universe file submitted to HSAG from the PIHP.
- Developing the agenda for the one-day virtual review.
- Providing the detailed agenda to the PIHP to facilitate preparation for HSAG's virtual review.

Virtual Review Activities

Virtual review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of the documents HSAG requested that the PIHP have available during the interview sessions.
- A review of service authorization denial records HSAG requested from the PIHP.
- A review of the data systems that the PIHP used in its operations such as utilization management and care coordination.
- Interviews conducted with the PIHP's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

HSAG documented its findings in the data collection tool (compliance review tool) shown in Appendix A—Compliance Review Tool, which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the PIHP's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Description of Data Obtained

To assess the PIHP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the PIHP, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- PIHP-maintained records for service authorization denials.
- PIHP's online member handbook and provider directory.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the PIHP's key staff members.

Table 2-1 lists the major data sources HSAG used in determining the PIHP's performance in complying with requirements and the time period to which the data applied.

Table 2-1—Description of PIHP Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	October 1, 2020–March 31, 2021
Information obtained through interviews	July 19, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding concurrent reviews) between October 1, 2020–March 31, 2021

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the PIHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a PIHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. The scoring methodology is displayed in Table 2-2.

Table 2-2—Scoring Methodology

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including PIHP data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof, are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.

Compliance Score	Point Value	Definition
		• Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice. • No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements *Not Applicable* to the PIHP were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

- For the member handbook, provider directory, member rights, appointment standards, and time/distance standards checklists reviewed, HSAG assessed each applicable element within the checklist as either (1) *Yes*, the element was contained within the associated document(s), or (2) *No*, the element was not contained within the document(s). The findings from the checklists were used to determine overall compliance with the applicable standard and element in the compliance review tool (i.e., member handbook content requirements within Standard I—Member Rights and Member Information).

HSAG conducted file reviews of the PIHP's records for service authorization denials to verify that the PIHP had put into practice what the PIHP had documented in its policy, as well as adhered to timely review of authorization requirements. HSAG selected 10 records of service authorization denials from the full universe of records provided by the PIHP. The file reviews were not intended to be a statistically significant representation of all the PIHP's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by PIHP staff members. Based on the results of the file reviews, the PIHP must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality and timeliness of, and access to, care and services the PIHP provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the PIHP's progress in achieving compliance with State and federal requirements.
- Scores assigned to the PIHP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to MDHHS for its review and comment prior to issuing final reports.

3. Corrective Action Plan Process

Appendix B contains the CAP template that HSAG prepared for **Mid-State Health Network** to use in preparing its CAP to be submitted to MDHHS. The template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **Mid-State Health Network** must use this template to submit its CAP to bring any elements scored *Not Met* into compliance with the applicable standard(s). **Mid-State Health Network**'s CAP must be submitted to MDHHS and HSAG no later than 30 calendar days of receipt of HSAG's final *State Fiscal Year 2021 Compliance Review* report.

The following criteria will be used to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned activities/interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the organization until approved by MDHHS. MDHHS maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **Mid-State Health Network** in its submitted CAP.

Appendix A. Compliance Review Tool

Following this page is the completed compliance review tool that HSAG used to evaluate **Mid-State Health Network**'s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring **Mid-State Health Network**'s performance into full compliance.

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Member Rights: General Rule		
1. The PIHP has written policies regarding the member rights specified in 42 CFR §438.100. 42 CFR §438.100(a)(1)	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • CS_Enrollee_Rights_Policy	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
2. The PIHP complies with any applicable Federal and State laws that pertain to member rights, and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms **Evidence as Submitted by the PIHP:** • CS_Enrollee_Rights_Policy • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, Delegation Grid, Pgs. 37 to 58 • MSHN Training Grid FY21 • PNM_Provider_Network_Mgmt_Policy • 2021 CMHSP Delegated Managed Care Tool, Section #2, ENROLLEE RIGHTS AND PROTECTIONS, Pgs. 4-5 • MMRS_ MSHN ABD Review Tool	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• MMRS_2020 Delegated Functions Review- Final, pgs. 8, 11, 27-28 • MMRS_SUD Corrective Action Plan_Accepted_03.15.21	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Specific Rights: Basic Requirement		
3. The PIHP ensures that each managed care member is guaranteed the rights as specified in 42 CFR §438.100(b)(2) and (3)—Refer to the Member Rights Checklist. 42 CFR §438.100(b)(1-3)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the PIHP: • R5-Mid-State_MI2021_PIHP_CR_Standard I_Member Rights Checklist_D1 • CS_Enrollee_Rights_Policy • MSHN_ FY21 LIFEWAYS_Handbook • 2021 CMHSP Delegated Managed Care Tool, Section #2, ENROLLEE RIGHTS AND PROTECTIONS, Pgs. 4-5	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Language Requirements: Basic Rule		
4. The PIHP uses: a. Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. b. Model member handbook and member notices. c. *Definitions for mental health terminology including: access; adult benefit waiver; amount, duration, and scope; beneficiary; CA; CMHSP; Fair Hearing; deductible (or spend-down); Developmental Disability; Health Insurance Portability and Accountability Act of 1996 (HIPAA); MDCH; Michigan Mental Health Code; MIChild; PIHP; recovery; resiliency; specialty supports and services; SED; serious mental illness; substance abuse disorder (or substance abuse).* 42 CFR §438.10(c)(4)(i-ii) Contract Schedule A–1(B)(4)(j)(i)(4); 1(M)(2)(vii)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD), grievance, and appeal letter templates **Evidence as Submitted by the PIHP:** • MSHN_ FY21 LIFEWAYS_Handbook, Behavioral Health & Substance Use Disorder Glossary, pgs. 84-93 • MSHN Customer Service Handbook Approval Letter 02.26.2021 • Final-FY19 #2 Adverse Benefit Determination • Final-FY19 #2 Notice of Receipt Grievance • Final-FY19 #2 Notice of Receipt of Appeal • Final-FY19 #2 Notice of Appeal Approval • Final-FY19 #2 Notice of Appeal Denial	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
5. Member information required in 42 CFR §438.10 may not be provided electronically by the PIHP unless all of the following are met: a. The format is readily accessible; b. The information is placed in a location on the PIHP's Web site that is prominent and readily accessible; c. The information is provided in an electronic form which can be electronically retained and printed; d. The information is consistent with the content and language requirements of 42 CFR §438.10; and e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days. 42 CFR §438.10(c)(6)(i-v) Contract Schedule A–1(M)(2)(a-b)	**HSAG Recommended Evidence:** • Policies and procedures • One example of member information that is only provided in an electronic format; and subsequent communication to inform member of the availability of electronic information • Reporting or tracking mechanisms for providing member materials in paper form upon request **Evidence as Submitted by the PIHP:** • CS_Enrollee_Rights_Policy • CS_Customer_Consumer_Service_Policy • BABH_Acknowledgement of Receipt • BABH-General Intake Process-Primary Care Services Policy.Procedure • GIHN Orientation Checklist • NCMH Consent for treatment	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Language and Format		
6. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the PIHP's member/customer service unit. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. 42 CFR §438.10(d)(3) Contract Schedule A–1(M)(2)(b)	**HSAG Recommended Evidence:** • Policies and procedures • Spanish member handbook (provide handbook and link to website; PIHP and community mental health services programs (CMHSPs), as applicable) • Spanish provider directory (provide excerpts of directory and link to website; PIHP and CMHSPs, as applicable) • Taglines included with member information **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP • MSHN_ FY21 LIFEWAYS_Handbook, pgs. 6,7, 10 • 2021 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • FY21 MSHN Guide to Services LIFEWAYS_SPANISH • Member Handbook - Mid-State Health Network (midstatehealthnetwork.org) • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 38 • CSC Meeting Minutes 10.15.18	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: Mid-State Health Network (MSHN) maintains an annual process to have the MSHN Guide to Services translated into Spanish. During the October 15, 2018 Customer Service Committee meeting, see minutes, it was discussed that the need is infrequent for LEP formatted appeal and grievance notices, and denial and termination notices. It was determined that providers would work with their contracted LEP translation service to translate Notices and extend the effective date to accommodate the additional timeframe for the translation of the notice.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The PIHP's written materials that are critical to obtaining services (e.g., provider directory, appeal and grievance notices, and denial and termination notices), with the exception of the member handbook, did not include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		
Required Actions: The PIHP must ensure that written materials that are critical to obtaining services include all the requirements identified in this element.		
7. The PIHP provides information to members who are limited English proficient through the provision of language services at no cost to the individual. a. *All written materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language,* and any additional prevalent languages identified by MDHHS in the future at no additional cost to MDHHS. b. Per 42 CFR §438.340(b)(6), at the time of enrollment with the PIHP, MDHHS will provide the primary language of each member. c. The PIHP shall also identify additional languages that are prevalent among the PIHP's membership. *For purposes of this requirement, prevalent non-English language is defined as any language spoken as the primary language by more than five percent (5%) of the population in the PIHP's Region.* d. Written information shall be provided in any such prevalent languages identified by the PIHP. 42 CFR §438.10(d)(4) 42 CFR §438.340(b)(6) Contract Schedule A–1(M)(2)(a)(iv)	**HSAG Recommended Evidence:** • Policies and procedures • Linguistic analysis of member population • Screenshot of health information system (HIS) where primary language of member is stored • Workflow for generating member materials/information in a member's primary language (English and Spanish) that is stored in the HIS • Two examples of member notices, such as ABD notice, grievance resolution letter, and appeal resolution letter, etc., sent in Spanish **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP • MSHN_ FY21 LIFEWAYS_Handbook, pg. 10 • 2021 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1, item #1.5 • FY21 MSHN Guide to Services LIFEWAYS_SPANISH • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 38 • The Right Door.ABD.Spanish	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** To further enhance the PIHP's monitoring of delegated functions to contracted CMHSPs, HSAG recommends that the PIHP consider including the evaluation of the CMHSPs' tracking mechanisms for member requests for translation of informational materials, and routine analysis of the linguistic needs of members to the PIHP's Annual Delegated Managed Care monitoring tool. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
8. The PIHP notifies its members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access the services in §438.10(d)(5)(i) and (ii). 42 CFR §438.10(d)(5)(i-iii) Contract 1(M)(2)(b)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP • MSHN_ FY21 LIFEWAYS_Handbook, pg. 10 • 2021 CMHSP Delegated Managed Care Tool, INFORMATION, Pg. 1, item 1.6, • FY21 MSHN Guide to Services LIFEWAYS_SPANISH • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 38	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
9. The PIHP provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. *All such materials must be written at the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the grade level criteria).* b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. 42 CFR §438.10(d)(6)(i-iii) Contract Schedule A–1(M)(2)(a-b)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Two examples of member notices, such as ABD notice, grievance resolution letter, and appeal resolution letter, etc. • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Workflow and verification procedures for ensuring member materials are Section 508 compliant • Taglines included with member information **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP • Final-FY19 #2 Adverse Benefit Determination • Final-FY19 #2 Notice of Receipt Grievance • MSHN_ FY21 LIFEWAYS_Handbook, pgs. 6,7, 10 • 2021 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1, items 1.2, 1.3 • FY21 MSHN Guide to Services LIFEWAYS_SPANISH • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 38	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** To further enhance the PIHP's monitoring of delegated functions to contracted CMHSPs, HSAG recommends that the PIHP consider including the evaluation of the CMHSPs' tracking mechanisms for member requests for alternative formats, verification of required reading grade level, and		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
auxiliary aids for informational materials to the PIHP's Annual Delegated Managed Care monitoring tool. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
Information for All Members With PIHP—General Requirements		
10. The PIHP must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. a. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) Contract Schedule A–1(M)(2)(b)(ii)(3)	**HSAG Recommended Evidence:** • Policies and procedures • One example of written notice to members of provider termination (include the effective date of the termination or receipt or issuance of the termination notice for this example) • Tracking or reporting mechanisms (mailing date and effective date of the termination or receipt or issuance of the termination notice must be notated) **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy, pg 2, item Q • Holy Cross Suspension and Termination of Services - 1.29.21 • Holy Cross Contract Termination Notice Acknowledgement - Eff. 3.30.21 • Holy Cross-Closure Notification Letter • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 39 • 2021 CMHSP Delegated Managed Care Tool, pg. 3, item 1.9	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: While the Customer_Consumer Service Policy and the CMHSP subcontracting agreement specified that the PIHP made a good faith effort to give affected members written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination, the		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
documents did not include the federal requirement that notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.		
Required Actions: The PIHP must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen regularly by, the terminated provider. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.		
11. The PIHP must make available, upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) Contract Schedule A–1(M)(2)(b)(ii)(4)	**HSAG Recommended Evidence:** • Policies and procedures • Summary of physician incentive plans • One example of a physician incentive plan provided to a member upon request (if an example is not available, state so under the PIHP Description of Process) **Evidence as Submitted by the PIHP:** • MSHN_ FY21 LIFEWAYS_Handbook, pg. 60	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Mid-State Health Network (MSHN) does not use any type of physician or other financial incentive plans to limit the services available to members. MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Medicaid enrollee.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Information for All Members With PIHP—Member Handbook		
12. The PIHP must provide each member a member handbook, within a reasonable time after receiving notice of the member's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR §147.200(a). 45 CFR §147.200(a) 42 CFR §438.10(g)(1) Contract Schedule A–1(B)(3)(f)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking or reporting mechanisms (include the date the PIHP received notice of the member's enrollment and the mailing date of the member handbook/member enrollment materials) **Evidence as Submitted by the PIHP:** • CS_Customer_Handbook_Policy • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 39 • BABH_Acknowledgement of Receipt • BABH-General Intake Process-Primary Care Services Policy.Procedure • GIHN Orientation Checklist • NCMH Consent for treatment • 2021 CMHSP Delegated Managed Care Tool, pg. 3, item 1.7(i)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
13. The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program—Refer to the Member Handbook Checklist. 42 CFR §438.10(g)(2)(i-xvi) Contract Schedule A–1(B)(4)	**HSAG Recommended Evidence:** • Member handbook (provide handbook and link to website) • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the PIHP:** • CS_Customer_Handbook_Policy • MSHN_ FY21 LIFEWAYS_Handbook, pgs. 2, 31-61 • https://midstatehealthnetwork.org/consumers-resources/customer-services/handbook • R5-Mid-State_MI2021_PIHP_CR_Standard I_Member Handbook Checklist_D1	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
14. Information required by 42 CFR §438.10(g) (member handbook) is considered to be provided if the PIHP: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the Web site of the PIHP and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot	**HSAG Recommended Evidence:** • Policies and procedures • Reporting or tracking mechanisms for providing member handbook in paper form via mail • Member enrollment materials **Evidence as Submitted by the PIHP:** • CS_Customer_Handbook_Policy • CS_Customer_Consumer_Service_Policy • CS_Enrollee_Rights_Policy	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 42 CFR §438.10(g)(3)(i-iv) Contract Schedule A–1(B)(3)(h)	• Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 39	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
15. The PIHP must give each member notice of any change that MDHHS defines as significant in the information specified in 42 CFR §438.10(g), at least 30 days before the intended effective date of the change. 42 CFR §438.10(g)(4)	**HSAG Recommended Evidence:** • Policies and procedures • One example of member notice due to a significant change in the information in the member handbook, including the date of notice and date of change (if no significant change, please state so under the PIHP Description of Process) • Tracking or reporting mechanisms for providing timely notice of a significant change **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy, pg. 2, item P • CS_Customer_Handbook_Policy, pg. 1, item A	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Mid-State Health Network (MSHN) has not provided any notice of significant changes to members. If/when MDHHS contractual requirement updates are made, MSHN will give each individual written notice of any significant change in the information at least 30 days		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
before the intended effective date of the change. Prior instances of written notice have been done by a Consumer Handbook insert to communicate the significant information changes.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Information for All Members of PIHP—Provider Directory		
16. The PIHP must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist. 42 CFR §438.10(h)(1)(i-viii) Contract Schedule A–1(M)(1)	**HSAG Recommended Evidence:** • Provider directory (provide excerpts of directory and link to website; PIHP and CMHSPs, as applicable) • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the PIHP:** • MSHN Provider Directory Website - https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory • Print Directory Example (midstate_directory_result_2021_04_12).xls - Example of the download produced from the website on 4.12.21 • PNM_Provider_Directory_Policy • CS_Customer_Consumer_Service_Policy, pg. 1, item A • MSHN_ FY21 LIFEWAYS_Handbook, pg. 14 • R5-Mid-State_MI2021_PIHP_CR_Standard I_Provider Directory Checklist_D1	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: CMHSPs are to submit their electronic directory on the 4th Friday of the month. The following week, MSHN exports the directories along with the SUD Network directory into a single CSV file and uploads the entire file into the MSHN website which is machine readable.		

