Michigan Department of Health and Human Services

Behavioral Health and Developmental Disabilities Administration

SFY 2022 External Quality Review Compliance Review Report *for* Prepaid Inpatient Health Plans

Region 5—Mid-State Health Network

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Michigan Department of Health and Human Services (MDHHS) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid inpatient health plan's (PIHP's), or prepaid ambulatory health plan's (PAHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As MDHHS' EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the contracted PIHPs delivering services to members enrolled in the Michigan Behavioral Health Managed Care Program. When conducting the compliance review, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

The state fiscal year (SFY) 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance review for Michigan PIHPs consist of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021), and a review of the remaining seven standards 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 three-year review cycle.

[1-1] 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: May 27, 2022.

Table 1-1—Compliance Review Standards

Standard	Associated Federal Citation[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.100	✓		Comprehensive review of each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan Medicaid health plans. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.

[3] This standard includes a comprehensive assessment of a PIHP's information systems (IS) capabilities.

Summary of Findings

Table 1-2 presents an overview of the results of the SFY 2022 compliance review for **Mid-State Health Network**. 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. 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 seven standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	**75%**
Standard VIII—Confidentiality[1]	11	11	10	1	0	**91%**
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	**84%**
Standard X—Subcontractual Relationships and Delegation	5	5	5	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems	12	12	11	1	0	**92%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	28	2	0	**93%**
Total	**119**	**119**	**105**	**14**	**0**	**88%**

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.

[1] Performance in this standard should be interpreted with caution as there were noted opportunities for the PIHP to enhance written documentation supporting the federal requirements; therefore, a high compliance score in this program area is not considered a strength within this compliance review. The PIHP's progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews.

Mid-State Health Network achieved full compliance in two of the seven standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of Subcontractual Relationships and Delegation and Practice Guidelines. The remaining five standards have identified opportunities for improvement. The areas with the greatest opportunity for improvement were related to Provider Selection and Grievance and Appeal Systems, as these areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **Mid-State Health Network** is required to submit a corrective action plan (CAP) to bring the element into compliance with the applicable standard(s). The process for submitting the CAP is described in Section 3.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with 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 post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the 10 PIHPs contracted with MDHHS to deliver services to Michigan Behavioral Health Managed Care Program members.

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The SFY 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in SFY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021), and a review of the remaining seven standards 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 2-1 outlines the standards reviewed over the three-year review cycle.

Table 2-1—Compliance Review Standards

Standard	Associated Federal Citation[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Member Rights and Member Information	§438.100	✓		Comprehensive review of each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews
Standard II—Emergency and Poststabilization Services	§438.114	✓		
Standard III—Availability of Services	§438.206	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard V—Coordination and Continuity of Care	§438.208	✓		
Standard VI—Coverage and Authorization of Services	§438.210	✓		
Standard VII—Provider Selection	§438.214		✓	

Standard	Associated Federal Citation[1, 2]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard VIII—Confidentiality	§438.224		✓	
Standard IX—Grievance and Appeal Systems	§438.228		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XI—Practice Guidelines	§438.236		✓	
Standard XII—Health Information Systems[3]	§438.242		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] The Disenrollment: Requirements and Limitations standard under §438.56 does not apply to the Michigan PIHPs as disenrollment requests are handled through the Michigan Medicaid health plans. Therefore, these requirements are not reviewed as part of the PIHPs' three-year compliance review cycle.

[3] This standard includes a comprehensive assessment of a PIHP's IS capabilities.

This report presents the results of the SFY 2022 review period. MDHHS and the individual PIHPs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the PIHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the compliance review tools was selected based on applicable federal and State regulations and laws, and the requirements set forth in the contract between MDHHS and the PIHPs as they related to the scope of the review. The review processes used by HSAG to evaluate the PIHPs' compliance were consistent with CMS EQR Protocol 3.

For each of the PIHPs, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools.

- Prepared and forwarded to the PIHP a detailed timeline, description of the compliance review process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the PIHP.
- Hosted a pre-site review preparation session with all PIHPs.
- Generated a sample of records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegation.
- Conducted a desk review of supporting documentation the PIHP submitted to HSAG.
- Followed up with the PIHP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the PIHP to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed PIHP key program staff members.
- Conducted a review of practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities' records.
- Conducted an IS review of the data systems that the PIHP used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the PIHP.
- Documented findings and assigned each element a score (*Met*, *Not Met*, or *NA* as described in the below Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an PIHP-specific report and CAP template for the PIHP to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the PIHP performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an PIHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

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.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- 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 *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard 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 all 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).

HSAG conducted file reviews of PIHP records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegation to verify that the PIHP had put into practice the processes and procedures documented in its policies. HSAG selected 10 records each for practitioner and organizational credentialing, grievances, appeals, and three delegated entities 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, timeliness, and accessibility of care and services the PIHP provided to members, HSAG aggregated and analyzed the data resulting from its desk and site 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 standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

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.
- Records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the PIHP's key staff members. Table 2-2 lists the major data sources HSAG used to determine the PIHP's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of PIHP Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	October 1, 2021–March 31, 2022
Information obtained through interviews	July 22, 2022

Data Obtained	Time Period to Which the Data Applied
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all practitioners and organizations who completed the credentialing process during Quarter (Q) 3 and Q4 of SFY 2021 (i.e., April to September 2021)
Information obtained from a review of a sample of member grievance files	Listing of all closed member grievances during Q4 of SFY 2021 (i.e., July to September 2021) and Q1 of SFY 2022 (i.e., October to December 2021)
Information obtained from a review of a sample of member appeal files	Listing of all closed member appeals during Q4 of SFY 2021 (i.e., July to September 2021) and Q1 of SFY 2022 (i.e., October to December 2021)
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Michigan Behavioral Health Managed Care Program between October 1, 2021, through March 31, 2022

3. Corrective Action Plan Process

For any program areas requiring corrective action, **Mid-State Health Network** is required to conduct a root cause analysis (RCA) of the finding and submit a CAP to bring the element into compliance.

The CAP must be submitted to MDHHS and HSAG within 30 days of receipt of the final report. For each element that requires correction, **Mid-State Health Network** must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible, and the timeline. HSAG has prepared a customized template under Appendix B to facilitate **Mid-State Health Network**'s submission and MDHHS' and HSAG's review of corrective actions. The template includes each standard with findings that require a CAP.

MDHHS and HSAG will review **Mid-State Health Network**'s corrective actions to determine the sufficiency of the CAP. If an action plan is determined to be insufficient, **Mid-State Health Network** will be required to revise its CAP until deemed acceptable by MDHHS and HSAG.

To ensure the CAP is fully implemented, **Mid-State Health Network** will be required to submit periodic progress reports on the status of each action plan. A progress report template and instructions for completing and submitting the progress reports will be provided after the approval of **Mid-State Health Network**'s CAP.