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Requirement	**Supporting Documentation**	**Score**
Any person who visits the MSHN web-based directory can download/print the directory by clicking on the 'Download/Print Directory' link. An excel file will download and can be further customized/formatted for a print friend version.		
HSAG Findings: The PIHP's provider directory did not include all required content. The specific details of provider office accommodations for persons with physical disabilities (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment) were not listed in the provider directory, only a "Yes" or "No" if the provider had Americans with Disabilities Act (ADA)-compliant accommodations. Additionally, the provider's cultural capabilities were not included in the directory as required.		
Required Actions: The PIHP must ensure that provider directories contain all federally required content.		
17. Information included in— a. A paper provider directory must be updated at least— i. Monthly, if the PIHP does not have a mobile-enabled, electronic directory; or ii. Quarterly, if the PIHP has a mobile-enabled, electronic provider directory. b. An electronic provider directory must be updated no later than 30 calendar days after the PIHP receives updated provider information. 42 CFR §438.10(h)(3)(i-ii) Contract Schedule A–1(M)(1)(a-b)	**HSAG Recommended Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow to update paper and electronic provider directory • Evidence how updates to paper and electronic provider directory are date stamped (version tracking) **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy, pg. 1, item A • PN – Provider Directory Policy • PN – Provider Directory Procedure • Provider Directory Upload (Internal procedure) • Screenshot – Provider Directory Uploads • REMI – Affiliate Submission Screenshot – Provider Directory • Provider Directory – phone screenshots • ITR Request - Directory Validations • Approved Contract Services List 12.3.20	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The file Provider Directory Upload (internal procedure) outlines the steps/workflow that CMHs and MSHN take to produce an updated directory on the MSHN website. The file titled Screenshot – Provider Directory Uploads provides evidence that MSHN has been following this process since April 2018 with date stamps reflecting dates of the Website upload. The file titled REMI – Affiliate Submission Screenshot – Provider		

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Requirement	**Supporting Documentation**	**Score**
Directory provides evidence of CMHs Directory Submission to MSHN with date stamps. While the electronic directory must be updated quarterly, MSHNs procedure includes monthly submission and refresh to ensure changes are captured within 30 days. To ensure consistency of 'services' provided by each provider, the region has develop an approved list to ensure the filtering feature is standardized. The file titled Approved Contract Services List 12.3.20 outlines the list of services which includes Independent Facilitation and Fiscal Intermediaries as noted on the directory checklist. During Nov 2020-February 2021, MSHN was working with PCE to automate the process of compiling and cleaning up a full network directory which was previously conducted by MSHN data analyst. We continue to refine the process and are working to put additional data validations into place to ensure all required information is provided. Refer to file titled ITR Request – Data Validations which was submitted to PCE on 3.8.21. NOTE: due to recent changes to the process, we are updating the board approved policy and procedure which are going to Committee in April 2021. Versions provided are the current board approved versions.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
18. Provider directories must be made available on the PIHP's Web site in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) Contract Schedule A–1(M)(1)(c)	**HSAG Recommended Evidence:** • Policies and procedures • Provider directory (provide link to website) • Verification provider directory is available in a machine-readable file and format (PIHP and CMHSPs, as applicable) **Evidence as Submitted by the PIHP:** • Provider Directory – phone screenshots	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Please refer to narrative above (#17). To verify it is optimized for mobile use, please visit https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory on your phone or refer to the file titled Provider Directory – phone screenshot. You will notice that a user can click on the phone number, email address, or provider website as well as utilize the filter function from their mobile device.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** According to CMS guidance provided in the 2016 Medicaid Managed Care Rule pertaining to provider directories, CMS proposed that "provider directories be made available on the MCO's, PIHP's, PAHP's, or if applicable, PCCM entity's Web site in a machine readable file and format specified by the Secretary." While not specifically identified in the Medicaid Managed Care Rule, "machine-readable file" is defined by the Hospital Price Transparency Final Rule as: "A digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats." Although the PIHP received a score of *Met* for this element, HSAG strongly recommends the PIHP implement a process to routinely evaluate and confirm its provider directory posted to its website is in a machine-readable format. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
Information for All Members of PIHP—Preferred Drug List		
19. The PIHP must make available in electronic or paper form, the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. c. Formulary drug lists must be made available on the PIHP's Web site in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(1-3)	**HSAG Recommended Evidence:** • Policies and procedures • Formulary (provide link to website and excerpts of the formulary) • Verification electronic formulary is available in a machine-readable file and format (PIHP and CMHSPs, as applicable) **Evidence as Submitted by the PIHP:** • This standard is not applicable.	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Per the MDHHS-PIHP Medicaid Managed Services and Specialty Supports Contract the PIHP is not responsible for providing any medication coverage to individuals it serves. This standard is not applicable.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Recommendations: Although the PIHP is not required to maintain a separate formulary from MDHHS' Medicaid Health Plan Common Formulary, the PIHP could consider adding a link to its website to the state Medicaid formulary to aid members in understanding medication coverage and benefits.		
Required Actions: None.		

Standard I—Member Rights and Member Information						
Met	=	16	X	1	=	16
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	19	Total Score		=	16
Total Score ÷ Total Applicable					=	84%

Member Rights Checklist (Refer to Standard I, Element 3 for findings)	
Reference	**Required Components**
	A member with the PIHP has the following rights:
42 CFR §438.100(b)(2)(i)	1. Receive information in accordance with 42 CFR §438.10. a. CS_Enrollee_Rights_Policy, Section 2(a) b. 2021 CMHSP Delegated Managed Care Tool, All section 1: INFORMATION (CUSTOMER SERVICES) section
42 CFR §438.100(b)(2)(ii)	2. Be treated with respect and with due consideration for his or her dignity and privacy. a. CS_Enrollee_Rights_Policy, Section 2(b) b. 2021 CMHSP Delegated Managed Care Tool, item 2.4

Member Rights Checklist (Refer to Standard I, Element 3 for findings)	
Reference	**Required Components**
42 CFR §438.100(b)(2)(iii)	3. Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR §438.10[g][2][ii][A] and [B].) a. CS_Enrollee_Rights_Policy, Section 2(c) b. 2021 CMHSP Delegated Managed Care Tool, item 2.5
42 CFR §438.100(b)(2)(iv)	4. Participate in decisions regarding his or her healthcare, including the right to refuse treatment. a. CS_Enrollee_Rights_Policy, Section 2(d) b. 2021 CMHSP Delegated Managed Care Tool, item 2.7
42 CFR §438.100(b)(2)(v)	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. a. CS_Enrollee_Rights_Policy, Section 2(e) b. 2021 CMHSP Delegated Managed Care Tool, item 2.9
42 CFR §438.100(b)(2)(vi)	6. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. a. CS_Enrollee_Rights_Policy, Section 2(f)
42 CFR §438.100(b)(3)	7. Be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210. a. CS_Enrollee_Rights_Policy, Section 2(g) b. 2021 CMHSP Delegated Managed Care Tool, item 1.3
42 CFR §438.100(c)	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PIHP and its network providers or MDHHS treat the member. a. CS_Enrollee_Rights_Policy, Section 3(a) b. 2021 CMHSP Delegated Managed Care Tool, item 2.9
42 CFR §438.100(d)	9. The PIHP shall comply with any other applicable federal and State laws including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972

Member Rights Checklist (Refer to Standard I, Element 3 for findings)	
Reference	**Required Components**
	(regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act. a. CS_Enrollee_Rights_Policy, Section 4(a)

Member Handbook Checklist (Refer to Standard I, Element 13 for findings)	
Reference	**Required Components**
The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program. This information must include at a minimum:	
42 CFR §438.10(g)(2)(i) Contract Schedule A–1(B)(4)(j)(ii)(1)	1. Benefits provided by the PIHP. a. LIFEWAYS_ FY21_Member Handbook, Pgs. 62-71, Medicaid Specialty Supports and Service Array
42 CFR §438.10(g)(2)(ii) Contract Schedule A–1(B)(4)(j)(ii)(2)	2. About how and where to access any benefits provided by MDHHS, including any cost sharing, and how transportation is provided. a. LIFEWAYS_ FY21_Member Handbook, Pgs. 62-76, Medicaid Specialty Supports and Service Array
42 CFR §438.10(g)(2)(ii)(A)	3. In the case of a counseling or referral service that the PIHP does not cover because of moral or religious objections, the PIHP must inform members that the service is not covered by the PIHP.
42 CFR §438.10(g)(2)(ii)(B)	4. The PIHP must inform members how they can obtain information from MDHHS about how to access the services described in 42 CFR §438.10(g)(2)(ii)(A).
42 CFR §438.10(g)(2)(iii) Contract Schedule A–1(M)(2)(b)(ii)(1)(c)	5. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. a. LIFEWAYS_ FY21_Member Handbook, pgs. 59-60
42 CFR §438.10(g)(2)(iv) Contract Schedule A–1(M)(2)(b)(ii)(1)(d)	6. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. a. LIFEWAYS_ FY21_Member Handbook, pgs. 59-60

Member Handbook Checklist (Refer to Standard I, Element 13 for findings)	
Reference	**Required Components**
42 CFR §438.10(g)(2)(v) Contract Schedule A– 1(M)(2)(b)(ii)(1)(e)	7. The extent to which, and how, after-hours care is provided. a. LIFEWAYS_ FY21_Member Handbook, pg. 33
42 CFR §438.10(g)(2)(v)(A)	8. What constitutes an emergency medical condition and emergency services. a. LIFEWAYS_ FY21_Member Handbook, pg. 33
42 CFR §438.10(g)(2)(v)(B)	9. The fact that prior authorization is not required for emergency services. a. LIFEWAYS_ FY21_Member Handbook, pg. 33
42 CFR §438.10(g)(2)(v)(C)	10. The fact that-the member has a right to use any hospital or other setting for emergency care. a. LIFEWAYS_ FY21_Member Handbook
42 CFR §438.10(g)(2)(vi) Contract Schedule A– 1(M)(2)(b)(ii)(1)(a)	11. Any restrictions on the member's freedom of choice among network providers. a. LIFEWAYS_ FY21_Member Handbook, pg. 60
42 CFR §438.10(g)(2)(vii) Contract Schedule A– 1(M)(2)(b)(ii)(1)(e)	12. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PIHP cannot require members to obtain a referral before choosing a family planning provider. a. LIFEWAYS_ FY21_Member Handbook, pg. 73
42 CFR §438.10(g)(2)(viii)	13. Cost sharing. a. LIFEWAYS_ FY21_Member Handbook, pgs. 61, 73
42 CFR §438.10(g)(2)(ix)	14. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. a. LIFEWAYS_ FY21_Member Handbook, pgs. 55-58 b. CS_Enrollee_Rights_Policy
42 CFR §438.10(g)(2)(x)	15. The process of selecting and changing the member's primary care provider. a. LIFEWAYS_ FY21_Member Handbook, pg. 71

Member Handbook Checklist (Refer to Standard I, Element 13 for findings)	
Reference	**Required Components**
Grievance, appeal, and State fair hearing procedures and time frames, consistent with 42 CFR §438 Subpart F, in an MDHHS-developed or MDHHS-approved description. Such information must include:	
42 CFR §438.10(g)(2)(xi)(A) Contract Schedule A–1(L)(3-4)	16. The right to file grievances and appeals. a. LIFEWAYS_ FY21_Member Handbook, pgs. 38-39
42 CFR §438.10(g)(2)(xi)(B) Contract Schedule A–1(L)(1)(b); 2(b-c)	17. The requirements and time frames for filing a grievance or appeal. a. LIFEWAYS_ FY21_Member Handbook, pgs. 38-39
42 CFR §438.10(g)(2)(xi)(C) Contract Schedule A–1(L)(2)(d)	18. The availability of assistance in the filing process. a. LIFEWAYS_ FY21_Member Handbook, pg. 39
42 CFR §438.10(g)(2)(xi)(D) Contract Schedule A–1(L)(2)(a)(iii)	19. The right to request a State fair hearing after the PIHP has made a determination on a member's appeal that is adverse to the member. a. LIFEWAYS_ FY21_Member Handbook, pg. 41
42 CFR §438.10(g)(2)(xi)(E) Contract Schedule A–1(L)(5)(g)	20. The fact that, when requested by the member, benefits that the PIHP seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing within the time frames specified for filing, and that the member may, consistent with MDHHS policy, be required to pay the cost of services furnished while the appeal or State fair hearing is pending if the final decision is adverse to the member. a. LIFEWAYS_ FY21_Member Handbook, pg. 40
42 CFR §438.10(g)(2)(xii) Contract Schedule A–1(Q)(5)	21. How to exercise an advance directive, as set forth in 42 CFR §438.3(j), including written information on advance directives policies, and a description of applicable State law. a. LIFEWAYS_ FY21_Member Handbook, Pg. 46 b. CS_Advance_Directives_Policy, Policy: Section 1 and Section 3 (B)
42 CFR §438.10(g)(2)(xiii) Contract Schedule A–1(M)(2)(b)(i)	22. How to access auxiliary aids and services, including additional information in alternative formats or languages. a. LIFEWAYS_ FY21_Member Handbook, Pg. 10

Member Handbook Checklist (Refer to Standard I, Element 13 for findings)	
Reference	**Required Components**
42 CFR §438.10(g)(2)(xiv) Contract Schedule A–1(B)(4)(j)(ii)(8)	23. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members, *including what are customer services and what it can do for the individual; hours of operation; and process for obtaining customer assistance after hours*. a. LIFEWAYS_ FY21_Member Handbook, pgs. 15-29, Behavioral Health Provider Directory b. LIFEWAYS_ FY21_Member Handbook, pg. 33-34, Emergency and After-Hours Access to Services
42 CFR §438.10(g)(2)(xv)	24. Information on how to report suspected fraud or abuse. a. LIFEWAYS_ FY21_Member Handbook, Pgs. 12-13
Any other content required by MDHHS:	
42 CFR §438.10(g)(2)(xvi) Contract Schedule A–1(B)(4)(j)(ii)(3)	*25. Access to out-of-network services.* *a.* LIFEWAYS_ FY21_Member Handbook, pg. 60
42 CFR §438.10(g)(2)(xvi) Contract Schedule A–1(B)(4)(j)(ii)(4)	*26. For affiliates, the names, addresses, and phone numbers of the following personnel:* *a. Executive Director* *b. Medical Director* *c. Member Rights Officer* *d. Customer Services* *e. Emergency* • LIFEWAYS_ FY21_Member Handbook, pgs. 16, 15-29, Behavioral Health Provider Directory
42 CFR §438.10(g)(2)(xvi) Contract Schedule A–1(B)(4)(j)(ii)(5)	*27. Community resource list (and advocacy organization) index.* *a.* LIFEWAYS_ FY21_Member Handbook, Pgs. 95-99
42 CFR §438.10(g)(2)(xvi) Contract Schedule A–1(B)(4)(j)(ii)(6)	*28. Right to information about PIHP operations (e.g., organizational chart, annual report) and services not covered under contract.* *a.* LIFEWAYS_ FY21_Member Handbook, Pgs. 2, 14, 76

Provider Directory Checklist (Refer to Standard I, Element 16 for findings)	
Reference	**Required Components**
The PIHP must make available in paper form upon request and electronic form, the following information about its network providers:	
42 CFR §438.10(h)(1)(i) Contract Schedule A– 1(M)(1)(f)(i)	1. The provider's name as well as any group affiliation.
42 CFR §438.10(h)(1)(ii) Contract Schedule A– 1(M)(1)(f)(ii)	2. Street address(es).
42 CFR §438.10(h)(1)(iii) Contract Schedule A– 1(M)(1)(f)(iii)	3. Telephone number(s).
42 CFR §438.10(h)(1)(iv) Contract Schedule A– 1(M)(1)(f)(iv)	4. Website URL, as appropriate.
42 CFR §438.10(h)(1)(v)	5. Specialty, as appropriate.
42 CFR §438.10(h)(1)(vi) Contract Schedule A– 1(M)(1)(f)(vii)	6. Whether the providers will accept new members.
42 CFR §438.10(h)(1)(vii) Contract Schedule A– 1(M)(1)(f)(ix)	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.
42 CFR §438.10(h)(1)(viii) Contract Schedule A– 1(M)(1)(f)(xi)	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
42 CFR §4358.10(h)(2) Contract Schedule A– 1(M)(1)(a); 1(M)(1)(f)(i-xi)	9. The provider directory must include the information in 42 CFR §438.10(h)(1) for each of the following provider types covered under the contract: a. Physicians, including specialists. b. Hospitals. c. Pharmacies.

Provider Directory Checklist (Refer to Standard I, Element 16 for findings)	
Reference	**Required Components**
	d. Medical suppliers. *e. Ancillary health providers.* *f. Independent facilitators and fiscal intermediaries.* g. Long-term services and supports (LTSS) providers, as appropriate.

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The PIHP defines emergency medical conditions as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** FY21 MSHN Guide to Services Consumer Handbook, pp.33-34	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The FY21 MSHN Guide to Services Consumer Handbook contains a definition of behavioral health emergency and instructions regarding how members can seek emergency services without prior authorization.		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
2. The PIHP defines emergency services covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under this Title. b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Behavioral Health Chapter: Section 3- Covered Services, 3.7, 3.8, 3.13, 3.14, 3.20 FY21 MSHN Guide to Services Consumer Handbook, pp.64, 66, 67	☒ Met ☐ Not Met ☐ NA

PIHP Description of Process: MSHN defines emergency services and provides covered inpatient and outpatient services as defined in the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Section 3 describes the services the PIHP is responsible to provide for Medicaid beneficiaries which include:

3.7 Crisis Intervention, pp. 19
3.8 Crisis Residential, pp.20
3.13 Inpatient Psychiatric Hospital Admission, pp.21
3.14 Intensive Crisis Stabilization Services, pp.21
3.20 Outpatient Partial Hospitalization Services, pp.21

The MSHN Guide to Services Consumer Handbook describes the type and nature of each of these covered emergency services on pages 64, 66, and 67.

HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element.

Recommendations: HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
3. The PIHP defines poststabilization care services as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition 42 CFR §438.114(a)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** FY21 MSHN Guide to Services Consumer Handbook, pp.34	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
Coverage and Payment		
4. The PIHP must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the PIHP. 42 CFR §438.114(c)(1)(i)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claims algorithm for emergency services **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Behavioral Health Chapter:	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74	
PIHP Description of Process: This standard is not applicable to the PIHP. The Michigan Medicaid Provider Manual requires authorization for all emergency/crisis services the PIHP is contracted to provide; there is no requirement that the PIHP must cover and pay for emergency services regardless of whether the provider has a contract with the PIHP. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific information relative to authorization and provider requirements for each type of service: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
5. The PIHP may not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in (1), (2), and	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claims algorithm for emergency services	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
(3) of the definition of emergency medical condition in 42 CFR §438.114(a). b. A representative of the PIHP instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii)(A-B) Contract Schedule A–1(C)(3)(f)	**Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Behavioral Health Chapter: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74	

PIHP Description of Process: This standard is not applicable to the PIHP. The Michigan Medicaid Provider Manual requires authorization for all emergency/crisis services the PIHP is contracted to provide. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific information relative to authorization and provider requirements for each type of service:

6.3 Crisis Residential, pp.49
8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60
9.1.A. Intensive Crisis Stabilization Services, pp. 69
10 Outpatient Partial Hospitalization Services, pp. 74

HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element.

Recommendations: HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.

Required Actions: None.

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Additional Rules for Emergency Services		
6. The PIHP may not: a. Limit what constitutes an emergency medical condition with reference to 42 CFR §438.114(a), on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, PIHP, or MDHHS of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Behavioral Health Chapter: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: This standard is not applicable to the PIHP. The Michigan Medicaid Provider Manual requires authorization for all emergency/crisis services the PIHP is contracted to provide; there is no requirement that the PIHP must cover and pay for emergency services regardless of whether the provider has a contract with the PIHP. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific information relative to authorization and provider requirements for each type of service: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. 42 CFR §438.114(d)(2) Contract Schedule A–1(C)(3)(g)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claims algorithm for emergency medical condition **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Hospital Chapter: 3.14.A, pp. 15	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: This standard is not applicable to the PIHP. The Michigan Medicaid Provider Manual Hospital Chapter identifies that responsibility for payment for screening and treatment needed to diagnose and stabilize an emergency medical condition is the responsibility of Medicaid FFS or Medicaid Health Plans, not PIHP.		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR §438.114(b) as responsible for coverage and payment. 42 CFR §438.114(d)(3)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Behavioral Health Chapter: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: This standard is not applicable to the PIHP. The Michigan Medicaid Provider Manual requires authorization for all emergency/crisis services the PIHP is contracted to provide. There is not a requirement that decisions of an emergency physician are binding on the PIHP as the entity responsible for payment for emergency/crisis mental health services. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific information relative to authorization and provider requirements for each type of service: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Coverage and Payment: Poststabilization Care Services		
9. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR §422.113(c). The PIHP: a. Is financially responsible (consistent with 42 CFR §422.214) for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other organization representative; b. Is financially responsible for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if— i. The organization does not respond to a request for pre-approval within 1 hour; ii. The organization cannot be contacted; or iii. The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met; and	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Medicaid Health Plan Chapter: 2.6.C, pp. 7	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
c. Must limit charges to members for poststabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the organization. For purposes of cost sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(i-iv) 42 CFR §422.214 42 CFR §438.114(e) Contract Schedule A–1(C)(3)(c-d)		
PIHP Description of Process: This standard is not applicable to PIHPs for the services it provides. The Michigan Medicaid Provider Manual Medicaid Health Plan Chapter Section 2.6.C describes the elements of this standard as the responsibility of the Medicaid Health Plan.		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
10. The PIHP's financial responsibility for poststabilization care services it has not pre-approved ends when— a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care; b. A plan physician assumes responsibility for the member's care through transfer;	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** Michigan Medicaid Provider Manual, Behavioral Health Chapter: 6.3 Crisis Residential, pp.49	☒ Met ☐ Not Met ☐ NA

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
c. An organization representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. 42 CFR §422.113(c)(3)(i-iv) 42 CFR §438.114(e)	8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74	
PIHP Description of Process: This standard is not applicable to the PIHP. The Michigan Medicaid Provider Manual requires authorization for all emergency/crisis services the PIHP is contracted to provide; there is no requirement that the PIHP must cover and pay for emergency services regardless of whether the provider has a contract with the PIHP. The following sections of the Michigan Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific information relative to authorization and provider requirements for each type of service: 6.3 Crisis Residential, pp.49 8.1, 8.2 Inpatient Psychiatric Hospital Admissions, pp. 59-60 9.1.A. Intensive Crisis Stabilization Services, pp. 69 10 Outpatient Partial Hospitalization Services, pp. 74		
HSAG Findings: HSAG has determined that the PIHP has met the intent of the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and poststabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard II—Emergency and Poststabilization Services						
Met	=	10	X	1	=	10
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	10	Total Score		=	10
Total Score ÷ Total Applicable					=	100%