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The PIHP implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. *The PIHP's written credentialing policy must reflect the scope, criteria, timeliness, and process for credentialing and re-credentialing providers. The policy must be approved by the PIHP's governing body, and* a. *Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;* b. *Describe any use of participating providers in making credentialing decisions;* c. *Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed prior to presentation to the credentialing committee for evaluation; and* d. *Describe how the findings of the PIHP's Quality Assessment Performance Improvement Program (QAPIP) are incorporated into the re-credentialing process.* *42 CFR §438.214(a)* *42 CFR §438.214(b)(2)* *42 CFR §438.214(e)* *Contract Schedule A—1(N)(1)* *Credentialing and Re-credentialing Processes—B(5)*	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • MSHN Personnel Manual: Credentialing and Recredentialing, pg.6 • FY2022 QAPIP Plan – pg 23 X.a) and pg 36, pg 42	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: MSHN completes organizational credentialing and delegates individual credentialing/recredentialing to the CMHSPs and the SUD Providers. MSHN completes individual credentialing/recredentialing for employees of MSHN. Written policies and procedures outline the requirements, including attachments for best practice (such as checklists). Compliance Committees (MSHN or Delegated) is responsible for oversight and approval for credentialing. The QAPIP includes a summary of the credentialing requirements and incorporates monitoring and improvement targets.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
2. The PIHP must follow a documented process for credentialing and recredentialing of network providers that meets MDHHS' requirements for acute, primary, behavioral, substance use disorders (SUDs), and long-term services and supports (LTSS) providers *and the process includes at least the following health care professionals:* a. *Physicians (M.D.s and D.O.s)* b. *Physician's Assistants* c. *Psychologists (Licensed, Limited License, and Temporary License)* d. *Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians* e. *Licensed Professional Counselors* f. *Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses* g. *Occupational Therapists and Occupational Therapist Assistants* h. *Physical Therapists and Physical Therapist Assistants* i. *Speech Pathologists*	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.214(b)(1-2) *42 CFR §438.214(e)* *Credentialing and Re-credentialing Processes—B(1)*		
PIHP Description of Process: MSHN completes organizational credentialing and delegates individual credentialing/recredentialing to the CMHSPs and the SUD Providers. Written policies and procedures outline the requirements, including a-i above on the individual practitioner procedure. Compliance Committees (MSHN or Delegated) is responsible for oversight and approval for credentialing. Delegated Managed Care site reviews are conducted to ensure compliance with delegated managed care activities.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. *The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures (which must conform to MDHHS credentialing process).* *Credentialing and Re-credentialing Processes—F(2)*	**HSAG Recommended Evidence:** • Policies and procedures • Provider contract templates (CMHSP, SUD, etc.) • HSAG will also use the results of the file reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • VII. MSHN FY 2022 Medicaid Subcontracting Agreement Section XII(C) Pg. 9, pg 47-50 • VII. FY22 SUD Treatment Section II(C)(2) Pg. 13	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirements as outlined in the CMHSP (Medicaid Subcontracting Agreement – including the delegation grid) and the SUD (SUD Treatment) contract.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
4. *The PIHP must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid members that providers be available to provide care prior to formal completion of the entire credentialing process.* a. *Temporary or provisional credentialing shall not exceed one-hundred and fifty (150) days.* b. *The PIHP shall have up to thirty-one (31) days from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.* c. *The PIHP's designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in the MDHHS Credentialing and Re-credentialing Processes, should be completed.* *Credentialing and Re-credentialing Processes—D*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking and reporting mechanisms **Evidence as Submitted by the PIHP:** • PNM_Credentialing_-_Individual_Practitioner_Procedure – pg 2-3 • 4.MDHHS_PIHP_Provider_Credentialing_Reporting_Template_V3_0921 • 4. MSHN SUD Provider Temporary Privileging Form 2.2022 • 4. MSHN_2022 Provider Staff Credentialing File Review Tool (Page 2) • 4. MSHN_ CMH DMC Review Tool Credentialing Section (page 1, Number 8) • 4. MSHN_SUD DMC Review Tool Credentialing Section (page 1, Number 8)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN's individual practitioner procedure outlines the requirements. MSHN delegates this activity to the CMHSP and SUD providers. SUD Providers LIPs are tracked in REMI (MSHN's electronic management systems) with temporary privileging approvals using the SUD Provider Temporary Privileging Form. Expiration dates that have past will not allow provider to bill. MSHN monitors credentialing as part of the delegated managed care reviews (Staff Credentialing file review, CMH DMC Review Tool and SUD DMC Review Tool).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Nondiscrimination		
5. The PIHP network provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. *42 CFR §438.214(c)* *42 CFR §438.12* *Credentialing and Re-credentialing Processes—B(2)(a)(ii)*	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • VII. MSHN FY 2022 Medicaid Subcontracting Agreement Section XII(C) Pg. 9 • VII. FY22 SUD Treatment Section II(C)(2) Pg. 13 • 5. MSHN_CMH DMC Review Tool Credentialing Section (Page 2, 22) • 5. MSHN_SUD DMC Review Tool Credentialing Section (Page 2, 22)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
6. The PIHP may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. In all contracts with network providers, the PIHP must comply with the requirements specified in 42 CFR §438.214. *42 CFR §438.214* *42 CFR §438.12(a)(1-2)* *Credentialing and Re-credentialing Processes—B(2)(a)(i)*	**HSAG Recommended Evidence:** • Policies and procedures • Example of one individual and one organizational executed provider contracts **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • VII. MSHN FY 2022 Medicaid Subcontracting Agreement Section XII(C) Pg. 9	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• VII. Montcalm MSHN FY 2022 Medicaid Subcontracting Agreement (Example) Section XII(C) Pg. 9 • VII. FY22 SUD Treatment Section II(C)(2) Pg. 13 • 5. MSHN_CMH DMC Review Tool Credentialing Section (Page 2, 22) • 5. MSHN_SUD DMC Review Tool Credentialing Section (Page 2, 22)	
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Excluded Providers		
7. The PIHP may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. *42 CFR §438.214(d)(1)* *Credentialing and Re-credentialing Processes—B(2)(b)*	**HSAG Recommended Evidence:** • Policies and procedures • Three consecutive months of ongoing monitoring reports/documentation **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • 7. Verify Comply List Summary 10.24.21 • 7. Verify Comply List Summary 11.28.21 • 7. Verify Comply List Summary 12.26.21 • VII. MSHN FY 2022 Medicaid Subcontracting Agreement	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	Section XII(D) Pg. 9 • VII. FY22 SUD Treatment Section II(C)(2) Pg. 13	
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors Provider compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN utilizes Verify Comply to monitor providers for exclusions on an ongoing basis via monthly checks.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
State Requirements		
8. *The PIHP must ensure that an individual credentialing/ re-credentialing file is maintained for each credentialed provider. Each file must include:* a. *The initial credentialing and all subsequent re-credentialing applications;* b. *Information gained through primary source verification (PSV); and* c. *Any other pertinent information used in determining whether the provider met or did not meet the PIHP's credentialing and re-credentialing standards.* *42 CFR § 438.214(e)* *Credentialing and Re-credentialing Processes—B(6)*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the file reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentialing_Policy – pg 3 • Human_Resources_-_Personnel_Records_Procedure – pg3 table 2. • 9. HBH_2021 DMC Credentialing Monitoring Score Report • 9. HBH_2021 Full DMC MSHN Monitoring Tool (Page 30)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN's Credentialing Policy outlines the requirement for record retention for the provider network and MSHN's Human Resource Personnel Procedure outlines the file structure for credentialing information for MHSN personnel. MSHN's monitors the provider network credentialing files during the Delegated Managed Care reviews (Example: HBH DMC Score Report for summary and detail in the full tool).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
9. *If the PIHP delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers that are required by MDHHS' policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services, a provider selected by that entity, and meet all requirements associated with the delegation of PIHP functions.* a. *The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.* *42 CFR §438.214(e)* *Credentialing and Re-credentialing Processes—B(3)*	**HSAG Recommended Evidence:** • Policies and procedures • Written delegation agreement template • Two consecutive reports demonstrating oversight and monitoring of delegated credentialing functions **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentialing_Policy – pg 2 • VII. MSHN FY 2022 Medicaid Subcontracting Agreement Section XII(D) Pg. 9 • VII. FY22 Medicaid Subcontract Delegation Grid – Page 11-12 • VII. FY22 SUD Treatment Section II(C)(2) Pg. 13 • 9. HBH_2021 DMC Credentialing Monitoring Score Report • 9. HBH_2021 Full DMC MSHN Monitoring Tool (Page 30 – 35, Page 53-55) • 9. HBH_2021 Credentialing File Review Monitoring Report-Final • 9. TBHS_2021 DMC Credentialing Monitoring Score Report • 9. TBHS_2021 Full DMC MSHN Monitoring Tool (Page 37-43, page 66-68) • 9. TBHS_2021 Credentialing File Review Monitoring Report	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract and the Delegation Grid. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. (Example: HBH DMC Score Report for summary, Detail in the full DMC tool and sample chart review in the credentialing file report).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
10. *Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. The PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where the PIHP chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHP's decisions in their administrative records.* *Credentialing and Re-credentialing Processes—G*	**HSAG Recommended Evidence:** • Policies and procedures • One example of PIHP accepting credentialing activities conducted by another PIHP • HSAG will also use the results of the file reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing Policy – pg 2 • 10. PNM_Service_Provider_Reciprocity – pg1, C • VII. FY22 SUD Treatment Contract Section II(C)(17.c.) Pg. 16 • 10. MSHN_CMH DMC Review Tool Credentialing Section (Page 2) • 10. MSHN_SUD DMC Review Tool Credentialing Section (Page 2)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN includes the language to allow for reciprocity and sharing of credentialing activities through the PNM credentialing policy, reciprocity policy and the SUD treatment contract. MSHN monitors compliance through the DMC Review tools for both the CMHSP and the SUD.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. *Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended, or terminated for any reason other than lack of need.* *Credentialing and Re-credentialing Processes—I*	**HSAG Recommended Evidence:** • Policies and procedures • One example of a provider notice of credentialing denial • One example of a provider appeal and subsequent PIHP review and determination **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy – pg 3 • 11. PN_Provider_Appeals_Procedure	☒ Met ☐ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• 11. MSHN_SUD DMC Review Tool Credentialing Section (page 2, number 16) • 11. MSHN_CMH DMC Review Tool Credentialing Section (page 2, number 16)	
PIHP Description of Process: MSHN's PNM credentialing policy includes the requirements for providers to have an appeal process and the procedure outlines MSHN's appeal process. MSHN monitors compliance through the DMC review tool for both CMH and SUD. To date, MSHN has not received a request to review an appeal for a credentialing decision.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
12. *The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.).* *Credentialing and Re-credentialing Processes—J*	**HSAG Recommended Evidence:** • Policies and procedures • One example of reporting of a provider to an appropriate authority due to improper conduct **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy – pg 3 • 12. Compliance_Reporting_and_Investigations • 12.Compliance_Disqualified_Providers • 12. 2022_MSHN_Compliance_Plan – page 11 • 12. MSHN_CMH DMC Review Tool Credentialing Section (Page 1-2, Number 11) • 12. MSHN_SUD DMC Review Tool Credentialing Section (Page 1, Number 11) • 12. OIG Referral Form – Central MI CMH	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The above-mentioned policies include required reporting to the PIHP. In addition, the Compliance Plan also outlines the process for reporting. The included Office of Inspector General Fraud Referral Form (Central MI CMH) shows required reporting to the appropriate authority regarding potential fraud by an organizational provider involving an identified credentialing issue. Since this was reported during FY22 Q2, this case is still under investigation and the outcome is pending.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
File Reviews		
13. The PIHP complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. *42 CFR §438.214(e)* *Credentialing and Re-credentialing Processes*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The initial credentialing file review identified the following deficiencies: • For one case, no attestation regarding felony convictions was present in the file. • For four cases, evidence that the provider was given written notification of the credentialing decision was not found in the file. • For one case, the credentialing process occurred outside the 90-day time frame requirement. • For one case, a completed National Practitioner Data Bank (NPDB) query was present in the file; however, it was dated over 180 days prior to the credentialing decision date, outside of the PIHP's verification time limit required by policy. • For one case, no NPDB query was present in the file. In lieu of the query, the PIHP or its delegated entity must verify a minimum five-year history of professional liability claims resulting in judgment or settlement, disciplinary status with regulatory board or agency, and Medicare/Medicaid sanctions. Although the files contained reports from the Office of Inspector General (OIG), MDHHS sanctions list, VerifyComply, and Licensing and Regulatory Affairs (LARA), no verification of a minimum five-year history of professional liability claims resulting in judgment or settlement was present in the file.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Although PIHP staff members stated that the LARA is utilized to verify graduation from an accredited school as this is a requirement for certain licenses, HSAG recommends the PIHP obtain verification of graduation from an accredited school directly from the source (e.g., university, clearinghouse). Alternatively, the PIHP should maintain evidence that LARA performs primary source verification (PSV) for graduation from an accredited school and the provider types for which this applies.		
Required Actions: The PIHP must comply with, and ensure delegates performing credentialing activities comply with, all initial credentialing requirements as outlined in its contract with MDHHS.		
14. The PIHP complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The recredentialing file review identified the following deficiencies: • For two cases, no attestation regarding felony convictions was present in the file. • For three cases, documentation was not provided to support that member concerns, grievances, appeal information, or quality issues were evaluated. • For one case, the recredentialing process occurred outside the two-year time frame requirement. • For one case, a completed NPDB query was present in the file; however, it was dated after the recredentialing decision date. • For one case, no evidence was found in the file that the provider was verified for Medicare/Medicaid sanctions; state sanctions; or limitations on licensure, registration, or certification.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The PIHP must comply with, and ensure delegates performing recredentialing activities comply with, all recredentialing requirements as outlined in its contract with MDHHS.		
15. The PIHP complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**- HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Credentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The initial organizational credentialing file review identified the following deficiencies: • For three cases, evidence that the provider was given written notification of the credentialing decision was not found in the file. • For two cases, the credentialing process occurred outside the 90-day time frame requirement. • For one case, no evidence that the provider was validated to be approved by an accredited body, or for those providers that are not accredited, that an on-site quality assessment or alternative quality assessment was conducted. • For one case, no evidence that the provider was validated to not be excluded from Medicaid or Medicare participation was present in the file. In follow up, the PIHP submitted a VerifyComply report that included this provider was reviewed for exclusions; however, it was dated a month after the credentialing decision date.		
Required Actions: The PIHP must comply with, and ensure delegates performing credentialing activities comply with, all initial organizational credentialing requirements as outlined in its contract with MDHHS.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
16. The PIHP complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The organizational recredentialing file review identified the following deficiencies: • For two cases, no evidence that the provider was validated to not be excluded from Medicaid or Medicare participation was present in the file. In follow up, the PIHP submitted a VerifyComply report that included this provider was reviewed for exclusions; however, it was dated a month after the credentialing decision date. • For one case, although a certification of accreditation was present in the file, it had an expiration date prior to the credentialing decision date. No evidence was submitted to support that the provider had an active accreditation at the time of the credentialing decision, or that an on-site quality assessment or alternative quality assessment was conducted.		
Required Actions: The PIHP must comply with, and ensure delegates performing credentialing activities comply with, all organizational recredentialing requirements as outlined in its contract with MDHHS.		