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The PIHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) Contract Schedule A–1(E)(1-2)	**HSAG Recommended Evidence:** • Provider contract • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III • Pg. 7 (IX)(A) • Pg. 9 (XI)(B) • Pg. 23 (XX)(D) • Pg. 38 (Information Requirements & Notices) • Pg. 46 (VII. Provider Network) • Pg. 47 FY21 SUD Treatment – Standard III • Pg. 9 (2) • Pg. 19 (C) • Pg. 24 (4)(6) • Pg. 32 (3) NCMH 2021 Delegated Managed Care – Standard III • 4.1 Pg. 10	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
2. The PIHP provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) Contract Schedule A–1(E)(12)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III • Pg. 37-38 (I. Customer Service) MSHN_ FY21 LIFEWAYS_Handbook • pgs. 38, 55, 60 NCMH 2021 Delegated Managed Care – Standard III • 4.3 Pg. 10 • 4.9 Pg. 11	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** PIHP staff members verbally confirmed a member's right to a second opinion as required by the element; however, HSAG recommends that the PIHP educate its staff members and update policy, as needed, to ensure a member's right to a second opinion as required under the federal managed care rule is widely understood in addition to a member's right to a second opinion for the denial of eligibility and the denial of inpatient hospitalization required under the Michigan Mental Health Code. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
3. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the PIHP must adequately and timely cover these services out of network for the member, for as long as the PIHP's provider network is unable to provide them. 42 CFR §438.206(b)(4) Contract Schedule A–1(E)(4)(a)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Tracking/analysis of services unavailable in network/provider out of network **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III • Pg. 39 (Information Requirements & Notices) FY21 SUD Treatment – Standard III • Pg. 19 (D) • Pg. 33 (6) MSHN_ FY21 LIFEWAYS_Handbook • pg. 60 NCMH 2021 Delegated Managed Care – Standard III • 4.3 Pg. 10	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
4. The PIHP requires out-of-network providers to coordinate with the PIHP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network, *including a prohibition on balance billing in compliance*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider billing manual • One example of an executed single case agreement	☐ Met ☒ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
with 42 CFR 438.106, 42 CFR 438.116 and the Medicaid Provider Manual. a. *The PIHP must comply with all related Medicaid Policies regarding authorization and reimbursement for Out-of-Network providers*. b. *The PIHP must pay Out-of-Network Medicaid providers' claims at established Medicaid fees in effect on the date of service*. c. *If Michigan Medicaid has not established a specific rate for the Covered Service, the PIHP must follow Medicaid Policy to determine the correct payment amount*. 42 CFR §438.206(b)(5) Contract Schedule A–1(E)(4)(d)	**Evidence as Submitted by the PIHP:** VCS Kalamazoo SCA – Standard III FY21 SUD Provider Manual • pp.44 SUD Single Case Procedure MSHN_ FY21 LIFEWAYS_Handbook • pg. 60 NCMH 2021 Delegated Managed Care – Standard III • 4.4 Pg. 10	
PIHP Description of Process:		
HSAG Findings: The PIHP's single case agreements (SCAs) did not include a prohibition on balance billing, nor did any other documentation support that an out-of-network provider will not balance bill a member. **Recommendations:** The PIHP should specifically include in its SCA a prohibition on balance billing. Additionally, while PIHP staff members could speak to sub-elements (a)–(c), HSAG recommends that these requirements are clearly reflected in the PIHP's policies, procedures, oversight and monitoring documentation, or other materials, as applicable. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: The PIHP must require out-of-network providers to coordinate with the PIHP for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network, including a prohibition on balance billing in compliance with 42 CFR §438.106, 42 CFR §438.116, and the Medicaid Provider Manual.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Timely Access		
5. The PIHP must do the following: a. Meet and require its network providers to meet MDHHS standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(i-vi) Contract Schedule A–1(E)(7)(a)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • Results of provider monitoring (e.g., secret shopper surveys) • One example of corrective action when a provider failed to meet access standards • HSAG will also use the results of the Access Standards: Appointment Times Checklist **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III • Pg. 9 (XI)(B) • Pg. 33 (XXX) (A-D) • Pg. 46 (VII. Provider Network) FY21 SUD Treatment – Standard III • Pg. 9 (2) • Pg. 13 (1) • Pg. 15 (12) FY21 LifeWays CMH Delegated Managed Care Review • Pg. 7-8 Access Policy • Pg. 1 2021 CMHSP Delegated Managed Care Tool PNM_Provider_Network_Mgmt_Policy • Pg. 1	☐ Met ☒ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process:		
HSAG Findings: The PIHP did not provide evidence of a process to actively monitor adherence to all time frame standards; for example, adherence to admission time frames for pregnant women receiving services for a SUD, which are more stringent than the appointment standards tracked and reported via Michigan's Mission-Based Performance Indicator System (MMBPIS). The SUD Delegation Functions Tool included a review of an element on appointment standards; however, it also appeared to focus on MMBPIS indicators. Additionally, the Access Priority Indicator Report included MMBPIS indicators but not admission time frame standards for all priority population standards, such as pregnant women receiving services for SUD. **Recommendations:** HSAG recommends that the PIHP include a provision within its provider contracts prohibiting providers from offering hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: The PIHP must meet and require its network providers to meet MDHHS' standards for timely access to care and services and establish mechanisms to regularly monitor compliance and take corrective action if there is a failure to comply. This should apply to all screening and appointment standards in addition to those reported through MMBPIS.		
Access and Cultural Considerations		
6. The PIHP participates in MDHHS' efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) Contract Schedule A–1(E)(9)(a, c)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence **Evidence as Submitted by the PIHP:** Cultural Competency Policy MSHN Training Grid FY 21 MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Pg. 8 (X)(A) • Pg. 46 (VII. Provider Network) FY21 SUD Treatment – Standard III • Pg. 19 (C) FY21 MSHN Guide to Services Consumer Handbook, Pg. 10-11 NCMH 2021 Delegated Managed Care – Standard III • 4.6 Pg. 11 • 4.10 Pg. 11	
PIHP Description of Process: In addition to contractual requirements of all providers, the MSHN provider directory located on the MSHN website provides information about each provider's linguistic capabilities and if the physical space is ADA compliant. MSHN and its CMHSP participants and SUDSP providers use the standard Guide to Services Consumer Handbook which also address non-discrimination and provides information about how to access language interpretation services.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. Refer to Standard I, Element 16 for additional findings.		
Required Actions: None.		
Accessibility Considerations		
7. The PIHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) Contract Schedule A–1(E)(2)(c); (E)(20)(c)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Analysis of provider network capability to provide services to members with physical or mental disabilities **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III • Pg. 22-23 (XX)(C)	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Pg. 82 (Exhibit H) FY21 SUD Treatment – Standard III • Pg. 9 (2) • Pg. 19 (C) MSHN_ FY21 LIFEWAYS_Handbook • pg. 10 NCMH 2021 Delegated Managed Care – Standard III • 4.12 Pg. 12	
PIHP Description of Process: In addition to contractual requirements of all providers, the MSHN provider directory located on the MSHN website provides information about each provider's linguistic capabilities and if the physical space is ADA compliant. MSHN and its CMHSP participants and SUDSP providers use the standard Guide to Services Consumer Handbook provides information about accessible services and how to request accommodations.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. Refer to Standard I, Element 16 for additional findings.		
Required Actions: None.		

Standard III—Availability of Services						
Met	=	5	X	1	=	5
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	**Total Score**		=	5
Total Score ÷ Total Applicable					=	71%

Access Standards: Appointment Times Checklist (Refer to Standard III, Element 5 for findings)	
Reference	**Required Components**
Walk-In Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*1. Individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*2. Individuals with routine needs must be screened or other arrangements made within thirty (30) minutes.*
Pregnant Injecting Drug User Admission Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*3. Screened and referred within 24 hours.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*4. Detoxification, Methadone, or Residential—Offer admission within 24 business hours.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*5. Other Levels of Care—Offer admission within (48) business hours.*
Pregnant Injecting Drug User Interim Service Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*6. Begin within 48 hours:* *a. Counseling and education on:* *i. Human immunodeficiency virus (HIV) and tuberculosis (TB).* *ii. Risks of needle sharing.* *iii. Risks of transmission to sexual partners and infants.* *iv. Effects of alcohol and drug use on the fetus.* *b. Referral for prenatal care.* *c. Early intervention clinical services.*

Access Standards: Appointment Times Checklist (Refer to Standard III, Element 5 for findings)	
Reference	**Required Components**
Pregnant Substance Use Disorder (SUD) Admission Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*7. Screened and referred within 24 hours.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*8. Detoxification, Methadone, or Residential—Offer admission within 24 business hours.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*9. Other Levels of Care—Offer admission within 48 business hours.*
Pregnant SUDs Interim Service Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*10. Begin within 48 hours:* *a. Counseling and education on:* *i. HIV and TB.* *ii. Risks of transmission to sexual partners and infants.* *ii. Effects of alcohol and drug use on the fetus.* *b. Referral for prenatal care.* *c. Early intervention clinical services.*
Injecting Drug User Admission Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*11. Screened and referred within 24 hours.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*12. Offer admission within 14 days.*

Access Standards: Appointment Times Checklist (Refer to Standard III, Element 5 for findings)	
Reference	**Required Components**
Injecting Drug User Interim Services Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*13. Begin within 48 hours:* *a. Counseling and education on:* *i. HIV and TB.* *ii. Risks of needle sharing.* *iii. Risks of transmission to sexual partners and infants.* *b. Early intervention clinical services.*
Parent at Risk of Losing Children Admission Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*14. Screened and referred within 24 hours.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*15. Offer admission within 14 days.*
Parent at Risk of Losing Children Interim Services Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*16. Begin within 48 hours:* *a. Early intervention clinical services.*
All Other Populations Admission Access Standards	
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*17. Screened and referred within 7 calendar days.*
Contract Schedule A–1(E)(7), MDHHS Behavioral Health and Developmental Disabilities Access Standards	*18. Capacity to offer admission within 14 days.*
PIHP Comments: Please refer to "Access Appointment Tracking Process" which demonstrates the brief screening in the PIHP managed care system. The priority population status is identified and the user will receive a pop-up box containing guidance regarding the appointment timeliness based on the	

Access Standards: Appointment Times Checklist (Refer to Standard III, Element 5 for findings)	
Reference	**Required Components**
priority population status that is indicated, as demonstrated in the "Access Appointment Tracking Process" document. The user then records the date of admission appointment that was offered and the outcome of the appointment. MSHN utilizes the "Access Priority Indicator Report" to track compliance/non-compliance with admission appointment time frames as required by MDHHS.	

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The PIHP gives assurances to MDHHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 §438.207, including the standards at §438.68 and §438.206(c)(1). a. Each PIHP must submit documentation to MDHHS, in a format specified by MDHHS, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of behavioral health, development disability, substance use and specialty services, and LTSS that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.68 42 CFR §438.206(1) 42 CFR §438.207(a), (b)(1-2) Contract Schedule A–1(E)(2)(a)	**HSAG Recommended Evidence:** • Policies and procedures • Most recent time/distance analysis • Most recent member/provider ratio analysis • Exceptions approved by MDHHS • HSAG will also use the results of the Access Standards: Time/Distance Checklist **Evidence as Submitted by the PIHP:** • 2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN • Re_Network Adequacy Standards Update—MDHHS Plan (EMAIL SUBMISSION TO MDHHS) • Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL) • MSHN Network Adequacy Assessment CLEAN version - Final Draft • Provider Network Management Policy (pg. 1, item B & C) • PNM_SUD_Direct_Service_Procurement Policy • Out-of-State Placement Policy • Out-of-State Placement Procedure • FY21 V2 SUD Provider Manual FINAL (pg. 24, Capacity) • FY21 – SUD Treatment (pg. 10, bullet 6 Waitlist; pg. 19 bullet C Accessibility; pg. 22 bullet 5 Notification of Staffing Changes)	☐ Met ☒ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
	• FY21 Medicaid Subcontracting Agreement (pg. 35, Bullet B; pg. 46 & 50 Provider Network Delegation) • Geo Maps: SUD MAT, SUD Residential, SUD Withdrawal Mgt, SUD OP, Inpatient Psych, Crisis Services	

PIHP Description of Process:

- In 2018, MSHN contracted with Dale Howe to conduct GeoMaps to determine adequacy of services by identifying where persons served reside and where providers are located to determine where gaps may exist. GeoMaps will be renewed every three years and will be updated during 2021.
- MSHN completes an annual assessment of adequacy to determine whether or not it offers appropriate range of services, and whether those services are adequate for the anticipated number of members in the region. To achieve this, we look at utilization trends/persons served trends as well as enrollment trends to determine if current provider network can meet needs of persons served (pg.10-36). The most recent assessment was reviewed and received by the MSHN BOD in May of 2021. As part of this process, and in accordance with the contract, CMHSPs conduct annual local needs assessments to assess local needs within their catchment areas and identify priorities (pg. 36). MSHN ensures availability of all SUD levels of care (pg. 26). Recommendations are included and an action plan is under development to monitor implementation (pg. 45).
- MSHN also completed an analysis of the enrollee/provider ratio standards developed by MDHHS. In instances where MSHN did not meet the MDHHS ratio standards, MSHN offered additional evidence to support capacity to meet persons served. This analysis was approved by MDHHS. This has since been incorporated into the overall Network Adequacy Assessment.

HSAG Findings: The PIHP has not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. The MSHN Network Adequacy Assessment was dated after the review period; however, after the interview session, a draft version was submitted that demonstrated the assessment was being worked on during the review period. Additionally, it did not address the time/distance standards specific to the provider types within MDHHS' defined time/distance standards (inpatient psychiatric and other select providers by adults and pediatric). Lastly, GeoMaps were provided that were dated from 2018 and, while they plotted members and providers, it is unclear if the time/distance standards were calculated and subsequently met.

Required Actions: The PIHP must give assurances to MDHHS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Timing of Documentation		
2. Each PIHP must submit the documentation described in 42 CFR §438.207(b) as specified by MDHHS, but no less frequently than the following: a. At the time it enters into a contract with MDHHS. b. On an annual basis. c. At any time there has been a significant change (as defined by MDHHS) in the PIHP's operations that would affect the adequacy of capacity and services, including— i. Changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the PIHP. 42 CFR §438.207(c)(3)(i-iii)	**HSAG Recommended Evidence:** • Policies and procedures • Most recent annual assurances of adequate capacity and services submission to MDHHS • Assurances of adequate capacity and services submission to MDHHS due to a significant change (if no significant change, state so in the PIHP Description of Process) **Evidence as Submitted by the PIHP:** • 2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN • Re_Network Adequacy Standards Update—MDHHS Plan (EMAIL SUBMISSION TO MDHHS) • Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL) • MSHN Network Adequacy Assessment CLEAN version - Final Draft • Provider Network Adequacy Assessment - Filing with MDHHS	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: In 2018, MDHHS developed enrollee/provider ratio standards. MSHN conducted an analysis and submitted its results/plan to MDHHS in December of 2018. There were instances where MSHN did not meet the identified standard but had evidence to support adequate capacity. Rationale was included in that analysis. MSHNs submission was approved by MDHHS in June of 2019. MDHHS has not requested additional information since this time; however, MSHN has incorporated these standards in its overall Network Adequacy Plan which was board approved in May 2021. MSHN has submitted a final copy to MDHHS on 5.12.21 and provided a copy of the email submission as evidence.		
HSAG Findings: While the PIHP demonstrated a network adequacy plan was internally approved in May 2021, it did not annually submit its assurances and supporting documentation that demonstrated that it had the capacity to serve the expected enrollment in its service area in accordance with the network		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, the reporting requirements (i.e., annual submission of assurances of adequate capacity and services, and at any time there has been a significant change) were not clearly documented within policy. **Recommendations:** The PIHP should work with MDHHS to determine when the annual submission of its assessment of adequate capacity, in accordance with MDHHS' defined network adequacy standards, should be submitted.		
Required Actions: The PIHP must submit its assurances of adequacy capacity to MDHHS annually and at any time there has been a significant change, including changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network, or for the enrollment of a new population in the PIHP.		
Changes in Provider Network		
3. The PIHP must: a. *Notify MDHHS within seven days of any changes to the composition of the provider network organizations that negatively affect access to care. The PIHP must have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.* b. *Have written procedures to address network changes that negatively affect beneficiaries' access to care; MDHHS may apply sanctions to the PIHP if a network change that negatively affects beneficiaries' access to care is not reported timely, or the PIHP is not willing or able to correct the issue.* Contract Schedule A–1(E)(3)(a-b)	**HSAG Recommended Evidence:** • Policies and procedures • Notification to MDHHS of a change in the composition of its provider network that negatively affects access to care; the date the PIHP became aware of this change and the date of the notification to MDHHS must be included (if no change, state so in the PIHP Description of Process) **Evidence as Submitted by the PIHP:** • Standard IV Holy Cross Termination Notice to MDHHS – 2.8.21 • MCN_Network Change Notification • FY21 V2 SUD Provider Manual FINAL (pg. 24, Capacity) • Provider Network Management Policy (pg. 1, item B & C) • FY21_March_Priority_Populations_Waiting_List_Deficiencies_Report • FY21 – SUD Treatment (pg. 10, bullet 6 Waitlist; pg. 19 bullet C Accessibility; pg. 22 bullet 5 Notification of Staffing Changes)	☒ Met ☐ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
	• FY21 Medicaid Subcontracting Agreement (pg. 35, Bullet B; pg. 46 & 50 Provider Network Delegation) • Termination Checklist (V3.0) Bullet 5	
PIHP Description of Process: Contracts with SUD providers and CMHSPs include notification requirements. SUD providers are required to provide a waitlist report to MSHN to identify access issues; however, providers do not report individuals being waitlisted. In instances when a provider contract is terminated, MSHN always notifies MDHHS even if it does not negatively impact access. Examples of such notification has been included (Holy Cross); however, we did not have an example that fell within the lookback period for this review. If a CMH has network changes impacting access to care, they are to notify MSHN along with a plan to address access. Example – MCN Network Change Notification.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations**: Although the PIHP provided contracts that included requirements for providers to notify the PIHP of changes to the provider network, and a termination checklist that included an action item to contact MDHHS in the event of a termination, HSAG recommends the PIHP has a documented process to ensure that MDHHS is notified within seven days of any changes to the composition of the provider network organizations that negatively affect access to care. HSAG also recommends the PIHP enhance written procedures to address network changes that negatively affect access to care that should consider various action steps such as an assessment of the impact of the change, addressing the health and safety of members, addressing gaps in member access to care, seeking out-of-network providers, recruitment and retention of providers, and identifying roles and responsibilities of various PIHP departments/staff, etc. Additionally, the PIHP's process should consider other changes in the composition of its provider network in addition to provider terminations (e.g., temporary closures, relocation of a provider). The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
Regional Specific Plans		
4. *The PIHP submits a plan on how standards will be effectuated by region. Understanding their diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. PIHPs must consider at least the following parameters for their plans:* a. *Maximum time and distance*	**HSAG Recommended Evidence:** • Policies and procedures • Regional network adequacy plan **Evidence as Submitted by the PIHP:** • 2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN	☐ Met ☒ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
b. *Timely appointments* c. *Language, Cultural competence, and Physical accessibility—42 CFR 438.68(c)(1)(vii-viii).* 42CFR 438.68(c)(1)(vii-viii) PIHP Network Adequacy Standard Procedural Document	• Re_Network Adequacy Standards Update—MDHHS Plan (EMAIL SUBMISSION TO MDHHS) • Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL) • MSHN Network Adequacy Assessment Clean Version – Final Draft • Provider Network Management Policy (pg. 1, item B & C)	
PIHP Description of Process: The MSHN Network Adequacy Assessment includes an analysis of access/timeliness (pg. 39), language/cultural competence/and physical accessibility (pg. 42-43) and time/distance (GeoMaps). Additionally, we consider consumer choice (pg. 42) and consumer satisfaction (pg. 37).		
HSAG Findings: The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards in accordance with MDHHS' PIHP Network Adequacy Standard Procedural Document. The PIHP's network adequacy assessment considered the percentage of members that speak non-English languages but did not identify those languages or assess the languages spoken by its provider network. The consideration of physical accessibility was also limited. The assessment suggested that providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the Community Mental Health Authority of Clinton, Eaton, & Ingham Counties' provider network; however, the PIHP should expand on its assessment. **Recommendations:** HSAG recommends that the PIHP consider the following in its network adequacy plan: • Time/distance standards in accordance with MDHHS policy. • Appointment time frames for priority populations, such as for pregnant SUD members. • More detailed information related to language, including an assessment of languages spoken by its membership and its provider network, and an analysis of the use of interpreter services. • More detailed information related to cultural competency, including an assessment of the cultural and ethnic make-up of the PIHP membership and the capability of the provider network to meet the needs of members. • More detailed information related to physical accessibility, including an analysis of provider types who can or cannot provide physical accessibility to members with disabilities (e.g., residential providers).		
Required Actions: The PIHP must maintain plan on how network adequacy standards will be effectuated in its region. The PIHP's plan must consider at least the following parameters: maximum time and distance; timely appointments; and language, cultural competence, and physical accessibility.		

Standard IV—Assurances of Adequate Capacity and Services						
Met	=	1	X	1	=	1
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	4	Total Score		=	1
Total Score ÷ Total Applicable					=	25%

Network Adequacy Standards—Time/Distance Checklist (Refer to Standard IV, Element 1)	
Time/Distance Standards	
Inpatient Psychiatric Services	
Adult: Inpatient Psychiatric	1. *Frontier: 150 minutes/125 miles. – No frontier communities in region*
	2. *Rural: 90 minutes/60 miles.*
	3. *Urban: 30 minutes/30 miles.*
Adult: All Other Select Services	4. *Frontier: 90 minutes/90 miles. – No frontier communities in region*
	5. *Rural: 60 minutes/60 miles.*
	6. *Urban: 30 minutes/30 miles.*
Pediatric: Inpatient Psychiatric	7. *Frontier: 330 minutes/355 miles. – No frontier communities in region*
	8. *Rural: 120 minutes/125 miles.*
	9. *Urban: 60 minutes/60 miles.*

Network Adequacy Standards—Time/Distance Checklist (Refer to Standard IV, Element 1)	
Time/Distance Standards	
Pediatric: All Other Select Services	*10. Frontier: 90 minutes/90 miles. – No frontier communities in region*
	11. Rural: 60 minutes/60 miles.
	12. Urban: 30 minutes/30 miles.
Member-to-Provider Ratio Standards	
Adult: Assertive Community Treatment	*13. 30,000:1 (Medicaid Member to Provider Ratio)*
PIHP Comment: Refer to file: *2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN* which includes rationale of adequacy and file: *Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL)*	
Adult: Psychosocial Rehabilitation (Clubhouses)	*14. 45,000:1 (Medicaid Member to Provider Ratio)*
Adult: Opioid Treatment Programs	*15. 35,000:1 (Medicaid Member to Provider Ratio)*
Adult: Crisis Residential	*16. 16 beds per 500,000 Total Population*
PIHP Comment: Refer to file: *2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN* which includes rationale of adequacy and file: *Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL)*	
Pediatric: Home-Based	*17. 2,000:1 (Medicaid Member to Provider Ratio)*
Pediatric: Wraparound	*18. 5,000:1 (Medicaid Member to Provider Ratio)*
Pediatric: Crisis Residential	*19. 8–12 beds per 500,000 Total Population*
PIHP Comment: Refer to file: *2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN* which includes rationale of adequacy and file: *Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL)*	