Standard VII—Provider Selection						
Met	=	12	X	1	=	12
Not Met	=	4	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	16	Total Score		=	12
Total Score ÷ Total Applicable					=	75%

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The PIHP must, for medical records and any other health and enrollment information that identifies a particular member, use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. *42 CFR §438.224* *Contract Schedule A—1(Q)4*	**HSAG Recommended Evidence:** • Policies and procedures • Disclosure form(s) or other forms used by the PIHP to take action regarding member PHI • Training materials **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Breach Notice Policy ○ Breach Notice Procedure ○ Information Management Policy ○ Consent to Share Information Policy • PIHP Provider Contracts ○ FY22 Substance Use Disorder (SUD) Treatment Contract (pgs. 15, 25-26, 27-28, 39, and 43 - 46) ○ SUD Provider Manual (pgs. 17 – 19) ○ MSHN FY 2022 Medicaid Subcontracting Agreement (pgs. 24 – 25 and 69 – 74) • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 25 – 36) • MSHN Privacy Notice • MSHN Breach Notification Template	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• Consent to Share Behavioral Health Information Form • MSHN HR-Personnel Manual – 7-15-2021 (pgs. 11 & 21) • FY22 MSHN Guide to Services (pg. 58)	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Uses and Disclosures of PHI		
2. The PIHP and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The PIHP is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the PIHP has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). *45 CFR §164.502(a)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • PIHP Provider Contracts ○ FY22 Substance Use Disorder (SUD) Treatment Contract (pgs. 15, 25-26, 27-28, 39, and 43 - 46) ○ SUD Provider Manual (pgs. 17 – 19) ○ MSHN FY 2022 Medicaid Subcontracting Agreement (pgs. 24 – 25 and 69 – 74) • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 25 – 36) • MSHN Privacy Notice • Consent to Share Behavioral Health Information Form • MSHN HR-Personnel Manual – 7-15-2021 (pgs. 11 & 21)	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. The PIHP, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the PIHP's compliance with CFR 45 §160 subpart C. *45 CFR §164.502(a)(2-4)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • PIHP Provider Contracts ○ FY22 Substance Use Disorder (SUD) Treatment Contract (pgs. 15, 25-26, 27-28, 39, and 44 - 46) ○ SUD Provider Manual (pgs. 17 – 19) ○ MSHN FY 2022 Medicaid Subcontracting Agreement (pgs. 24 – 25 and 70 – 74) • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 25 – 36) • MSHN Privacy Notice (Pgs. 3- 4) • Consent to Share Behavioral Health Information Form	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP's policies included general language to support appropriate disclosures of protected health information (PHI), HSAG strongly recommends that the PIHP have detailed and comprehensive policies and procedures in place to support awareness of all confidentiality-related requirements under both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and Michigan Mental Health Code, including those requirements under 45 CFR §164.502(a)(2-4).		
Required Actions: None.		
Minimum Necessary		
4. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the PIHP must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. *45 CFR §164.502(b)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy (pg. 5) • PIHP Provider Contracts ○ FY22 Substance Use Disorder (SUD) Treatment Contract (pgs. 15, 25-26, 27-28, 39, and 44 - 46) ○ SUD Provider Manual (pgs. 17 – 19) ○ MSHN FY 2022 Medicaid Subcontracting Agreement (pgs. 24 – 25 and 70 – 74)	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31) • MSHN Privacy Notice (Pgs. 2 - 4)	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
5. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law. f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR. *45 CFR §164.502(b)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • PIHP Provider Contracts ○ FY22 Substance Use Disorder (SUD) Treatment Contract (pgs. 15, 25-26, 27-28, 39, and 44 - 46) ○ SUD Provider Manual (pgs. 17 – 19) ○ MSHN FY 2022 Medicaid Subcontracting Agreement (pgs. 24 – 25 and 71 – 74) • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13)	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 2 - 4) • Consent to Share Behavioral Health Information Form (pg. 3)	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP was able to explain how its practices for uses and disclosures comply with the minimum necessary rule and do not limit the disclosure of PHI when permitted under federal rule, HSAG recommends that the PIHP's policies and procedures be updated specifically to include the exceptions that apply to the minimum necessary requirement under the HIPAA Privacy Rule.		
Required Actions: None.		
Uses and Disclosures Requiring Authorizations		
6. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity must provide the individual with a copy of the signed authorization. *45 CFR §164.508(a)(1)* *45 CFR §164.508(b)(1-6)* *45 CFR §164.508(c)(1-4)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • PIHP Provider Contracts ○ FY22 Substance Use Disorder (SUD) Treatment Contract (pgs. 15, 25-26, 27-28, 39, and 44 - 46) ○ SUD Provider Manual (pgs. 17 – 19)	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	○ MSHN FY 2022 Medicaid Subcontracting Agreement (pgs. 24 – 25 and 71 – 74) • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 25-36) • Consent to Share Behavioral Health Information Form	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP provided three examples of completed MDHHS 5515 Consent to Share Behavioral Health Information forms that contained checkmarks that indicated the members received copies of the signed consent forms. However, HSAG recommends the PIHP ensure its oversight process of its delegated entities includes a component to evaluate the procedures for providing members with copies of signed authorization forms when the CMHSPs or other delegated entities are requesting members to sign such forms.		
Required Actions: None.		
Privacy Rights		
7. The PIHP complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. *45 CFR §164.522*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 4 - 5) • Consent to Share Behavioral Health Information Form • Montcalm Care Network (MCN) Examples: ○ MCN- Policy 11860: Right to Request Restrictions ○ MCN- Procedure 11860A- Right to Request Restrictions • Bay Arenac Behavioral Health (BABH) Example: ○ BABH- Screenshot showing right to decline to share information, exclude information and revoke consent	
PIHP Description of Process: This is a delegated function to the Community Mental Health Service Providers (CMHSP). A beneficiary can request a restriction to the information shared/released by the CMHSP at any time. A form/document is not required to make this request. The client can make their request in writing or use the standardized MDHHS Consent to Share Behavioral Health Information Form. The beneficiary can indicate on the form that they do not consent to the sharing of any type of information, which can include the purposes of coordination of care, payment and treatment. Any such request is documented within the beneficiary record. These requests are very infrequent. Provided as examples of compliance with this requirement is Montcalm Care Networks Policy and Procedure regarding requesting privacy restrictions to PHI and screenshots from Bay Arenac Behavioral Health's (BABH) electronic medical record showing compliance with allowing the beneficiary to decline to share information, exclude certain information and revoke consent to share information		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP confirmed that most privacy rights requests are managed by the contracted Community Mental Health Services Programs (CMHSPs) and provided examples of appropriate procedures occurring, it is important that the PIHP also have policies and procedures in place to detail the delineation of responsibilities between the PIHP and its CMHSPs and to ensure that procedures are in place should the PIHP receive a request directly from a member. The PIHP's Notice of Privacy Practices informs members of their privacy rights; however, HSAG strongly recommends that the PIHP develop detailed policies and processes that outline the requirements, steps, and procedures the PIHP takes (or requires its CMHSPs to take) to ensure compliance with member rights requests under the HIPAA Privacy Rule. At a minimum, the written documentation should include the procedures for		

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Requirement	**Supporting Documentation**	**Score**
intaking the request from the member (e.g., use of a template to be completed by the member, field in the system to note the request); the system(s) and fields used to document the privacy rights request; tracking mechanism(s) for monitoring completion of the request to ensure time frame compliance (when applicable); steps taken to update the health information system to notate any implemented requests (e.g., alerts, record modifications); internal notification requirements to obtain information as necessary and to ensure the appropriate individuals (e.g., staff members, providers) are informed of the right(s) exercised by the member; location of the system where copies of information provided to members (when required) are maintained; and the method for providing the member with confirmation of completion of the rights request (e.g., mailed notices, copies of documentation requested when appropriate). The PIHP should also consider developing request forms (as applicable) and notification template letters specific to each privacy right request. Further, the PIHP's formal oversight process of its delegated entities should include a component for assessing each entity's procedures for complying with members' requests to exercise their privacy rights under the HIPAA Privacy Rule.		
Required Actions: None.		
8. The PIHP complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The PIHP must act on a request for access no later than 30 days after receipt of the request. b. The PIHP must provide the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the PIHP and member. *45 CFR §164.524*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 4 - 5)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Clinton-Eaton-Ingham Community Mental Health Authority (CEI-CMHA) Examples: ○ CEI CMHA Website Screenshot – Request for Records ○ CEI CMHA Authorization for Release of Information • Bay Arenac Behavioral Health (BABH) example: ○ BABH- Screenshot – 45 CFR 164.524 Access to PHI • Community Mental Health for Central Michigan (CMHCM) example: ○ CMHCM-Completed Request for Records • LifeWays CMH Examples: ○ LifeWays -Policy 060302 – Consumer Access to Medical Record ○ LifeWays -Application to Access to Recipient Case Record • Montcalm Care Network (MCN) Example: ○ MCN- HIPAA Right to Request Access to Records Policy • Right Door Process Example: ○ Right Door- Step by Step Process for Completing Record Requests • Shiawassee Health and Wellness Examples: ○ Shiawassee- Sample release letter ○ Shiawassee – Releasing Information to Consumer	
PIHP Description of Process: This is a delegated function to the Provider Network. The right to receive a copy of PHI (beneficiary records) no later than 30 days after receipt of the request and within a format requested by the beneficiary is identified within the privacy notice and the other documents listed above. MSHN is not the holder of records for the beneficiaries served so the requirement to provide copies of records is that of the Providers. An example		

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Requirement	**Supporting Documentation**	**Score**
has been provided by Clinton-Eaton-Ingham Community Mental Health Authority (CEI-CMHA) that includes a screenshot of their website providing instructions of how to request a copy of clinical records, the timeline (30 days) for fulfilling the request for information, that the information can be hard copy or electronic (based on beneficiary preference), and who to send the request to. Also included is a copy of the authorization for release of information used by CEI CMHA for this purpose. Additional examples are provided by BABH, CMHCM, LifeWays, MCN and Shiawassee and include screenshots, policies, disclosure log, a release letter and a completed request for records.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP confirmed that most privacy rights requests are managed by the contracted CMHSPs and provided examples of appropriate procedures occurring, it is important that the PIHP also have policies and procedures in place to detail the delineation of responsibilities between the PIHP and its CMHSPs and to ensure that procedures are in place should the PIHP receive a request directly from a member. The PIHP's Notice of Privacy Practices informs members of their privacy rights; however, HSAG strongly recommends that the PIHP develop detailed policies and processes that outline the requirements, steps, and procedures the PIHP takes (or requires its CMHSPs to take) to ensure compliance with member rights requests under the HIPAA Privacy Rule. At a minimum, the written documentation should include the procedures for intaking the request from the member (e.g., use of a template to be completed by the member, field in the system to note the request); the system(s) and fields used to document the privacy rights request; tracking mechanism(s) for monitoring completion of the request to ensure time frame compliance (when applicable); steps taken to update the health information system to notate any implemented requests (e.g., alerts, record modifications); internal notification requirements to obtain information as necessary and to ensure the appropriate individuals (e.g., staff members, providers) are informed of the right(s) exercised by the member; location of the system where copies of information provided to members (when required) are maintained; and the method for providing the member with confirmation of completion of the rights request (e.g., mailed notices, copies of documentation requested when appropriate). The PIHP should also consider developing request forms (as applicable) and notification template letters specific to each privacy right request. Further, the PIHP's formal oversight process of its delegated entities should include a component for assessing each entity's procedures for complying with members' requests to exercise their privacy rights under the HIPAA Privacy Rule.		
Required Actions: None.		
9. The PIHP complies with the member's right to have the PIHP amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The PIHP complies with the requirements under 45 CFR §164.526.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form	☒ Met ☐ Not Met ☐ NA

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
a. The PIHP must act on the member's request for an amendment no later than 60 days after receipt of such a request. *45 CFR §164.526*	**Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 4 - 5) • Bay Arenac Behavioral Health (BABH) Example: ○ BABH- Denial of Request to Amend PHI Letter • Clinton-Eaton-Ingham Community Mental Health Authority (CEI-CMHA) Example: ○ CEI CMHA Request for Correction and Amendment form • Community Mental Health for Central Michigan (CMHCM) Example: ○ Confidentiality and Disclosure Policy (section VI.Y) • Montcalm Care Network (MCN) Example: ○ MCN- Corrections, Additions, and Authentication of Legal Documents Procedure ○ MCN- Requests to Amend Record- Customer Srvc Module-Redacted ○ MCN–Correspondence Scanned into EHR- amendment to chart	

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Requirement	**Supporting Documentation**	**Score**
	○ MCN – Tracking-Admin Document- Correspondence List Screen	
PIHP Description of Process: This is a delegated function to the Provider Network. The right to request an amendment to the beneficiary record is identified within the privacy notice and the other documents listed above. MSHN is not the holder of records for the beneficiaries served so this requirement is that of Providers to carry out. Examples of compliance with this requirement have been provided by BABH, CEI CMHA, CMHCM, and MCN. The examples provided include a Request for Correction and Amendment form, policies, procedures, a denial to amend the record form, correspondence to amend the record, and a tracking document.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP confirmed that most privacy rights requests are managed by the contracted CMHSPs and provided examples of appropriate procedures occurring, it is important that the PIHP also have policies and procedures in place to detail the delineation of responsibilities between the PIHP and its CMHSPs and to ensure that procedures are in place should the PIHP receive a request directly from a member. The PIHP's Notice of Privacy Practices informs members of their privacy rights; however, HSAG strongly recommends that the PIHP develop detailed policies and processes that outline the requirements, steps, and procedures the PIHP takes (or requires its CMHSPs to take) to ensure compliance with member rights requests under the HIPAA Privacy Rule. At a minimum, the written documentation should include the procedures for intaking the request from the member (e.g., use of a template to be completed by the member, field in the system to note the request); the system(s) and fields used to document the privacy rights request; tracking mechanism(s) for monitoring completion of the request to ensure time frame compliance (when applicable); steps taken to update the health information system to notate any implemented requests (e.g., alerts, record modifications); internal notification requirements to obtain information as necessary and to ensure the appropriate individuals (e.g., staff members, providers) are informed of the right(s) exercised by the member; location of the system where copies of information provided to members (when required) are maintained; and the method for providing the member with confirmation of completion of the rights request (e.g., mailed notices, copies of documentation requested when appropriate). The PIHP should also consider developing request forms (as applicable) and notification template letters specific to each privacy right request. Further, the PIHP's formal oversight process of its delegated entities should include a component for assessing each entity's procedures for complying with members' requests to exercise their privacy rights under the HIPAA Privacy Rule.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
10. The complies with the member's right to receive an accounting of disclosures of PHI made by the PIHP in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The PIHP must act on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The PIHP must document the accounting of disclosures and retain the documentation as required by 45 CFR §164.530(j). *45 CFR §164.528*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 4 - 5) • Bay Arenac Behavioral Health (BABH) Example: ○ BABH – Accounting of Disclosures • Clinton-Eaton-Ingham Community Mental Health Authority (CEI-CMHA) Examples: ○ CEI Disclosure Log – Screen Shot 1 ○ CEI Disclosure Log – Screen Shot 2 • Community Mental Health for Central Michigan (CMHCM) Example: ○ Confidentiality and Disclosure Policy (section VI.) • Montcalm Care Network (MCN) Examples:	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	○ MCN – Disclosure Log Sample – Redacted ○ MCN- Disclosure Log – Screen Shot of Link in Consumer Chart • Right Door Process Example: ○ Right Door- Step by Step Process for Completing Record Requests	
PIHP Description of Process: This is a delegated function to the Provider Network. The right to request a disclosure of PHI that has been released by the agency is documented within the beneficiary record. The right to request this disclosure is noted in the MSHN Privacy Notice. The CMHSPs utilize the electronic medical record (HER) to track the disclosures. Examples were provided by BABH, CEI CMH, CMHCM, MCN and the Right Door. The examples provided include accounting of disclosures, screen shots of log sheets, policies and processes for completing an accounting of disclosures.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP confirmed that most privacy rights requests are managed by the contracted CMHSPs and provided examples of appropriate procedures occurring, it is important that the PIHP also have policies and procedures in place to detail the delineation of responsibilities between the PIHP and its CMHSPs and to ensure that procedures are in place should the PIHP receive a request directly from a member. The PIHP's Notice of Privacy Practices informs members of their privacy rights; however, HSAG strongly recommends that the PIHP develop detailed policies and processes that outline the requirements, steps, and procedures the PIHP takes (or requires its CMHSPs to take) to ensure compliance with member rights requests under the HIPAA Privacy Rule. At a minimum, the written documentation should include the procedures for intaking the request from the member (e.g., use of a template to be completed by the member, field in the system to note the request); the system(s) and fields used to document the privacy rights request; tracking mechanism(s) for monitoring completion of the request to ensure time frame compliance (when applicable); steps taken to update the health information system to notate any implemented requests (e.g., alerts, record modifications); internal notification requirements to obtain information as necessary and to ensure the appropriate individuals (e.g., staff members, providers) are informed of the right(s) exercised by the member; location of the system where copies of information provided to members (when required) are maintained; and the method for providing the member with confirmation of completion of the rights request (e.g., mailed notices, copies of documentation requested when appropriate). The PIHP should also consider developing request forms (as applicable) and notification template letters specific to each privacy right request. Further, the PIHP's formal oversight process of its delegated entities should include a component for assessing each entity's procedures for complying with members' requests to exercise their privacy rights under the HIPAA Privacy Rule.		
Required Actions: None.		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Notice of Privacy Practices		
11. The PIHP's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the PIHP, and of the member's rights and the PIHP's legal duties with respect to PHI. a. The PIHP must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The PIHP must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). *45 CFR §164.520(a)(1)* *45 CFR §164.520(b)(1)(i-viii)* *45 CFR §164.520(c)(1-3)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 4 - 5) • Consent to Share Behavioral Health Information Form	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The HIPAA Notice of Privacy Practices did not include a description of the types of uses and disclosures that require an authorization under 45 CFR §164.508(a)(2)-(a)(4), including psychotherapy notes, marketing, and the sale of PHI. Additionally, although the notice included a statement that individuals may complain to the local agency, the PIHP, and to the Secretary if they believe their privacy rights have been violated and also included organizations, addresses, and telephone numbers, the notice did not include a statement that the individual will not be retaliated against for filing a complaint, nor did the notice contain the name or title of the person to contact for further information as required by 45 CFR §164.530(a)(1)(ii). Finally, the notice did not include the right of an individual, including an individual who has agreed to receive the notice electronically, to obtain a paper copy of the notice from the PIHP upon request. Also, although the PIHP indicated that a Notice of Privacy Practices is required to be part of the new client packet at intake, and also stated that the Notice of Privacy Practices is supposed to be provided as part of the annual person-centered planning process and posted at the service location, the PIHP did not provide evidence that this is occurring or provide other evidence to support that members receive a Notice of Privacy Practices upon enrollment, at least every three years, and when there is a material change to the notice.		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Federal rule under 45 CFR §164.520(b)(1)(i-viii) requires the Notice of Privacy Practices to specifically include a statement indicating, "*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully*." The PIHP's Notice of Privacy Practices indicated, "*…describes how health information….*" Although not noted as a deficiency, HSAG recommends the PIHP consider updating the statement to mirror the statement required under federal rule.		
Required Actions: The PIHP must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). The PIHP must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3).		

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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%