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care and Coordination of Services for All PIHP Member		
1. The PIHP must ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1)	**HSAG Recommended Evidence:** • Policies and procedures • One example of member notification of designated person or entity **Evidence as Submitted by the PIHP:** Access Policy, pp. 1 FY21 MSHN Guide to Services Consumer Handbook, pp.35-37, pp. 43	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN delegates access to services and care coordination to each CMHSP for the individuals they serve. The Access Policy describes the availability of the access system 24/7/365 for all individuals seeking information, services, or support. This information is also available on the MSHN website and all new beneficiaries are provided with a Guide to Services handbook containing the customer service information for their local CMHSP as well as information on care coordination.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
2. The PIHP must coordinate the services the PIHP furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;	**HSAG Recommended Evidence:** • Policies and procedures • Two case examples of care coordination with hospital or institutional provider; another PIHP, MHP, or PAHP; fee-for-service (FFS) Medicaid; or community or social support provider. Examples must be with different entities (i.e., both examples should not be with hospital or institutional provider).	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
b. With the services the member receives from any other PIHP, Medicaid health plan (MHP), or (pre-paid ambulatory health plan (PAHP); c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers. 42 CFR §438.208(b)(2)(i-iv)	**Evidence as Submitted by the PIHP:** Service Philosophy & Treatment Policy, Section B, C, G Population Health & Integrated Care Policy Care Coordination Planning Procedure, pp.1 Follow Up After Hospitalization Procedure, pp.1 PIHP_SUD_CMHSP Coordination_Medicaid ID 0056067669 PIHP_MHP Care Plan Medicaid ID 0075463047	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
3. The PIHP must make a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *Since the PIHP is not an enrollment model, screening once an individual presents for services would meet this requirement.* 42 CFR §438.208(b)(3) Contract Section 1(H)(2)(a)(iii)	**HSAG Recommended Evidence:** • Policies and procedures • Initial health risk assessment template • One case example of a completed initial health risk assessment • Internal tracking mechanisms **Evidence as Submitted by the PIHP:** Access Policy, pp. 5 Completed Initial Screening Medicaid ID 0020475172, pp. 2-3	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP delegates screening activities to its CMHSP participants and SUD service providers (SUDSP); basic health information is collected as a standard part of all initial screenings at the time an individual makes a request for service. Expectations related to inclusion of health information in screening is contained in the MSHN Access Policy (p. 5). All individuals who contact the access system participate in the initial screening, therefore health screening occurs 100% of the time and subsequent attempts to contact the member are not needed.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
4. The PIHP must share with MDHHS or other PIHPs, MHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4)	**HSAG Recommended Evidence:** • Policies and procedures • Two case examples of the PIHP sharing assessment results; one with another PIHP, MHP, or PAHP serving the member and one with MDHHS **Evidence as Submitted by the PIHP:** Service Philosophy & Treatment Policy, Section B.3.vi HSW Application WSA #175665 PIHP MHP Coordination Medicaid ID #0096038643	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN shares the results of assessments and identified needs of beneficiaries with MDHHS on an ongoing basis. The example provided (HSW Application WSA #175665) is a packet that was submitted to MDHHS on 10/19/2020 via the Waiver Support Application (WSA). The packet contains an assessment of the beneficiary's performance on areas of major life activity (p. 3-4), Psychological Evaluation (pp. 16-22), SIS Assessment (pp. 23- 39), and biopsychosocial assessment (pp. 40-53). Additionally, on a monthly basis MSHN meets with each of the Medicaid Health Plans (MHPs) to discuss shared beneficiaries with special needs. One of the primary objectives of these care coordination meetings is to share information related to beneficiaries' needs and identify which entity will be assisting the member with each need in order to prevent duplication. The document PIHP MHP Coordination Medicaid ID #0096038643 includes care coordination meeting minutes with updates that were provided to the MHP during monthly care coordination meetings between November 2020-April 2021. Additionally the document contains evidence of coordination and information sharing between the PIHP, MHP, SUD Provider and CMHSP during the month of March 2021 related to newly identified substance use treatment needs and plan of care.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
5. The PIHP must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5)	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Oversight of provider medical record practices, such as audits, site visits, etc. **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement, Section XXII, pp.24-25 Medicaid Information Management Policy Record Retention Policy FY21 Gratiot Delegated Managed Care Tool, pp. 59-61	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Requirements regarding health information systems are clearly defined in the MSHN contract as well as policy. Adherence to requirements is monitored through annual site review activity as noted in the FY21 Delegated Managed Care Tool (evidence submitted as example for Gratiot Integrated Health Network however other examples are available if needed).		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Additional Services for Members With Special Health Care Needs or Who Need Long-Term Supports and Services (LTSS)—Identification		
6. The PIHP must implement mechanisms to identify persons who need LTSS or persons with special health care needs. 42 CFR §438.208(c)(1)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms for method(s) of identification **Evidence as Submitted by the PIHP:** Utilization Management Plan, Section III.A.3, pp. 6-7 Access Policy, pp.3 HSW Application Tracking Spreadsheet FY21 Sample Email for Potential Enrollees CEI Potential Enrollees 4.5.2021	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP delegates eligibility determination for LTSS to its CMHSP participants. The eligibility requirements are outlined in the Access Policy and Utilization Management Plan. The HSW Application Tracking Spreadsheet demonstrates how the PIHP receives and tracks new referrals from the CMHSPs of individuals that have been identified as meeting eligibility requirements for LTSS through the Habilitation Supports Waiver. Additionally, although this does not fall within the HSAG review timeframe of 10/1/2020 through 3/31/2021, MSHN would like to note the recent implementation of enhanced methods for identification or persons in need of LTSS and/or persons who may have special health care needs. These enhancements were developed in response to MDHHS corrective action recommendations and were implemented in April 2021. On a quarterly basis MSHN waiver coordinators will send a list of potential enrollees to each CMHSP in the region to review for eligibility for additional LTSS. Potential enrollees are identified based on cost of services and assessed needs using the Supports Intensity Scale (SIS) assessment. The following evidence demonstrates implementation of these enhancements in April 2021: Sample Email for Potential Enrollees CEI Potential Enrollees 4.5.2021		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Additional Services for Members With Special Health Care Needs or Who Need LTSS—Assessment		
7. The PIHP must implement mechanisms to comprehensively assess each Medicaid member identified by MDHHS (through the mechanism specified in 42 CFR §438.208(c)(1)) and identified to the PIHP by MDHHS as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of MDHHS or the PIHP as appropriate. 42 CFR §438.208(c)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Comprehensive assessment template • One case example of a completed comprehensive assessment • Job descriptions for staff conducting comprehensive assessments • Training requirements for staff conducting comprehensive assessments **Evidence as Submitted by the PIHP:** Habilitation Supports Waiver Policy, pp.1 Habilitation Supports Waiver Initial Application and Eligibility Procedure, pp.1 Supports Intensity Scale Policy, pp.1 Supports Intensity Scale Quality Lead Procedure SIS Assessor Job Description 7.2020 Completed SIS Assessment Medicaid ID #0091006997	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Habilitation Supports Waiver (HSW) policy provides an overview of the LTSS that are available to individuals who meet eligibility requirements for the HSW. The Habilitation Supports Waiver Initial Application and Eligibility Procedure describes the process by which the CMHSP and PIHP screen individuals for initial eligibility and notify MDHHS via the Waiver Support Application (WSA). The application packet which is submitted to MDHHS via the WSA contains initial screening and assessment tools designed to identify an individuals' LTSS care needs. These include the MDHHS HSW Level of Care (LOC) assessment and other assessments rendered by qualified healthcare specialists as applicable to the individual and his/her needs and conditions. These may include but are not limited to assessments in the following areas: psychological, psychiatric, occupational therapy. physical therapy, speech and language, nutritional. behavioral, and nursing. Additionally, all Medicaid-eligible individuals 16 and older assessed as having an Intellectual/Developmental Disability and who are receiving certain LTSS services (supports coordination, case management, respite services) are assessed using the Supports Intensity Scale (SIS) to determine their support needs as required by MDHHS. MSHN has a strong regional infrastructure for ensuring that individuals administering SIS assessments are appropriately		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
trained and qualified to do so. The Supports Intensity Scale Quality Lead Procedure describes the regional process for monitoring quality and reliability skills for individuals performing SIS assessments.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Additional Services for Members With Special Health Care Needs or Who Need LTSS—Treatment/Service Plan		
8. The PIHP must produce a treatment or service plan meeting the criteria in 42 CFR §438.208(c)(3)(i) through (v) for members who require LTSS and must produce a treatment or service plan meeting the criteria in 42 CFR §438.208(c)(3)(iii-v) for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: a. Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member; b. Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans; c. Approved by the PIHP in a timely manner, if this approval is required by the PIHP; d. In accordance with any applicable MDHHS quality assurance and utilization review standards; and e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or	**HSAG Recommended Evidence:** • Policies and procedures • Treatment/service plan template for members receiving LTSS • Treatment/service plan template for members with a special health care need • One case example of a completed treatment/service plan for a member receiving LTSS • One case example of a completed treatment/service plan for a member with a special health care need • Job descriptions for staff completing treatment/service plans • Training requirements for staff completing treatment/service plans • Internal tracking and reporting mechanisms **Evidence as Submitted by the PIHP:** Person/Family Centered Plan of Service Policy, pp.1-2 MSHN Training Grid FY21 Job Description Case Coordinator Shiawassee CMH Job Description Client Services Manager Saginaw CMH PDN Care Plan Documents_WSA# 5984	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3). 42 CFR §438.208(c)(3)		
PIHP Description of Process: The PDN Care Plan Documents WSA# 5984 contains the service plan for a beneficiary with special health care needs who is receiving LTSS. Included as an attachment to the service plan are the 24-hour nursing duties care plan and documentation templates used by nursing staff each shift to monitor the member's health care needs.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Additional Services for Members With Special Health Care Needs or Who Need LTSS—Direct Access to Specialists		
9. For members with special health care needs determined through an assessment (consistent with 42 CFR §438.208(c)(2)) to need a course of treatment or regular care monitoring, the PIHP must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) Contract Section 1(F)(9)(a)	**HSAG Recommended Evidence:** • Policies and procedures • Benefit guide **Evidence as Submitted by the PIHP:** Access Policy, pp.1 Autism Service Plan, pp. 5-9	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Autism Service Plan contains standing authorizations for specialty services on pages 5-9. Services include Applied Behavioral Analysis, Occupational Therapy, and Speech/Language Therapy.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Integrated Physical and Mental Health Care		
10. *The PIHP must initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid members. These efforts must focus on persons that have a chronic condition such as a serious mental health illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.* a. *The PIHP must implement practices to encourage all members eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the member's MHP as defined in H.1.* b. *As authorized by the member, the PIHP must include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the PCP process.* Contract Section 1(H)(2)(a)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Three case examples of completed physical health assessments, coordinated through the MHP, within a member's health record (each example must pertain to a different CMHSP/provider) **Evidence as Submitted by the PIHP:** Service Philosophy & Treatment Policy, Section B.3.i, vi, pp. 1-2 V.10 Case Example LifeWays V.10 Case Example CMHCM V.10 Case Example GIHN	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: V.10 Case Example LifeWays- Evidence of CMHSP coordination with primary health care provider for the purpose of comprehensive evaluation for autism. V.10 Case Example CMHCM- During each medication review appointment at CMHCM the psychiatric provider reviews recent physical health information through a health information exchange (HIE) including recent healthcare appointments and any prescriptions by other providers (evidence highlighted on pages 1-2, 7-8, 13-14). The External Copy Request Report (beginning on page 19) demonstrates that CMHCM shared copies of the CMHCM psychiatric medication review appointments with the member's primary care provider. On 10/20/2020 CMHCM sent documentation for psychiatric medication review appointments occurring on the following dates of service: 6/11/2020 7/9/2020 9/24/2020 On 5/12/2021 CMHCM sent documentation for psychiatric medication review appointments occurring on the following dates of service: 11/19/2020 12/10/2020 1/21/2021 2/18/2021		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Primary Care Coordination		
11. *In accordance with 42 CFR, the PIHP must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care.* a. *Care coordinating agreements or joint referral agreements, by themselves, are not sufficient to show that the PIHP has taken all appropriate steps related to coordination of care.* b. *Member treatment case file documentation is also necessary.* c. *Member treatment case files must include, at minimum, the primary care physician's name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release.* Contract Section 1(H)(2)(a)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Three case examples of substance use disorder (SUD) health records with signed release or refusal for care coordination (each example must pertain to a different SUD provider) **Evidence as Submitted by the PIHP:** FY21 SUD Treatment Contract, Attachment A.7, pp. 33 FY21 SUD Provider Manual, pp.32 SUD Medical Coordination Medicaid ID 0076796559, pp.4 SUD Medical Coordination Medicaid ID 0038566576, pp. 14 SUD Medical Coordination Medicaid ID 0069227652, pp.5	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** While the SUD Delegated Functions Tool included a scoring element related to coordination of care with the member's primary care physician, HSAG recommends that the PIHP explicitly clarify that a review of signed release of information forms or a statement that the member has refused is included in the PIHP's review as well as the primary care physician's name and address. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Person-Centered Planning Process/Service Plan		
12. Members must lead the person-centered planning process where possible. The member's representative should have a participatory role, as needed and as defined by the member, unless State law confers decision-making authority to the legal representative. a. The person-centered service plan must reflect that the setting in which the member resides is chosen by the member. The setting chosen by the member is integrated in, and supports full access of member receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. b. The setting is selected by the member from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs, preferences, and, for residential settings, resources available for room and board. 42 CFR §441.301(c)(1),(2)(i) 42 CFR §441.530(a)(ii) 42 CFR §441.710(a)(1)(ii) Person-Centered Planning Practice Guideline Section VI	**HSAG Recommended Evidence:** • Policies and procedures • Three case examples of completed service plans (each example must pertain to a different CMHSP/provider) • Oversight and monitoring documentation • The PIHP should be prepared to conduct a system demonstration **Evidence as Submitted by the PIHP:** Service Philosophy & Treatment Policy. Section D, 1, 3.i, iii, iv, vii, viii, pp. 2-3 FY21 Gratiot Delegated Managed Care Tool, Standards 7.6, 7.7, 7.10, 7.22, (pp. 52-53) FY21 Gratiot Program-Specific Waiver Review Tool, Standards 2.5, 2.6, 2.7 WSA 75965 IPOS CEI CMH WSA 6415 IPOS CMHCM WSA 4526 IPOS BABHA	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: MSHN monitors its network of CMHSP partners and subcontracted providers to ensure compliance with federal and state regulations for home and community -based settings. The FY21 Delegated Managed Care tool is used during site review activity to verify that appropriate policies and procedures are in place to support the standard. The FY21 Program-Specific Waiver Review Tool is used to verify implementation of policies and procedures is occurring as expected. Specific client case records are reviewed as part of the program-specific waiver review. Evidence submitted as example for Gratiot Integrated Health Network however other examples are available if needed. Additionally, example service plans are provided as evidence from 3 different CMH organizations. Specific items related to member choice of residential setting and community participation are highlighted in each plan of service for ease of reference.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. Of note, the PIHP's Combined Chart Review Tool suggested a thorough review of member records related to the requirements of this element and documented deficiencies and/or opportunities for improvement in this area.		
Required Actions: None.		
Home- and Community-Based Settings		
13. Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: a. Identify a specific and individualized assessed need. b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan. c. Document less intrusive methods of meeting the need that have been tried but did not work. d. Include a clear description of the condition that is directly proportionate to the specific assessed need.	**HSAG Recommended Evidence:** • Policies and procedures • Three case examples of completed service plans with restrictions to the member's freedom (each example must pertain to a different CMHSP/provider) • Oversight and monitoring documentation • Reporting and tracking mechanisms • The PIHP should be prepared to conduct a system demonstration **Evidence as Submitted by the PIHP:** Behavior Treatment Plan Review Committee Policy, Section H, b.i-iv, c.i-viii, (pp. 3) Behavior Treatment Plan Review Procedure MSHN Behavior Treatment Review Data FY21 Q1	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
e. Include regular collection and review of data to measure the ongoing effectiveness of the modification. f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. g. Include the informed consent of the member. h. Include an assurance that interventions and supports will cause no harm to the member. 42 CFR §441.301(c)(4)(vi)(F)(*1-8*) 42 CFR §441.530(a)(1)(vi)(F)(*1-8*) 42 CFR §441.710(a)(1)(vi)(F)(*1-8*) Person-Centered Planning Practice Guideline Section VII	Shiawassee Combined Chart Review Standard V.13 Restrictive Plan Shiawassee CMH Standard V.13 Restrictive Plan CEI CMH Standard V.13 Restrictive Plan CMHCM	
PIHP Description of Process: Example service plans are provided as evidence from 3 different CMH organizations. Specific items related to restrictive or intrusive modifications to person-centered plans are highlighted in each plan of service for ease of reference. Also included with each plan are the functional behavioral assessment and recommendations from a psychologist which led to the modifications of the person-centered plan. MSHN conducts regular monitoring and oversight of the CMHSPs through the site review process. The Shiawassee Combined Chart Review demonstrates that member charts were audited in March 2021 for compliance with this standard of care. Please see pp. 23-25 for detailed findings.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. Of note, the PIHP's Combined Chart Review Tool suggested a thorough review of member records related to the requirements of this element and documented deficiencies and/or opportunities for improvement in this area. **Recommendations:** While the PIHP submitted its policies and procedures related to behavioral treatment plans/review, they did not reference the HCBS Final Rule. HSAG recommends that the PIHP's policies appropriately reflect the HCBS Final Rule and the requirements should there be a modification to a member's freedom and rights afforded under the HCBS Final Rule and the required documentation that must be included in the service plan. The PIHP's processes should clarify expectations for when a modification is imposed due to a physical need or due to the restrictions of another individual residing in the home.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Conflict-Free Case Management		
14. The PIHP must establish conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not: a. Related by blood or marriage to the member, or to any paid caregiver of the member. b. Financially responsible for the member. c. Empowered to make financial or health-related decisions on behalf of the member. d. Individuals who would benefit financially from the provision of assessed needs and services. e. Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when MDHHS demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, MDHHS must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for assigning support coordinators/case managers to members • Attestation documentation • Three examples of member records confirming conflict-free case management • Oversight and monitoring documentation • The PIHP should be prepared to conduct a system demonstration **Evidence as Submitted by the PIHP:** Self-Determination Practice & Fiscal Intermediary Guideline (pp. 4, 9, 11) Person-Centered Planning Practice Guideline Access Policy, Section VIII, (pp.11) CMH Employer Guide (pp. 6, 12) Conflict Free Case Management Policy Huron	☐ Met ☒ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
by CMS. Members must be provided with a clear and accessible alternative dispute resolution process. 42 CFR §441.301(c)(1)(vi) 42 CFR §441.555(c)(1-5) 42 CFR §441.730(b)(1-5) Person-Centered Planning Practice Guideline Section VIII		
PIHP Description of Process: MSHN adopts the MDHHS Practice Guidelines including the Self-Determination Practice & Fiscal Intermediary Guideline and Person-Centered Planning Practice Guideline, both of which contain requirements for establishing conflict of interest standards. The practice guidelines are published as provider requirements on the MSHN website: Practice Guidelines - Mid-State Health Network. Additionally, the Access Policy (Section VIII, pp.11) provides assurance for no conflict of interest in service authorization decisions. Each CMHSP is responsible for having its own policies and procedures in place to support this standard. The document Conflict Free Case Management Policy Huron is provided as example. Additionally, MSHN and its 12 CMHSP Participants utilize a standardized regional contract for Fiscal Intermediary Services to ensure that individuals being served through self-determination arrangements using a Fiscal Intermediary have protections in place to prevent conflicts of interest. Please reference CMH Employer Guide (pp.6, 12) which is a document prepared by the fiscal intermediary provider Stuart Wilson explaining to beneficiaries the prohibitions on using spouses, family members, or guardians as paid service providers.		
HSAG Findings: The documents initially submitted by the PIHP did not specifically address conflict-free case management provisions required by this element with the exception of one CMHSP that had developed a policy related to conflict-free case management. When prompted, discussion with PIHP staff members confirmed understanding of these provisions; however, limited documentation related to conflict-free case management was provided and no additional documentation was submitted after the interview session. **Recommendations:** HSAG recommends that the PIHP create a written procedure specific to conflict-free case management and the safeguards in place to avoid conflicts of interest (and/or ensure its provider network has the necessary written procedures and safeguards in place). The PIHP should ensure its provider network complies with and understands these provisions. Additionally, the PIHP should ensure that case managers specifically receive training on conflict-free case management.		
Required Actions: The PIHP must establish conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private.		