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. The PIHP defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the PIHP to make an authorization decision. *42 CFR §438.400(b)* *42 CFR §438.228* *Appeal and Grievance Resolution Processes Technical Requirement—II*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 87 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy, Definitions • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** PIHP staff members stated that a complaint may be a grievance; however, the definition of a grievance in federal rule is an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD); therefore, all complaints meet the definition of a grievance. HSAG recommends that the PIHP conduct ongoing education of staff members on what constitutes a grievance to ensure that all grievances (i.e., any complaint or expression of dissatisfaction) are appropriately being opened and processed when a member has a complaint or an expression of dissatisfaction.		
Required Actions: None.		
2. A member may file a grievance with the PIHP at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. *42 CFR §438.402(c)(1)(ii)*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.402(c)(2)(i) *42 CFR §438.228* *Appeal and Grievance Resolution Processes Technical Requirement—III; VII(B)(2)*	• CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 13 • Authorized Representative Documentation	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the case file review confirmed that all grievances were filed by the member or a parent of a minor; therefore, no member written consent was required.		
Required Actions: None.		
3. The member may file a grievance either orally or in writing. *42 CFR §438.402(c)(3)(i)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(d)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(A)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 9 • Grievance Submission Methods	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Grievances		
4. The PIHP must acknowledge receipt of each grievance. *42 CFR §438.406(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(e)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 13 • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. 37 • MSHN Notice of Grievance Receipt	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the grievance was not acknowledged until nearly six weeks after the grievance was filed, which does not meet the intent of an acknowledgement. Although MDHHS does not define a time frame requirement in contract, HSAG considers six weeks for an acknowledgement excessive. Additionally, the PIHP's grievance training materials required acknowledgement letters to be sent within three days. **Recommendations:** HSAG recommends that the PIHP enhance quality assurance (QA) processes to ensure grievance acknowledgement letters are grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member. Additionally, the grievance and appeal resolution process training document required written acknowledgment of the grievance to be mailed within three business days. However, this standard was not defined in policy. As such, HSAG recommends that the PIHP update its policy accordingly.		
Required Actions: The PIHP must acknowledge receipt of each grievance.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
5. The PIHP must ensure that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. *42 CFR §438.406(b)(2)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(f)(1-2)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(5)(a-b)*	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 14	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP enhance processes to ensure the name and credentials of the individual(s) making the decision on the grievance is clearly documented in the case file. The PIHP could enhance its grievance module to include a specific data field to identify the decision maker on the grievance and the credentials of the decision maker.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely Resolution and Notification of Grievances		
6. The PIHP must resolve each grievance, and provide *written* notice *of resolution*, as expeditiously as the member's health condition requires, within MDHHS timeframes that may not exceed the timeframes specified in 42 CFR §438.408. a. The PIHP must resolve the grievance and send notice to the affected parties within ninety (90) calendar days from the day the PIHP receives the grievance. b. The notice must meet the standards described at 42 CFR §438.10. *42 CFR §438.408(a)* *42 CFR §438.408(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(v); (L)(2)(k)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(D)(1); VII(D)(3)(a)*	**HSAG Recommended Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 14 • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. 37 • MSHN Notice of Grievance Resolution	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the grievance was not resolved within 90 calendar days (resolved in 98 days). After the site review, PIHP staff members acknowledged that the resolution letter was not sent out timely due to staff error. **Recommendations:** HSAG recommends that the PIHP enhance QA processes to ensure grievance resolution notices are professional, grammatically correct, free of errors, have abbreviations spelled out with first use, and are written to the member. Additionally, HSAG recommends that the PIHP require each grievance resolution notice, or a certain percentage of grievance resolution notices, be assessed for professionalism and reading grade level prior to mailing. The reading grade level must be written at the 6.9 reading grade level.		
Required Actions: The PIHP must resolve each grievance and provide written notice of resolution to the affected parties within 90 calendar days from the day the PIHP receives the grievance.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
7. The PIHP may extend the timeframe for resolving grievances by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The PIHP shows (to the satisfaction of MDHHS, upon its request) that there is need for additional information and how the delay is in the member's interest. *42 CFR §438.408(c)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(D)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frame • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 14 • Grievance Extension Letter Template • CustomerServiceCommitteeMeetingSnapshot 20_01_13	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the case file review did not include any grievances in which a resolution extension was applied, and PIHP staff members were unaware of any extensions applied during the time period of review. **Recommendations:** While the PIHP submitted a grievance resolution time frame extension letter template, the remainder of the documents submitted as evidence of compliance did not include the requirements of this element. As such, HSAG recommends that the PIHP update it grievance materials accordingly.		
Required Actions: None.		
8. If the PIHP extends the grievance resolution timeframe not at the request of the member, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frame • Grievance extension template letter • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR §438.408(c)(2-3)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(vi)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(D)(2)(a)*	• CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 14 • Grievance Extension Letter Template	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the case file review did not include any grievances in which a resolution extension was applied, and PIHP staff members were unaware of any extensions applied during the time period of review. **Recommendations:** While the PIHP submitted a grievance resolution time frame extension letter template, the remainder of the documents submitted as evidence of compliance did not include the requirements of this element. As such, HSAG recommends that the PIHP update it grievance materials accordingly.		
Required Actions: None.		
9. *The notice of grievance resolution meets the requirements of 42 CFR §438.10 and must include:* a. *The results of the grievance process;* b. *The date the grievance process was concluded;* c. *The notice of the member's right to request a State fair hearing, if the notice of resolution is more than ninety (90) calendar days from the date of the grievance; and* d. *Instructions on how to access the State fair hearing process, if applicable.* *Appeal and Grievance Resolution Processes Technical Requirement—VII(D)(3)(b)*	**HSAG Recommended Evidence:** • Policies and procedures • Grievance resolution template **Evidence as Submitted by the PIHP:** • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 15 • MSHN Notice of Grievance Resolution	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While all grievance resolution letters included notice of the member's right to request a State fair hearing (SFH), if the notice of resolution is more than 90 calendar days from the date of the grievance, and instructions on how to access the SFH process, HSAG recommends that the PIHP remove this language when grievances are resolved timely as the member would not have SFH rights.		
Required Actions: None.		
Appeals General Requirements		
10. The PIHP defines an appeal as a review by the PIHP of an ABD. *42 CFR §438.400(b)* *42 CFR §438.228* *Appeal and Grievance Resolution Processes Technical Requirement—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:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 3	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
11. The PIHP may have only one level of appeal for members. *42 CFR §438.402(b)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(iii)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(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:** • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 5	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
12. The PIHP must establish and maintain an expedited review process for appeals, when the PIHP determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR §438.410(a-b)* *42 CFR §438.228* *Contract Schedule A—1(L)(8)(a); 1(L)(8)(b)(vi)*	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Expedited Appeal EMR • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11 • MSHN Adverse Benefit Determination Notice	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(2)(a-b)		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendation:** HSAG recommends that the PIHP clearly document in its appeal procedures and provider materials the following provision: "*The PIHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal*."		
Required Actions: None.		
13. Following receipt of a notification of an ABD by a PIHP, the member has sixty (60) calendar days from the date on the ABD notice in which to file a request for an appeal to the PIHP. *42 CFR §438.402(c)(2)(ii)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(c)* *Contract Schedule A—1(L)(8)(b)(ii)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(A)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 9 • MSHN Adverse Benefit Determination Notice	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. *42 CFR §438.402(c)(1)(ii)* *42 CFR §438.402(c)(3)(ii)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(d); 1(L)(8)(b)(i)* *Appeal and Grievance Resolution Processes Technical Requirement—III; VI(A)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 9 • Appeal Method of Filing	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the case file review included appeals that were filed by the member, a parent of a minor, or a legal guardian; therefore, no member written consent was required.		
Required Actions: None.		
Handling of Appeals		
15. If the PIHP denies a request for expedited resolution of an appeal, it must: a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follow the requirements in 42 CFR §438.408(c)(2), including: i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
frame and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR §438.406(b)(1)* *42 CFR §438.410(c)* *42 CFR §438.228* *Contract Schedule A—1(L)(8)(b)(v)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(2)(c)(i-iii)*		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, PIHP staff members verbalized they were unaware of any denied expedited appeal requests during the time period of review. **Recommendations:** HSAG recommends that the PIHP develop a letter template that would be used when an expedited appeal resolution request is denied. This letter must include member grievance rights.		
Required Actions: None.		
16. The PIHP must acknowledge receipt of each appeal. *42 CFR §438.406(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(e)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38\9 • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 10 • MSHN Notice of Grievance Receipt • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. 37	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The case file review identified one record in which the appeal was not acknowledged until 44 days after receipt of the appeal request, which was 14 days after the resolution due date. Although MDHHS does not define a time frame requirement in contract, HSAG considers 44 days for an acknowledgement excessive. **Recommendations:** HSAG recommends that the PIHP define a time frame in which members are mailed the written acknowledgement of the appeal (e.g., within three business days of receipt of the appeal). Additionally, HSAG recommends that the PIHP enhance QA processes to ensure appeal acknowledgement letters are grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member. Further, the acknowledgment letters informed members that they may request continuation of benefits within 10 calendar days from the date of the acknowledgement notice. However, this is inaccurate as a member must request continuation of benefits within 10 calendar days of the notice of the ABD, not from the appeal acknowledgement letter. The acknowledgement letter also informed members that a request for an SFH must be received within 10 calendar days of the acknowledgement letter notice. However, as the appeal is not yet completed, the member does not have access to an SFH. As this language was template language included in MDHHS' letter template, HSAG recommends that the PIHP consult with MDHHS to have this template revised accordingly. HSAG will also recommend that MDHHS revise or remove this language in the letter template.		
Required Actions: The PIHP must acknowledge receipt of each appeal.		
17. The PIHP must ensure that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 10	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.406(b)(2) *42 CFR §438.228* *Contract Schedule A—1(L)(2)(f)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(4)*		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP enhance processes to ensure the name and credentials of the individual(s) making the appeal decision are clearly documented in the case file. The PIHP could enhance its appeal module to include a specific data field to identify the decision maker on the appeal and the credentials of the decision maker. The PIHP should also consider entering the decision maker on the initial ABD within the appeal case file to confirm the decision maker on the appeal was not involved in a previous level of review.		
Required Actions: None.		
18. The PIHP must provide that oral inquiries seeking to appeal an ABD are treated as appeals. *42 CFR §438.406(b)(3)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(g)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(A)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 9	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The case file review identified one record in which a written signed appeal was requested after receiving an oral request for an appeal. However, this provision was removed from the federal rule in 2020 and the PIHP cannot request/require a written signed appeal after an oral request for an appeal. As the appeal was processed as an appeal, the PIHP received a *Met* score for the element. However, HSAG recommends that the PIHP ensure all CMHSP processes clearly align with the requirements of this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
19. The PIHP must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The PIHP must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. *42 CFR §438.406(b)(4)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(h)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(5)*	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 10	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP's ABD notice template included the following language: "*You, your representative, or your physician can send in your request that must include...Any evidence you want us to review, such as medical records, letters from your physicians, or other information that explains why you need the item or service. If you are asking for an Expedited Appeal, you will need a physician's supporting statement. Call your physician if you need this information*." However, HSAG recommends that the PIHP add language to further align with the federal rule, specifically informing members that additional information may be provided in person or in writing and that there is limited time available to present additional evidence in the case of an expedited appeal resolution. HSAG will also recommend that MDHHS update its ABD notice template in its policy.		
Required Actions: None.		
20. The PIHP must provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PIHP (or at the direction of the PIHP) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). *42 CFR §438.406(b)(5)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(i)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(6)*	• Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 10 • MSHN Notice of Appeal Approval • MSHN Notice of Appeal Denial	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP stipulate in policy the mechanism in which members would be provided a copy of their case file, and how the PIHP ensures that members would receive the case file sufficiently in advance of an expedited appeal resolution (e.g., overnight mail, in-person drop off, secure email with the member's permission).		
Required Actions: None.		
Resolution and Notification of Appeals		
21. The PIHP must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than thirty (30) calendar days from the day the PIHP receives the appeal. *42 CFR §438.408(a)* *42 CFR §438.408(b)(2)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11 • MSHN Adverse Benefit Determination Notice	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• MSHN Notice of Appeal Receipt	
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the standard appeal was not resolved with 30 calendar days (resolved in 45 calendar days).		
Required Actions: The PIHP must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the PIHP receives the appeal.		
22. The PIHP must resolve expedited appeals and send notice to the affected parties no later than seventy-two (72) hours after the PIHP receives the appeal. *42 CFR §438.408(b)(3)* *42 CFR §438.228* *Contract Schedule A—1(L)(8)(b)(iii)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(2)(d)*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11 • MSHN Adverse Benefit Determination Notice	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
23. The PIHP may extend the standard or expedited appeal resolution timeframes by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. *42 CFR §438.408(c)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(3)*	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended time frame • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11-12 • Appeal Extension Template	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
24. If the PIHP extends the standard or expedited appeal resolution timeframes not at the request of the member, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give 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 or she disagrees with that decision.	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended time frame • Appeal extension template letter • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11-12	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR §438.408(c)(2)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(vi)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(3)(a)*	• Appeal Extension Template	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
25. In the case that the PIHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process. The member may initiate a State fair hearing. *42 CFR §438.408(c)(3)* *42 CFR §438.408(f)(1)(i)* *42 CFR §438.228* *Contract Schedule A—1(L)(7)(c)(i)* *MDHHS Appeal and Grievance Resolution Processes Technical Requirement—III*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 5 • MSHN Adverse Benefit Determination Notice	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The case file review identified one record in which the appeal was not resolved timely and, when it was realized that the time frame expired (which was 14 days after the appeal time frame expired), the appeal process was continued. However, once the appeal time frame has expired, the appeal process is deemed exhausted (i.e., appeal denied), and members must be informed of their SFH rights for untimely appeal resolutions.		
Required Actions: For untimely appeal resolutions, the PIHP must ensure that the appeal is deemed exhausted, and members are provided immediate access to their SFH rights.		
26. For all appeals, the PIHP must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a State fair hearing, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's ABD related to the appeal. *42 CFR §438.408(d)(2)(i)* *42 CFR §438.408(e)(1-2)* *42 CFR §438.10* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(k); 1(L)(8)(b)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(4)(c); VI(C)(5)*	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 40 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 12-13 • MSHN Notice of Appeal Approval • MSHN Notice of Appeal Denial	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the appeal resolution letters did not include the following provision: "*That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the PIHP's ABD related to the appeal.*" However, this language is not included in MDHHS' template language, and PIHP staff members confirmed that under no circumstances would its members be financially liable for continued benefits during the appeal process; therefore, this was not considered a deficiency. **Recommendations:** HSAG recommends that the PIHP enhance QA processes to ensure appeal resolution letters are grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member. Additionally, HSAG recommends that the PIHP require each appeal resolution notice, or a certain percentage of appeal resolution notices (i.e., text entered by the PIHP and not template language), be assessed for reading grade level prior to mailing. The appeal resolution notices must be written at the 6.9 reading grade level. Further, the case file review identified one record in which language in the resolution letter could have been enhanced to clearly explain the specific reason for the denial. As such, HSAG recommends that the PIHP enhance oversight and monitoring processes to review the content of resolution letters for appropriateness.		
Required Actions: None.		
27. For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice. *42 CFR §438.408(d)(2)(ii)* *42 CFR §438.228* *42 CFR §438.228* *Contract Schedule A—1(L)(8)(b)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(4)(a)*	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of oral notice for an expedited appeal resolution • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 12	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which there was no documentation to confirm the member was provided oral notice of the expedited appeal resolution. After the site review, the PIHP provided an email communication between staff members in response to the case file review findings that suggested the member was seen in person and that a staff member later contacted the member via telephone with the determination. However, documentation of these contacts was not included in the appeal case file at the time of the appeal resolution determination.		
Required Actions: For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
State Fair Hearings		
28. The member may request a State fair hearing only after receiving notice that the PIHP is upholding the ABD related to the appeal. *42 CFR §438.408(f)(1)(i)* *42 CFR §438.228* *Contract Schedule A—1(L)(7)(c)* *Appeal and Grievance Resolution Processes Technical Requirement—III; VIII(A)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 5 • MSHN Adverse Benefit Determination Notice • MSHN Notice of Appeal Denial	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
29. The member is given *one hundred twenty (120) calendar days* from the date of the PIHP's notice of appeal resolution to request a State fair hearing. *42 CFR §438.408(f)(2)* *42 CFR §438.228* *Contract Schedule A—1(L)(7)(d)* *Appeal and Grievance Resolution Processes Technical Requirement—VIII(D)*	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 **Nothing specific** • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 15 • MSHN Notice of Appeal Denial	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Continuation of Benefits		
30. The PIHP must continue the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. *Timely files* means on or before the later of the following: within ten (10) calendar days of the PIHP sending the notice of ABD, or the intended effective date of the PIHP's proposed ABD. *42 CFR §438.420(a-b)*	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • Three examples of member requests for continuation of member benefits **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 8	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 *Contract Schedule A—1(L)(5)(h)* *Appeal and Grievance Resolution Processes Technical Requirement—III; V(A)*		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The grievance and appeal training document included the requirements of this element with the exception of sub-element (c). As such, HSAG recommends that the PIHP update its appeal and SFH materials accordingly. Additionally, during the site review, PIHP staff members explained that the typical process is to automatically continue benefits when an appeal is requested. However, benefits should only be continued when requested by the member and the criteria stipulated under federal rule are met. As such, HSAG strongly recommends that the PIHP revise its current processes accordingly.		
Required Actions: None.		
31. If, at the member's request, the PIHP continues or reinstates the member's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of following occurs: a. The member withdraws the appeal or request for State fair hearing. b. The member fails to request a State fair hearing and continuation of benefits within ten (10) calendar days after the PIHP sends the notice of an adverse resolution to the member's appeal. c. A State fair hearing office issues a hearing decision adverse to the member. d. *The authorization expires or authorization service limits are met.* *42 CFR §438.420(c)* *42 CFR §438.228*	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of documentation related to continuation of member benefits **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pgs. 8-9	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(L)(5)(i) *Appeal and Grievance Resolution Processes Technical Requirement—V(B)*		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The grievance and appeal training document included the requirements of this element with the exception of sub-element (d). As such, HSAG recommends that the PIHP update its appeal and SFH materials accordingly. Additionally, during the site review, PIHP staff members explained that the typical process is to automatically continue benefits when an appeal is requested. However, benefits should only be continued when requested by the member and in accordance with the criteria stipulated under federal rule, and be stopped when one of the above criteria is met. As such, HSAG strongly recommends that the PIHP revise its current processes accordingly.		
Required Actions: None.		
32. If the PIHP or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR §438.424(a)* *42 CFR §438.228* *Contract Schedule A—1(L)(5)(j)* *Appeal and Grievance Resolution Processes Technical Requirement—V(F)*	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of reinstatement of services (the date of the reversal and date the services were reinstated must be included) **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 9 • MSHN Notice of Appeal Approval	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** During the site review, PIHP staff members explained that the typical process is to automatically continue benefits when an appeal is requested; therefore, if a decision is reversed, the member has already been receiving the benefits. However, benefits should only be continued when		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
requested by the member and the criteria stipulated under federal rule are met. When a decision is reversed, the PIHP has 72 hours to authorize or provide the disputed service. As such, HSAG recommends that the PIHP revise its current processes accordingly.		
Required Actions: None.		
33. If the PIHP or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PIHP must pay for those services. *42 CFR §438.424(b)* *42 CFR §438.228* *Contract Schedule A—1(L)(5)(k)* *Appeal and Grievance Resolution Processes Technical Requirement—V(E)*	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 9	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Grievances, Appeals, and State Fair Hearings		
34. In handling grievances and appeals, the PIHP must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR §438.406(a)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(d)*	**HSAG Recommended Evidence:** • Policies and procedures • Member handbook(s) • Example of assistance to members on filing a grievance **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft	☒ Met ☐ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(1); VII(C)(1)	• Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 10	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
35. The PIHP must provide information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. *42 CFR §438.414* *42 CFR §438.228* *Contract Schedule A—1(L)(3-4)*	**HSAG Recommended Evidence:** • Policies and procedures • Provider manual • Provider contract and subcontractor agreement template **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 1 • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. • Lifeways CMH FY22 SUD Treatment Contract, pg. 20 • FY22 MSHN Training Grid • MSHN Provider Grievance and Appeal Resolution Process Training	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Per the CS_Medicaid_Enrollee_Appeals_Grievances_Policy each CMHSP Participant, SUD Provider, and their subcontractors shall have a local procedure in place that is in compliance with the with the Michigan Department of Health and Human Services (MDHHS), Grievance and Appeal Technical Requirement and 42 CFR 438 Subpart F – Grievance and Appeal System. Per the Medicaid Subcontracting Agreement, each CMHSP Participant, SUD Provider, and their subcontractors are required to train staff about the grievance and appeal system. Per the FY22 MSHN Training Grid, provider staff are required to receive Appeals and Grievance training initially within 90 days of hire and annually thereafter.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The training grid did not require training on the grievance and appeal processes for all member-facing provider types. As such, HSAG recommends that the PIHP require training for all member-facing providers. This training could be a general overview of the member grievance and appeal systems and not as detailed of a training that is necessary for other providers (e.g., providers responsible for processing member grievances and appeals).		
Required Actions: None.		
36. The PIHP must include as parties to the appeal and State fair hearing: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For State fair hearings, the PIHP. *42 CFR §438.406(b)(6)* *42 CFR §438.408(f)(3)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(j)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(7); VIII(G)*	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 15	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the grievance and appeal training document identified parties to an SFH, it did not include sub-element (b) of this element. It was also specific to SFHs and did not include appeals. As such, HSAG recommends that the PIHP update its appeal and SFH materials accordingly.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recordkeeping Requirements		
37. Grievance and appeal records must be accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. *42 CFR §438.416(b-c)* *42 CFR §438.228* *Contract Schedule A—1(L)(9)(a)* *Appeal and Grievance Resolution Processes Technical Requirement—IX*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals and Grievances File Reviews **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 16 • MSHN SUD_Provider_Manual, pg. 15 • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pgs. 37, 39 • Lifeways CMH FY22 SUD Treatment Contract, pg. 37	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
38. *Grievance and appeal records must be retained for ten (10) years from the final date of the contract period of from the date of completion of any audit, whichever is later.* *Contract Schedule A—1(L)(9)(c)*	**HSAG Recommended Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pgs. 6, 21	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The CMHSP contract included the following provision: "*The parties hereto agree to retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years*." However, HSAG recommends that the PIHP add the following language as required by this element: "…*from the final date of the contract period of from the date of completion of any audit, whichever is later.*" Additionally, HSAG recommends that the PIHP specifically include the requirements of this element in its substance use disorder (SUD) provider contracts.		
Required Actions: None.		

Standard IX—Grievance and Appeal Systems						
Met	=	32	X	1	=	32
Not Met	=	6	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	38	Total Score		=	32
Total Score ÷ Total Applicable					=	84%

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the PIHP may have with any delegate, PIHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 3 • Pg. 7, Section IX (A) X. FY22 Medicaid Subcontract Delegation Grid • Pg. 37 X. FY22 SUD Treatment Contract • Pg. 16, Section II (C)(19)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Compliance with delegated functions are monitored through the desk review and on-site review process. Delegated functions are included in the Medicaid Subcontracting Agreements with all CMH's within the MSHN Region in the form of a delegation grid. The sanction language within the contracts identify the steps that can lead to revocation of delegated functions should the delegate meet contractual requirements or take necessary corrective action steps to resolve matters of not compliance. Both SUD contracts as well as the Medicaid Subcontracts address the compliance with the MDHHS/PIHP Master Agreement and incorporates, by reference those terms into the respective contracts.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the PIHP's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the PIHP determine that the delegate has not performed satisfactorily. *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)*	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 8, Section IX (A)(C) • Pg. 19, Section XVII (A) • Pg. 33, Section XXX (D) • Pg. 80, Exhibit G X. FY22 Medicaid Subcontract Delegation Grid • Pg. 37 X. FY22 MSHN SUD Reporting Requirements X. FY22 SUD Treatment Contract • Pg. 17, II (C) (14) • Pg. 17, II (C) (21) (d) • Pg. 22, VI (B)(1) • Pg. 30, I (1)(g) • Pg. 41, Attachment C	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Delegated functions are included in the Medicaid Subcontracting Agreements with all CMH's within the MSHN Region in the form of a delegation grid. The sanction language within the Medicaid Subcontracts as well as the SUD contract identify the steps that can lead to		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
revocation of delegated functions should the delegate meet contractual requirements or take necessary corrective action steps to resolve matters of not compliance.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR §438.230(c)(2)*	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 4, Section III (A-D) • Pg. 21, Section XIX (A-F) X. FY22 SUD Treatment Contract • Pg. 16, Section II (C)(19) • Pg. 17, II (C)(21)(d) • Pg. 22, VI (B)(1)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Medicaid subcontracts include delegation agreement grids which clearly delineates the functions delegated to the CMHSP and functions retained by MSHN. Refer to Medicaid Subcontracting Agreement and delegation grid. Reporting requirements are also included in contracts. MSHN's contract compliance procedure indicates MSHN reserves the right to revoke delegated functions. SUD contracts, while they do not have a specific delegation grid attached, identify specific functions the provider is required to perform.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. b. The delegate agrees that the delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3)(i-iv)	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 20, Section XVIII (A-D) X. FY22 SUD Treatment Contract • Pg. 13, Section II (C)(1) • Pg. 14, Section II (C)(12) • Pg. 16, Section II (C)(19) X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 21, Section XVIII (B & E) X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 21, Section XVIII (G) X. FY22 SUD Treatment Contract • Pg. 17, Section II (C)(21)(A-G)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Contracts include language specific to this standard and have been identified by section and page number. Please refer to the Medicaid Subcontract and SUD treatment contract as noted above. Contracts refer to the inspection standards required. Contracts refer to the inspection standards required. MSHN contracts include the 10 year requirement; please see the referenced contracts and highlighted sections/page numbers referenced above.		