Standard V—Coordination and Continuity of Care						
Met	=	13	X	1	=	13
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	14	Total Score		=	13
Total Score ÷ Total Applicable					=	93%

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The PIHP must ensure that services identified in 42 CFR §438.210(a)(1) be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441. 42 CFR §438.210(a)(1-2) 42 CFR §440.230 42 CFR Part 441 Subpart B	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan **Evidence as Submitted by the PIHP:** FY21 MSHN Guide to Services Consumer Handbook, pp.62	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Under MDHHS-PIHP Contract the PIHP is responsible for provision of specialty behavioral health and substance use services to all Medicaid/Healthy Michigan Plan beneficiaries including individuals served under FFS Medicaid and for members under the age of 21, therefore there are no differences in the amount, duration and scope of services provided since it is all managed by the same entity, the PIHP.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
2. The PIHP— a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan **Evidence as Submitted by the PIHP:** Access Policy, pp. 5-6 Level of Care System (LOC) for Parity Procedure	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A–1(F)(a) Contract Schedule A–1(Q)(15)		
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
3. The PIHP may place appropriate limits on a service— a. On the basis of criteria applied under the MDHHS plan, such as medical necessity; or b. For the purpose of utilization control, provided that— i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i); ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. 42 CFR §438.210(a)(4)(i-ii) Contract Schedule A–1(Q)(15)	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** Access Policy, pp. 5-6 Utilization Management Plan, pp. 5-7 Level of Care System (LOC) for Parity Policy Level of Care System (LOC) for Parity Procedure, Section G	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
4. The PIHP specifies what constitutes "medically necessary services" in a manner that— a. Is no more restrictive than that used in the MDHHS Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in MDHHS statutes and regulations, the MDHHS Plan, and other MDHHS policy and procedures; and b. Addresses the extent to which the PIHP is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. ii. The ability for a member to attain, maintain, or regain functional capacity. iv. The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice. 42 CFR §438.210(a)(5)(i-ii)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** Access Policy, pp. 5-6 Utilization Management Policy, pp.3, Items 1-3 Utilization Management Plan, pp. 7	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Authorization of Services		
5. For the processing of requests for initial and continuing authorizations of services, the PIHP shall— a. Have in place, and follow, written policies and procedures. b. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions. c. Consult with the requesting provider for medical services when appropriate. d. Authorize LTSS based on a member's current needs assessment and consistent with the person-centered service plan, e. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or long-term services and supports needs. 42 CFR §438.210(b)(1-2) Contract Schedule A–1(E)(13)	**HSAG Recommended Evidence:** • Policies and procedures • Results of interrater reliability (IRR) activities • One case example of a peer-to-peer (P2P) consult • Workflow to authorize LTSS consistent with the person-centered service plan (PCSP) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** Utilization Management Policy, pp.2 Level of Care System (LOC) for Parity Policy Level of Care System (LOC) for Parity Procedure Access Policy, pp. 2 Utilization Management Plan, pp.7	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Access Policy and Utilization Management Policy provide an overview of MSHN's regional utilization program including those functions which are delegated to CMHSP Participants and those functions which are retained by the PIHP. The Utilization Management Plan and Level of Care System (LOC) for Parity Policy and Procedure provide more detailed information regarding how MSHN and its CMHSP participants ensure consistent application of criteria when performing utilization management functions.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** Although the PIHP demonstrated effective mechanisms to ensure consistency in making authorization decisions through standardized assessments and tools and was conducting quarterly reviews of region-wide data to determine variation in services across the entire region, the PIHP should		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
consider implementing a standardized interrater reliability process that includes standardized test case scenarios, reviewing the performance of each individual authorization decision-maker and taking corrective action when appropriate, and using the overall interrater reliability results to conduct targeted training and update policies and processes, as necessary, to improve the consistency in authorization decision-making. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
Notice of Adverse Benefit Determination		
6. The PIHP must notify the requesting provider (*notice of the provider does NOT need to be in writing*), and give the member written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of 42 CFR §438.404. The notice must explain the following: a. The adverse benefit determination the PIHP has made or intends to make. b. The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the PIHP's adverse benefit determination, including information on exhausting the PIHP's one level of appeal described at 42 CFR §438.402(b)	**HSAG Recommended Evidence:** • Policies and procedures • Adverse benefit determination (ABD) notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** Utilization Management Policy, pp.2 FY21 MSHN Guide to Services Consumer Handbook, pp. 39-41 FY21 Adverse Benefit Determination.FINAL Medicaid Enrollee Appeals/Grievances Policy LifeWays_2021 ABD Review Tool	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
and the right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with MDHHS policy, under which the member may be required to pay the costs of these services. g. *An explanation the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* 42 CFR §438.210(c) 42 CFR §438.404(b)(1-6) Appeal and Grievance Resolution Processes Technical Requirement IV(A)(1-10) Appeal and Grievance Resolution Processes Technical Requirement IV(C)(1-2)		
PIHP Description of Process:		
HSAG Findings: Although the PIHP's template adverse benefit determination (ABD) notice complied with the MDHHS-mandated template language, and the PIHP had a process in place to monitor the CMHSPs' ABD notices, there were noted issues with four out of the 10 ABD notices that were included as part of the case file review. Specifically, the ABD notices did not consistently include the services being requested, a clear explanation for why the services were being denied, and/or the inclusion of multiple citations that were not applicable to the member.		
Required Actions: The PIHP's ABD notices must include the content requirements of 42 CFR §438.404.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
7. The PIHP must mail the notice within the following timeframes: a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR §431.211, §431.213, and §431.214. b. For denial of payment, at the time of any action affecting the claim. c. For standard or expedited service authorization decisions, (including the extension of service authorization timeframes), that deny or limit services, within the timeframe specified in 42 CFR §438.210(d)(l-2); d. For service authorization decisions not reached within the timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(d)(1-2) 42 CFR §438.404(c)(1-6) Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1-2)	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for payment denial on a claim to trigger ABD notice • One case example of an ABD notice sent to a member for the denial of payment on a claim • One case example of an ABD notice sent to a member due to the PIHP's failure to make a service authorization decision timely • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** Medicaid Enrollee Appeals/Grievances Policy FY21 MSHN Guide to Services Consumer Handbook, pp. 39-41 Utilization Management Policy, pp.3	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Standard Authorization Decisions		
8. For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within MDHHS-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— a. The member, or the provider, requests extension; or b. The PIHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1)(b-c)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization extension letter template • One case example of an extension letter sent to a member for standard authorization • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** Utilization Management Policy, pp.3 Service Authorization Extension Template-Final	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Expedited Authorization Decisions		
9. For cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization extension letter template • One case example of an extension letter sent to a member for expedited authorization • HSAG will also use the results of the service authorization denial file review	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
a. The PIHP may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the PIHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(2)(i-ii) Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1)(b-c)	**Evidence as Submitted by the PIHP:** Utilization Management Policy, pp.3 Medicaid Enrollee Appeals/Grievances Policy	
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element.		
Required Actions: None.		
Extension Notification		
10. If the PIHP extends the review of the service authorization timeframe NOT at the request of the member, the PIHP must: a. *Make reasonable efforts to give the member prompt oral notice of the delay;* b. *Within two calendar days*, provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision; and c. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date. 42 CFR §438.404(c)(4)(i-ii) Appeal and Grievance Resolution Processes Technical Requirement IV(B)(1)(c)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Service authorization extension letter template • Two case examples of extension letters sent to a member for a service authorization • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** Utilization Management Policy, pp.3 Medicaid Enrollee Appeals/Grievances Policy Service Authorization Extension Template-Final	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** Although the PIHP's Notice of Service Authorization Extension template appropriately explained that an extension would be taken, included the date the oral notice was made to the member, and provided the member with grievance rights, the letter only addressed extensions for the standard service authorization time frame. Since a 14-day extension can also be taken for an expedited authorization request, the PIHP should update its template letter to be more general. Additionally, although the extension requirements were noted in the template letter, HSAG strongly recommends that the PIHP also update its policies and procedures with these requirements to ensure the applicable processes are documented for staff member awareness. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		
Compensation for Utilization Management Activities		
11. The PIHP must provide that, consistent with 42 CFR §§438.3(i), and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) Contract Section 1(K)(1)(a)	**HSAG Recommended Evidence:** • Policies and procedures • New hire and ongoing training for staff • One example of a staff attestation **Evidence as Submitted by the PIHP:** Access Policy, pp. 6 Utilization Management Policy, pp. 4 FY21 MSHN Guide to Services Consumer Handbook, pp. 60 LifeWays Procedure Utilization Management Criteria pp.3-4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP has policies/procedures in place to ensure that compensation to individuals or entities that conduct utilization management activities is not structure so as to provide incentives to deny, limit, or discontinue medically necessary services. Evidence of PIHP policies/procedures include the following: Access Policy, pp. 6 Utilization Management Policy, pp. 4 FY21 MSHN Guide to Services Consumer Handbook, pp. 60		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Additional evidence is provided to demonstrate the monitoring procedure at the CMH level. The document LifeWays Procedure Utilization Management Criteria (pp.3-4) describes the process the CMH uses to monitor utilization review activity of individual staff members in order to identify potential concerns of review criteria being applied in a way that would financially benefit the UM reviewer.		
HSAG Findings: HSAG has determined that the PIHP has met the requirements for this element. **Recommendations:** Although the PIHP's policies indicated its utilization management program is not structured to provide compensation or incentives to staff members making authorization decisions, HSAG recommends the PIHP and its CMHSPs develop a mechanism to confirm staff awareness, such as an affirmation or attestation that utilization management staff members making authorization decisions are required to sign upon employment and annually specifying they understand they will not be incentivized for denying, limiting, or discontinuing medically necessary services to any member. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services						
Met	=	10	X	1	=	10
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	11	**Total Score**		=	10
Total Score ÷ Total Applicable					=	91%

Appendix B. Corrective Action Plan

Following this page is a document HSAG prepared for **Mid-State Health Network** to use in preparing its CAP. For each of the requirements listed as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the PIHP will measure the effectiveness of the intervention.
- Individual(s) responsible for ensuring that the planned interventions are completed.
- Proposed timeline for completing each planned intervention.
- Evidence of compliance. This could include proposed revisions to policies and procedures, report templates, or other documentation, as needed.

This plan is due to MDHHS and HSAG no later than 30 calendar days following receipt of this final *State Fiscal Year 2021 Compliance Review* report.

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Language and Format		
6. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the PIHP's member/customer service unit. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. 42 CFR §438.10(d)(3) Contract Schedule A–1(M)(2)(b)	**HSAG Recommended Evidence:** • Policies and procedures • Spanish member handbook (provide handbook and link to website; PIHP and community mental health services programs (CMHSPs), as applicable) • Spanish provider directory (provide excerpts of directory and link to website; PIHP and CMHSPs, as applicable) • Taglines included with member information **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP • MSHN_ FY21 LIFEWAYS_Handbook, pgs. 6,7, 10 • 2021 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • FY21 MSHN Guide to Services LIFEWAYS_SPANISH • Member Handbook - Mid-State Health Network (midstatehealthnetwork.org) • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 38 • CSC Meeting Minutes 10.15.18	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: Mid-State Health Network (MSHN) maintains an annual process to have the MSHN Guide to Services translated into Spanish. During the October 15, 2018 Customer Service Committee meeting, see minutes, it was discussed that the need is infrequent for LEP formatted appeal and grievance notices, and denial and termination notices. It was determined that providers would work with their contracted LEP translation service to translate Notices and extend the effective date to accommodate the additional timeframe for the translation of the notice.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The PIHP's written materials that are critical to obtaining services (e.g., provider directory, appeal and grievance notices, and denial and termination notices), with the exception of the member handbook, did not include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		
Required Actions: The PIHP must ensure that written materials that are critical to obtaining services include all the requirements identified in this element.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
Information for All Members With PIHP—General Requirements		
10. The PIHP must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. a. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) Contract Schedule A–1(M)(2)(b)(ii)(3)	**HSAG Recommended Evidence:** • Policies and procedures • One example of written notice to members of provider termination (include the effective date of the termination or receipt or issuance of the termination notice for this example) • Tracking or reporting mechanisms (mailing date and effective date of the termination or receipt or issuance of the termination notice must be notated) **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_Policy, pg 2, item Q • Holy Cross Suspension and Termination of Services - 1.29.21	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Holy Cross Contract Termination Notice Acknowledgement - Eff. 3.30.21 • Holy Cross-Closure Notification Letter • Lifeways FY 2021 MEDICAID SUBCONTRACTING AGREEMENT, pg. 39 • 2021 CMHSP Delegated Managed Care Tool, pg. 3, item 1.9	
PIHP Description of Process:		
HSAG Findings: While the Customer_Consumer Service Policy and the CMHSP subcontracting agreement specified that the PIHP made a good faith effort to give affected members written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination, the documents did not include the federal requirement that notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.		
Required Actions: The PIHP must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen regularly by, the terminated provider. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Information for All Members of PIHP—Provider Directory		
16. The PIHP must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist. 42 CFR §438.10(h)(1)(i-viii) Contract Schedule A–1(M)(1)	**HSAG Recommended Evidence:** • Provider directory (provide excerpts of directory and link to website; PIHP and CMHSPs, as applicable) • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the PIHP:** • MSHN Provider Directory Website - https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory • Print Directory Example (midstate_directory_result_2021_04_12).xls - Example of the download produced from the website on 4.12.21 • PNM_Provider_Directory_Policy • CS_Customer_Consumer_Service_Policy, pg. 1, item A • MSHN_ FY21 LIFEWAYS_Handbook, pg. 14 • R5-Mid-State_MI2021_PIHP_CR_Standard I_Provider Directory Checklist_D1	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: CMHSPs are to submit their electronic directory on the 4th Friday of the month. The following week, MSHN exports the directories along with the SUD Network directory into a single CSV file and uploads the entire file into the MSHN website which is machine readable. Any person who visits the MSHN web-based directory can download/print the directory by clicking on the 'Download/Print Directory' link. An excel file will download and can be further customized/formatted for a print friend version.		
HSAG Findings: The PIHP's provider directory did not include all required content. The specific details of provider office accommodations for persons with physical disabilities (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment) were not listed in the provider directory, only a "Yes" or "No" if the provider had Americans with Disabilities Act (ADA)-compliant accommodations. Additionally, the provider's cultural capabilities were not included in the directory as required.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The PIHP must ensure that provider directories contain all federally required content.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
4. The PIHP requires out-of-network providers to coordinate with the PIHP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network, *including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116 and the Medicaid Provider Manual*. a. *The PIHP must comply with all related Medicaid Policies regarding authorization and reimbursement for Out-of-Network providers*. b. *The PIHP must pay Out-of-Network Medicaid providers' claims at established Medicaid fees in effect on the date of service*. c. *If Michigan Medicaid has not established a specific rate for the Covered Service, the PIHP must follow Medicaid Policy to determine the correct payment amount*. 42 CFR §438.206(b)(5) Contract Schedule A–1(E)(4)(d)	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider billing manual • One example of an executed single case agreement **Evidence as Submitted by the PIHP:** VCS Kalamazoo SCA – Standard III FY21 SUD Provider Manual • pp.44 SUD Single Case Procedure MSHN_ FY21 LIFEWAYS_Handbook • pg. 60 NCMH 2021 Delegated Managed Care – Standard III • 4.4 Pg. 10	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: The PIHP's single case agreements (SCAs) did not include a prohibition on balance billing, nor did any other documentation support that an out-of-network provider will not balance bill a member. **Recommendations:** The PIHP should specifically include in its SCA a prohibition on balance billing. Additionally, while PIHP staff members could speak to sub-elements (a)–(c), HSAG recommends that these requirements are clearly reflected in the PIHP's policies, procedures, oversight and monitoring documentation, or other materials, as applicable. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The PIHP must require out-of-network providers to coordinate with the PIHP for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network, including a prohibition on balance billing in compliance with 42 CFR §438.106, 42 CFR §438.116, and the Medicaid Provider Manual.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Timely Access		
5. The PIHP must do the following: a. Meet and require its network providers to meet MDHHS standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers.	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • Results of provider monitoring (e.g., secret shopper surveys) • One example of corrective action when a provider failed to meet access standards • HSAG will also use the results of the Access Standards: Appointment Times Checklist **Evidence as Submitted by the PIHP:** MSHN FY 2021 Medicaid Subcontracting Agreement – Standard III • Pg. 9 (XI)(B)	☐ Met ☒ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(i-vi) Contract Schedule A–1(E)(7)(a)	• Pg. 33 (XXX) (A-D) • Pg. 46 (VII. Provider Network) FY21 SUD Treatment – Standard III • Pg. 9 (2) • Pg. 13 (1) • Pg. 15 (12) FY21 LifeWays CMH Delegated Managed Care Review • Pg. 7-8 Access Policy • Pg. 1 2021 CMHSP Delegated Managed Care Tool PNM_Provider_Network_Mgmt_Policy • Pg. 1	
PIHP Description of Process:		
HSAG Findings: The PIHP did not provide evidence of a process to actively monitor adherence to all time frame standards; for example, adherence to admission time frames for pregnant women receiving services for a SUD, which are more stringent than the appointment standards tracked and reported via Michigan's Mission-Based Performance Indicator System (MMBPIS). The SUD Delegation Functions Tool included a review of an element on appointment standards; however, it also appeared to focus on MMBPIS indicators. Additionally, the Access Priority Indicator Report included MMBPIS indicators but not admission time frame standards for all priority population standards, such as pregnant women receiving services for SUD. **Recommendations:** HSAG recommends that the PIHP include a provision within its provider contracts prohibiting providers from offering hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		
Required Actions: The PIHP must meet and require its network providers to meet MDHHS' standards for timely access to care and services and establish mechanisms to regularly monitor compliance and take corrective action if there is a failure to comply. This should apply to all screening and appointment standards in addition to those reported through MMBPIS.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The PIHP gives assurances to MDHHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 §438.207, including the standards at §438.68 and §438.206(c)(1). a. Each PIHP must submit documentation to MDHHS, in a format specified by MDHHS, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of behavioral health, development disability, substance use and specialty services, and LTSS that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.68 42 CFR §438.206(1) 42 CFR §438.207(a), (b)(1-2) Contract Schedule A–1(E)(2)(a)	**HSAG Recommended Evidence:** • Policies and procedures • Most recent time/distance analysis • Most recent member/provider ratio analysis • Exceptions approved by MDHHS • HSAG will also use the results of the Access Standards: Time/Distance Checklist **Evidence as Submitted by the PIHP:** • 2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN • Re_Network Adequacy Standards Update—MDHHS Plan (EMAIL SUBMISSION TO MDHHS) • Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL) • MSHN Network Adequacy Assessment CLEAN version - Final Draft • Provider Network Management Policy (pg. 1, item B & C) • PNM_SUD_Direct_Service_Procurement Policy • Out-of-State Placement Policy • Out-of-State Placement Procedure • FY21 V2 SUD Provider Manual FINAL (pg. 24, Capacity) • FY21 – SUD Treatment (pg. 10, bullet 6 Waitlist; pg. 19 bullet C Accessibility; pg. 22 bullet 5 Notification of Staffing Changes) • FY21 Medicaid Subcontracting Agreement (pg. 35, Bullet B; pg. 46 & 50 Provider Network Delegation)	☐ Met ☒ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
	• Geo Maps: SUD MAT, SUD Residential, SUD Withdrawal Mgt, SUD OP, Inpatient Psych, Crisis Services	