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Monitoring and Auditing		
5. The PIHP ensures that the delegate complies with all delegated activities and required reporting responsibilities and issues corrective action when the delegate has not performed satisfactorily. *42 CFR §438.230*	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Monitoring and audit documentation • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the PIHP:** X. MSHN FY 2022 Medicaid Subcontracting Agreement • Pg. 21, Section XIX (A-F) • Pg. 33, Section XXX (D) X. FY22 Medicaid Subcontract Delegation Grid X. FY22 SUD Treatment Contract • Pg. 15, Section II (C)(16) • Pg. 17, Section II (C)(21) • Pg. 30, Section VI (I)(1) • Pg. 33, Attachment A (9) • Pg. 41, Attachment C X. FY22 MSHN SUD Reporting Requirements X. MCN_2021 Delegated Managed Care Review – Final X. MCN_2021 Delegated Managed Care Review – CAP Approved	☒ Met ☐ Not Met ☐ NA

Standard X—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Medicaid subcontracts include delegation agreement grids which clearly delineates the functions delegated to the CMHSP and functions retained by MSHN. Refer to Medicaid Subcontracting Agreement and delegation grid. Reporting requirements are also included in each contract (Medicaid Subcontract (CMH's) and SUD). MSHN's contract compliance procedure indicates MSHN reserves the right to revoke delegated functions.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard X—Subcontractual Relationships and Delegation						
Met	=	5	X	1	=	5
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	5	Total Score		=	5
Total Score ÷ Total Applicable					=	100%

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. The PIHP must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. *42 CFR §438.236(b)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the PIHP:** FY2022 QAPIP MSHN, Section IX.b (pp. 20-21) Evidence Based Practices Policy, (pp.1) MSHN Clinical Practice Guidelines List	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
2. The PIHP must adopt practice guidelines that consider the needs of the PIHP's members. *42 CFR §438.236(b)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the PIHP:** FY2022 QAPIP MSHN, Section IX.b (pp. 20) Evidence Based Practices Policy, Section A.b.ii (pp.1) SUD Residential COVID_19 Practice Guideline	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN developed a *Substance Use Disorder (SUD) Residential Treatment Practice Guideline for COVID-19 Positive Cases* in January 2022 after receiving multiple customer service complaints from members stating they had been discharged from SUD residential treatment prematurely due to testing positive for COVID-19. This is the most recent example of the PIHP adopting practice guidelines that address the specific needs of its members.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
3. The PIHP must adopt practice guidelines that are adopted in consultation with network providers. *42 CFR §438.236(b)(3)*	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval • Evidence of consultation of network providers **Evidence as Submitted by the PIHP:** FY2022 QAPIP MSHN, Section IX.b (pp. 20) Clinical Leadership Committee Charter (pp.1) MSHN Operations Council Meeting Minutes 2_28_2022 Residential Workgroup 1_10_2022	☒ Met ☐ Not Met ☐ NA

PIHP Description of Process: Clinical practice guidelines are developed with input and approval of MSHN regional councils, committees, and workgroups which are comprised of representatives from Community Mental Health Service Programs (CMHSP) and Substance Use Disorder Service Providers (SUDSP). The charter document for the Clinical Leadership Committee specifically identifies that a primary responsibility of the committee is to advise MSHN in the development of clinical best practice guidelines.

The MSHN Operations Council Meeting Minutes 2_28_2022 provide evidence of MSHN seeking regional council/committee input and approval on a set of draft service protocols (practice guidelines) for services and supports covered under the Medicaid 1915(i) benefit. As noted in the meeting minutes, the guidelines were approved by the Clinical Leadership Committee in November 2021 before being presented to the regional Operations Council for final approval.

The Residential Workgroup 1_10_2022 meeting minutes provide evidence of MSHN consultation with a regional workgroup of SUD residential treatment providers on the SUD Residential COVID-19 Practice Guideline.

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

Recommendations: Although the Operations Council meeting minutes included the names of attendees and evidence supported network providers attended the meetings, meeting minutes could be enhanced to clearly identify all attendees and the organizations they represent. As such, HSAG recommends that the PIHP document each attendee's title and organization in the meeting minutes.

Required Actions: None.

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
4. The PIHP must adopt practice guidelines that are reviewed and updated periodically as appropriate. *42 CFR §438.236(b)(4)*	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the PIHP:** Policy & Procedure Development Procedure (pp.1, pp.4) MSHN Clinical Practice Guidelines List	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN reviews and updates all policies and procedures, including practice guidelines, on a biennial basis. The Policy & Procedure Development Procedure describes the review process which includes review and feedback by regional councils and committees and concludes with review and approval by the MSHN Operations Council and MSHN Board of Directors. The next scheduled biennial review for clinical policies, procedures, and practice guidelines will occur beginning in August 2022 as noted on the calendar on page 4 of the Policy & Procedure Development Procedure.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although PIHP staff members explained that the language in the committee meeting minutes was the approval of the practice guidelines, HSAG recommends the PIHP enhance its committee meeting minutes to specifically indicate that practice guidelines are being adopted/approved. Additionally, the Evidence Based Practices Policy did not specify which committee was responsible for adopting practice guidelines; therefore, HSAG recommends that the PIHP update its policy to clearly demonstrate which committee has this responsibility.		
Required Actions: None.		
Dissemination of Guidelines		
5. The PIHP disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request *42 CFR §438.236(c)* *Contract Schedule A—1(K)(5)(a)*	**HSAG Recommended Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) **Evidence as Submitted by the PIHP:** MSHN Provider Constant Contact 2_22_2022 (pp.2) SUD Residential Treatment COVID_19 Email	☒ Met ☐ Not Met ☐ NA

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: All practice guidelines, policies, and procedures are available to the general public, members, and providers on the MSHN website: Practice Guidelines - Mid-State Health Network (midstatehealthnetwork.org) New practice guidelines are also disseminated to the provider network via the MSHN Provider Constant Contact newsletter and targeted emails to affected providers.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR §438.236(d)* *Contract Schedule A—1(K)(5)(a)*	**HSAG Recommended Evidence:** • Policies and procedures • Inter-rater reliability studies **Evidence as Submitted by the PIHP:** Access System Policy (pp.6) FY22 MSHN Guide to Services (pp. 62-68)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The FY22 MSHN Guide to Services (pp.62-68) provides member education regarding the coverage of services consistent with MSHN practice guidelines.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
7. *The PIHP must assure services are planned and delivered in a manner that reflects the values and expectations contained in the:* a. *Inclusion Practice Guideline* b. *Housing Practice Guideline* c. *Consumerism Practice Guideline* d. *Personal Care in Non-Specialized Residential Settings Practice Guideline*	**HSAG Recommended Evidence:** • Policies and procedures • Staff/provider training materials • Provider materials, such as provider manual **Evidence as Submitted by the PIHP:** Evidence Based Practices Policy, Section A.a.i-vii (pp.1) 2021 HCBS Program Specific Audit_The Right Door (pp.4-6) 2021 Clinical Chart Review_The Right Door (pp.5-8)	☒ Met ☐ Not Met ☐ NA

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
e. *Family-Driven and Youth-Guided Policy and Practice Guideline* f. *Employment Works! Policy* *Contract Schedule A—1(K)(5)(a)(i-vi)*		
PIHP Description of Process: MSHN assures that services are planned and delivered in a manner that reflects the values and expectations of the practice guidelines through a delegated managed care site review process. Review tools incorporate standards to assess that practice guidelines are being implemented in all aspects of service planning and delivery.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XI—Practice Guidelines						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	**Total Score**		=	7
Total Score ÷ Total Applicable					=	100%