PIHP Description of Process:

- In 2018, MSHN contracted with Dale Howe to conduct GeoMaps to determine adequacy of services by identifying where persons served reside and where providers are located to determine where gaps may exist. GeoMaps will be renewed every three years and will be updated during 2021.
- MSHN completes an annual assessment of adequacy to determine whether or not it offers appropriate range of services, and whether those services are adequate for the anticipated number of members in the region. To achieve this, we look at utilization trends/persons served trends as well as enrollment trends to determine if current provider network can meet needs of persons served (pg.10-36). The most recent assessment was reviewed and received by the MSHN BOD in May of 2021. As part of this process, and in accordance with the contract, CMHSPs conduct annual local needs assessments to assess local needs within their catchment areas and identify priorities (pg. 36). MSHN ensures availability of all SUD levels of care (pg. 26). Recommendations are included and an action plan is under development to monitor implementation (pg. 45).
- MSHN also completed an analysis of the enrollee/provider ratio standards developed by MDHHS. In instances where MSHN did not meet the MDHHS ratio standards, MSHN offered additional evidence to support capacity to meet persons served. This analysis was approved by MDHHS. This has since been incorporated into the overall Network Adequacy Assessment.

HSAG Findings: The PIHP has not implemented processes to evaluate its provider network using the time/distance standards required by MDHHS' PIHP Network Adequacy Standard Procedural Document. The MSHN Network Adequacy Assessment was dated after the review period; however, after the interview session, a draft version was submitted that demonstrated the assessment was being worked on during the review period. Additionally, it did not address the time/distance standards specific to the provider types within MDHHS' defined time/distance standards (inpatient psychiatric and other select providers by adults and pediatric). Lastly, GeoMaps were provided that were dated from 2018 and, while they plotted members and providers, it is unclear if the time/distance standards were calculated and subsequently met.

Required Actions: The PIHP must give assurances to MDHHS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Timing of Documentation		
2. Each PIHP must submit the documentation described in 42 CFR §438.207(b) as specified by MDHHS, but no less frequently than the following: a. At the time it enters into a contract with MDHHS. b. On an annual basis. c. At any time there has been a significant change (as defined by MDHHS) in the PIHP's operations that would affect the adequacy of capacity and services, including— i. Changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the PIHP. 42 CFR §438.207(c)(3)(i-iii)	**HSAG Recommended Evidence:** • Policies and procedures • Most recent annual assurances of adequate capacity and services submission to MDHHS • Assurances of adequate capacity and services submission to MDHHS due to a significant change (if no significant change, state so in the PIHP Description of Process) **Evidence as Submitted by the PIHP:** • 2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN • Re_Network Adequacy Standards Update—MDHHS Plan (EMAIL SUBMISSION TO MDHHS) • Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL) • MSHN Network Adequacy Assessment CLEAN version - Final Draft	☐ Met ☒ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
	• Provider Network Adequacy Assessment - Filing with MDHHS	
PIHP Description of Process: In 2018, MDHHS developed enrollee/provider ratio standards. MSHN conducted an analysis and submitted its results/plan to MDHHS in December of 2018. There were instances where MSHN did not meet the identified standard but had evidence to support adequate capacity. Rationale was included in that analysis. MSHNs submission was approved by MDHHS in June of 2019. MDHHS has not requested additional information since this time; however, MSHN has incorporated these standards in its overall Network Adequacy Plan which was board approved in May 2021. MSHN has submitted a final copy to MDHHS on 5.12.21 and provided a copy of the email submission as evidence.		
HSAG Findings: While the PIHP demonstrated a network adequacy plan was internally approved in May 2021, it did not annually submit its assurances and supporting documentation that demonstrated that it had the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards defined in MDHHS' PIHP Network Adequacy Standard Procedural Document. Additionally, the reporting requirements (i.e., annual submission of assurances of adequate capacity and services, and at any time there has been a significant change) were not clearly documented within policy. **Recommendations:** The PIHP should work with MDHHS to determine when the annual submission of its assessment of adequate capacity, in accordance with MDHHS' defined network adequacy standards, should be submitted.		
Required Actions: The PIHP must submit its assurances of adequacy capacity to MDHHS annually and at any time there has been a significant change, including changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network, or for the enrollment of a new population in the PIHP.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Regional Specific Plans		
4. *The PIHP submits a plan on how standards will be effectuated by region. Understanding their diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. PIHPs must consider at least the following parameters for their plans:* a. *Maximum time and distance* b. *Timely appointments* c. *Language, Cultural competence, and Physical accessibility—42 CFR 438.68(c)(1)(vii-viii).* 42CFR 438.68(c)(1)(vii-viii) PIHP Network Adequacy Standard Procedural Document	**HSAG Recommended Evidence:** • Policies and procedures • Regional network adequacy plan **Evidence as Submitted by the PIHP:** • 2018-12 MDHHS Network Adequacy Standards Final Plan for MSHN • Re_Network Adequacy Standards Update—MDHHS Plan (EMAIL SUBMISSION TO MDHHS) • Mid-State Network Adequacy Standards V2 06.06.2019 (MDHHS APPROVAL) • MSHN Network Adequacy Assessment Clean Version – Final Draft • Provider Network Management Policy (pg. 1, item B & C)	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The MSHN Network Adequacy Assessment includes an analysis of access/timeliness (pg. 39), language/cultural competence/and physical accessibility (pg. 42-43) and time/distance (GeoMaps). Additionally, we consider consumer choice (pg. 42) and consumer satisfaction (pg. 37).		
HSAG Findings: The PIHP did not maintain a current plan on how MDHHS' network adequacy standards will be effectuated in its region that addresses time/distance standards in accordance with MDHHS' PIHP Network Adequacy Standard Procedural Document. The PIHP's network adequacy assessment considered the percentage of members that speak non-English languages but did not identify those languages or assess the languages spoken by its provider network. The consideration of physical accessibility was also limited. The assessment suggested that providers are empaneled in areas with concentrations of ethnic or cultural groups, such as the Latino counseling services available through the Community Mental Health Authority of Clinton, Eaton, & Ingham Counties' provider network; however, the PIHP should expand on its assessment. **Recommendations:** HSAG recommends that the PIHP consider the following in its network adequacy plan: • Time/distance standards in accordance with MDHHS policy. • Appointment time frames for priority populations, such as for pregnant SUD members.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
• More detailed information related to language, including an assessment of languages spoken by its membership and its provider network, and an analysis of the use of interpreter services. • More detailed information related to cultural competency, including an assessment of the cultural and ethnic make-up of the PIHP membership and the capability of the provider network to meet the needs of members. • More detailed information related to physical accessibility, including an analysis of provider types who can or cannot provide physical accessibility to members with disabilities (e.g., residential providers).		
Required Actions: The PIHP must maintain plan on how network adequacy standards will be effectuated in its region. The PIHP's plan must consider at least the following parameters: maximum time and distance; timely appointments; and language, cultural competence, and physical accessibility.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Conflict-Free Case Management		
14. The PIHP must establish conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not: a. Related by blood or marriage to the member, or to any paid caregiver of the member. b. Financially responsible for the member. c. Empowered to make financial or health-related decisions on behalf of the member. d. Individuals who would benefit financially from the provision of assessed needs and services. e. Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when MDHHS demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, MDHHS must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for assigning support coordinators/case managers to members • Attestation documentation • Three examples of member records confirming conflict-free case management • Oversight and monitoring documentation • The PIHP should be prepared to conduct a system demonstration **Evidence as Submitted by the PIHP:** Self-Determination Practice & Fiscal Intermediary Guideline (pp. 4, 9, 11) Person-Centered Planning Practice Guideline Access Policy, Section VIII, (pp.11) CMH Employer Guide (pp. 6, 12) Conflict Free Case Management Policy Huron	☐ Met ☒ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
by CMS. Members must be provided with a clear and accessible alternative dispute resolution process. 42 CFR §441.301(c)(1)(vi) 42 CFR §441.555(c)(1-5) 42 CFR §441.730(b)(1-5) Person-Centered Planning Practice Guideline Section VIII		
PIHP Description of Process: MSHN adopts the MDHHS Practice Guidelines including the Self-Determination Practice & Fiscal Intermediary Guideline and Person-Centered Planning Practice Guideline, both of which contain requirements for establishing conflict of interest standards. The practice guidelines are published as provider requirements on the MSHN website: Practice Guidelines - Mid-State Health Network. Additionally, the Access Policy (Section VIII, pp.11) provides assurance for no conflict of interest in service authorization decisions. Each CMHSP is responsible for having its own policies and procedures in place to support this standard. The document Conflict Free Case Management Policy Huron is provided as example. Additionally, MSHN and its 12 CMHSP Participants utilize a standardized regional contract for Fiscal Intermediary Services to ensure that individuals being served through self-determination arrangements using a Fiscal Intermediary have protections in place to prevent conflicts of interest. Please reference CMH Employer Guide (pp.6, 12) which is a document prepared by the fiscal intermediary provider Stuart Wilson explaining to beneficiaries the prohibitions on using spouses, family members, or guardians as paid service providers.		
HSAG Findings: The documents initially submitted by the PIHP did not specifically address conflict-free case management provisions required by this element with the exception of one CMHSP that had developed a policy related to conflict-free case management. When prompted, discussion with PIHP staff members confirmed understanding of these provisions; however, limited documentation related to conflict-free case management was provided and no additional documentation was submitted after the interview session. **Recommendations:** HSAG recommends that the PIHP create a written procedure specific to conflict-free case management and the safeguards in place to avoid conflicts of interest (and/or ensure its provider network has the necessary written procedures and safeguards in place). The PIHP should ensure its provider network complies with and understands these provisions. Additionally, the PIHP should ensure that case managers specifically receive training on conflict-free case management.		
Required Actions: The PIHP must establish conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Notice of Adverse Benefit Determination		
6. The PIHP must notify the requesting provider (*notice of the provider does NOT need to be in writing*), and give the member written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of 42 CFR §438.404. The notice must explain the following: a. The adverse benefit determination the PIHP has made or intends to make. b. The reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the PIHP's adverse benefit determination, including information on exhausting the PIHP's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it.	**HSAG Recommended Evidence:** • Policies and procedures • Adverse benefit determination (ABD) notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** Utilization Management Policy, pp.2 FY21 MSHN Guide to Services Consumer Handbook, pp. 39-41 FY21 Adverse Benefit Determination.FINAL Medicaid Enrollee Appeals/Grievances Policy LifeWays_2021 ABD Review Tool	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with MDHHS policy, under which the member may be required to pay the costs of these services. g. *An explanation the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* 42 CFR §438.210(c) 42 CFR §438.404(b)(1-6) Appeal and Grievance Resolution Processes Technical Requirement IV(A)(1-10) Appeal and Grievance Resolution Processes Technical Requirement IV(C)(1-2)		
PIHP Description of Process:		
HSAG Findings: Although the PIHP's template adverse benefit determination (ABD) notice complied with the MDHHS-mandated template language, and the PIHP had a process in place to monitor the CMHSPs' ABD notices, there were noted issues with four out of the 10 ABD notices that were included as part of the case file review. Specifically, the ABD notices did not consistently include the services being requested, a clear explanation for why the services were being denied, and/or the inclusion of multiple citations that were not applicable to the member.		
Required Actions: The PIHP's ABD notices must include the content requirements of 42 CFR §438.404.		
PIHP Corrective Action Plan		
Action Plan/Interventions:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	