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The PIHP must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems must provide information on areas including, but not limited to: a. Utilization, *including by population group and categories* b. Claims, *including third party liability* c. Grievances and appeals covered in d. Disenrollments for other than loss of Medicaid eligibility e. *Eligibility* f. *Provider enrollment* *42 CFR §438.242(a)* *Contract Schedule A—1(O)(2-3)*	**HSAG Recommended Evidence:** • Systems integration mapping documentation • Most current Information Systems Capabilities Assessment (ISCA) • Technical manual(s) • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • 1a_Data Flow Diagram MSHN 2021 • 1b_UM_Utilization_Management_Procedure • 1c_Finance_Claims_Procedure_2.3.21 • 1d_CS_ReportingMedicaidAppealsGrievancesRRProcedure_FY20 • 1e_PNM_Provider_Network_Management_Policy • 1f_MDHHS Master Agreement FY21-22_MA-PIHP_Contract_Option-Year-1-with-all-CN as of 1.31.22	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN delegates a-f above to the CMHSPs. Each CMHSP has their own health information system that is used to collect data, analyze and report data regarding their clients. Specifically, for utilization, any sub contracted claims, grievances, appeals, disenrollment, eligibility and provider enrollment, their systems allow them to manage these areas internally and provide any data to be reported up to the PIHP as needed. At the PIHP level, we can also collect, integrate, analyze and report on all these areas. MSHN utilizes REMI, (MSHN's Managed Care software) that allows us to gather data from our CMHs via 837 encounters and claims, BH TEDS records and spreadsheets of grievance and appeals, and provider enrollment data. REMI is used to manage SUD provider enrollment, utilization, grievances, appeals and claims. REMI also gathers Medicaid enrollment data via the 834 and 820 files from MDHHS and eligibility data from the State via the 270/271 process. Having all this data together in one system allows a multitude of reporting and analytical possibilities.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
2. *A PIHP organized as a regional entity must ensure that health plan information technology functions are clearly defined and separately contracted from any other function provided by a Community Mental Health Services Program (CMHSP). A PIHP organized as a regional entity may have a single CMHSP perform PIHP health plan information technology functions on behalf of the regional entity if each of the following requirements are met:* a. *The contract between the PIHP and the CMHSP clearly describes the CMHSP's contractual responsibility to the PIHP for the health plan information technology related functions.* b. *The contract between the PIHP and the CMHSP for PIHP health plan information technology functions must be separate from other electronic health record (EHR) functions performed as a CMHSP.* *Contract Schedule A—1(O)(1)*	**HSAG Recommended Evidence:** • Contracts/delegation agreement between PIHP and CMHSP, if CMHSP performs IT functions on behalf of the PIHP **Evidence as Submitted by the PIHP:** • 2a_CEI FY22 File Management Historical Data Repository Data Exchange Processing 10.1.21 - Fully Executed 10.4.21 • 2b_IT_Information_Management_Policy • 2c_FY22 Medicaid Subcontract Delegation Grid	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN delegates portions of information technology to the CMHSPs in the region as outlined in the delegation grid and. provides oversight through the Delegated Managed Care reviews. MSHN has a separate contract with CEICMH to provide information management services for BH-TEDS and Encounter reporting for the region. This contract is reviewed by often through using the Utilization Net Cost Report and Encounter Comparison Report, changes in utilization and shifts in funding sources, and monitoring volume of encounters submitted monthly, quarterly and annually.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of a Health Information System		
3. The PIHP must comply with section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act. *42 CFR §438.242(b)(1)* *Contract Schedule A—1(O)(2)(a)(i)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • 1c_Finance_Claims_Procedure_2.3.21 **same as above** • 3a_MDCH_5010A1_CG_837P_Enc_PIHP_CMHSP_11V202 • 3b_MDCH_5010A1_CG_837I_Enc_PIHP_CMHSP_11V202	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN subscribes to the HIPAA 837 transaction set standard and the MDHHS companion guides and validates all encounter transactions. All encounter transaction must meet these validations or REMI will not process them. All SUD Claims must meet the requirements to allow encounter submission as well. MSHN ensures compliance of the CMHSPs through the delegated managed care review,		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. The PIHP must collect data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State. *42 CFR §438.242(b)(2)* *Contract Schedule A—1(O)(2)(a)(ii)* *Contract Schedule E—Reporting Requirements*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • 1c_Finance_Claims_Procedure_2.3.21 • 3a_MDCH_5010A1_CG_837P_Enc_PIHP_CMHSP_11V202 • 3b_MDCH_5010A1_CG_837I_Enc_PIHP_CMHSP_11V202	☒ Met ☐ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: MSHN subscribes to the HIPAA 837 transaction set standard and the MDHHS companion guides and validates all encounter transactions. All encounter transaction must meet these validations or REMI will not process them. All SUD Claims must meet the requirements to allow encounter submission as well.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
5. The PIHP must ensure that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the PIHP is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and coordination of care efforts. *42 CFR §438.242(b)(3)* *Contract Schedule A—1(O)(2)(a)(iii)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the PIHP:** • 1a_Data Flow Diagram MSHN 2021 • 1c_Finance_Claims_Procedure_2.3.21 • 3a_MDCH_5010A1_CG_837P_Enc_PIHP_CMHSP_11V202 • 3b_MDCH_5010A1_CG_837I_Enc_PIHP_CMHSP_11V202 • 3c.BH TEDS File-Specs-FY22 • 3d.BH-TEDS_Coding_Instructions_FY22_Rev220209 • 5a_EncounterVolume	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Accuracy of data is ensured by the validation edits applied to incoming data. Both BH TEDS and Encounters are validated using edits that are very similar to the edits at the State. Both data types are collected using the same format that is required at the State level. Timeliness of data is monitored regularly to ensure that we meet or exceed the contract requirements. BH TEDS and encounter data are processed weekly by MSHN. CMHSPs are required to submit their data monthly or more often as appropriate for their situation. All SUD Claims must meet the requirements to allow encounter submission as well.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
6. The PIHP must make all collected data available for the State and upon request to CMS. *42 CFR §438.242(b)(4)* *Contract Schedule A—1(O)(2)(a)(iv)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements/reports • Encounter data acceptance/rejection reports **Evidence as Submitted by the PIHP:** • 1a_Data Flow Diagram MSHN 2021 • 1f_MDHHS Master Agreement FY21-22_MA-PIHP_Contract_Option-Year-1-with-all-CN as of 1.31.22 • 6a.EncounterProcessingResultsReports	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: All data collected for contract requirements are submitted to the State as specified, and the data is continuously available to be reviewed upon request.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Application Programming Interface (API)		
7. The PIHP must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCO. Information must be made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed.	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the PIHP:** • 7a_Payer Data Exchange - PCE User Manual • 7b_PIX_9_3_API_Documentation • https://fhir.pcesecure.com:9443/PCEFhirServer/MSH/Organization	☐ Met ☒ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments. c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the MCO. e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. *42 CFR §438.242(b)(5)* *42 CFR §431.60*	• https://fhir.pcesecure.com:9443/PCEFhirServer/MSH/Practitioner?name=a	
PIHP Description of Process: REMI provide access to the required data as data becomes available. There is no delay from receipt or entry of data to when it becomes available. Consumers must request and register for data to be made available.		
HSAG Findings: The PIHP had not implemented a Patient Access API that meets the requirements of 42 CFR §431.60 (member access to and exchange of data). **Recommendations:** As the PIHP implements a CAP to address this deficiency, HSAG recommends the PIHP thoroughly review all published guidance to ensure its Patient Access API meets CMS' implementation guidelines (e.g., https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index). Additionally, while the Payor-to-Payor API was not included as part of this year's compliance review, HSAG recommends that the PIHP familiarize itself with CMS' technical guidelines and proceed with its implementation.		
Required Actions: The PIHP must implement a Patient Access API that meets all requirements under 42 CFR §431.60 (member access to and exchange of data) and complies with the implementation guidelines required by CMS.		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
8. The PIHP must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). *42 CFR §438.242(b)(6)* *42 CFR §431.70* *42 CFR §438.10(h)(1-2)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Link to web-based provider directory(ies) • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the PIHP:** • 7a_Payer Data Exchange - PCE User Manual • 8a.PNM_Provider Directory Policy • 8b.PNM_Provider Directory Procedure • 8c.Provider Directory Upload • 8d_PN_-_Provider_Directory_Procedure • Directory - Mid-State Health Network (midstatehealthnetwork.org)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The MSHN web site has a provider directory page that allows users to search any and all of the contract and sub-contract providers of any type in the MSHN region. Each entry for a provider contains providers name, address and phone number as well as fields for the providers website, specialty information, service types provided, whether accepting new enrollees, languages offered, disability accommodations, accreditations and counties served.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Member Encounter Data		
9. The PIHP must collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • Attestations/audit results • HSAG will use the results from the information systems demonstration, including reporting capabilities	☒ Met ☐ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
a. *The PIHP must ensure all encounter data is complete and accurate for the purposes of rate calculations and quality and utilization management.* *42 CFR §438.242(c)(1)* *Contract Schedule A—1(O)(2)(b)* *Contract Schedule A—1(O)(2)(b)(i)*	**Evidence as Submitted by the PIHP:** • 1c_Finance_Claims_Procedure_2.3.21 • 9a.Quality_Medicaid_Event_Verification • 9b.Quality-Medicaid_Event_Verification_Procedure_3.0_Draft	
PIHP Description of Process: MSHN subscribes to the HIPAA 837 transaction set standard and the MDHHS companion guides and validates all encounter transactions. All encounter transaction must meet these validations in order to be allowed into the REMI system. SUD Claims must meet all the requirements to be submitted as encounters to MDHHS as well. REMI uses this data for quality and utilization management and for submission to the State. Data sent to MDHHS is used for rate calculation and other reporting requirements.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
10. The PIHP must submit member encounter data to the State at a frequency and level of detail specified by CMS and the State, based on program administration, oversight, and program integrity needs. a. The member encounter data must include allowed amount and paid amount that the State is required to report to CMS under 42 CFR § 438.818. b. The member encounter data must be submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. *42 CFR §438.242(c)(2-4)* *Contract Schedule A—1(O)(2)(b)(ii-iii)* *Contract Schedule E—Reporting Requirements*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent months of submission compliance (acceptance/rejection reports) **Evidence as Submitted by the PIHP:** • 1c_Finance_Claims_Procedure_2.3.21 • 3a_MDCH_5010A1_CG_837P_Enc_PIHP_CMHSP_11V202 • 3b_MDCH_5010A1_CG_837I_Enc_PIHP_CMHSP_11V202 • 3c.BH TEDS File-Specs-FY22 • 3d.BH-TEDS_Coding_Instructions_FY22_Rev220209 • 6a.EncounterProcessingResultsReports	☒ Met ☐ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: MSHN subscribes to the ASC X12N 837 transaction set standard and the MDHHS companion guides and validates all encounter transactions. REMI validates this data before submission to the State. Data sent to MDHHS is used meet the financial reporting requirements. SUD claims data must meet all the requirements to be submitted as encounters to MDHHS as well.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. *The PIHP must ensure that providers establish and maintain a comprehensive individual service record system consistent with the provisions of Medical Services Administration (MSA) Policy Bulletins, and appropriate State and federal statutes.* a. *The PIHP must ensure that providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided.* b. *The records must be retained according to the retention schedules in place by the Department of Technology, Management and Budget (DTMB) General Schedule #20.* c. *This requirement must be extended to all of the PIHP's provider agencies.* *Contract Schedule A—1(O)(4)*	**HSAG Recommended Evidence:** • Policies and procedures • Provider contracts • Provider manual **Evidence as Submitted by the PIHP:** • 11a.MSHN_FY_2022_MEDICAID_SUBCONTRACTING_AGREEMENT • 11b.FY22_SUD_Treatment • 11c.SUD_Provider_Manual • 11d.MCN_2021 BHTED Encounters Business Processes – Final • 11e.MCN_Encounters Record Review – Final • 11f.MCN_2021 Delegated Managed Care - Final (1) • 11g.Catholic Charities-JLH_2021 Delegated Functions Tool – Final	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: We verify that there is appropriate documentation through our various reviews and audits of the providers. The Delegated managed care review ensures that documentation meets the standards required in the Medicaid Provider Manual. The MEV reviews that the reported encounter data matches the values recorded for each service. Records are retained for the appropriate periods based on all governing requirements, including the DTMB general schedule #20.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
12. *The PIHP must analyze claims and encounter data to create utilization reports. The utilization data must be detailed for each CMSHP and consolidated for the entire geographic service area.* a. *The PIHP must utilize this information to develop and update their risk management strategies and other health plan functions.* *Contract Schedule A—1(O)(5)*	**HSAG Recommended Evidence:** • Policies and procedures • Utilization management documents, including program description and evaluation • Examples of utilization reports **Evidence as Submitted by the PIHP:** • 12a.MSHN_UM_Plan_FY21-22 • 12b.ACT Utilization FY22 Q1 • 12c.FY21 Q4 Compiled MCG Reviews Final • 12d_2022 Risk Management Strategy - Mid State Health Network Final • 12e_Fin_Costing Policy • 12f_Fin_Financial_Management Policy • 12g_FY2022 Savings Estimates through March 05.05.22 • 12h_FY2021 Medicaid Service Use Evaluation	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN has reports of utilization at both the CMHSP level and the MSHN level, and the data can be used to update the risk management strategy.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XII—Health Information Systems						
Met	=	11	X	1	=	11
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	12	**Total Score**		=	11
Total Score ÷ Total Applicable					=	92%

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The PIHP must establish and implement an ongoing comprehensive quality assessment and performance improvement program (QAPIP) for the services it furnishes to its members. *42 CFR §438.330(a)(1)*	**HSAG Recommended Evidence:** • QAPIP program description • QAPIP work plan **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan (includes the workplan)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the Quality Assessment and Performance Improvement Program (QAPIP) work plan included most QAPIP activities conducted by the PIHP, not all activities included a goal/target; therefore, HSAG recommends the PIHP consider adding a goal/target for each activity. Additionally, HSAG recommends that the PIHP add a field to the QAPIP work plan to include regular (e.g., monthly or quarterly) updates on progress toward the goals.		
Required Actions: None.		
2. *The PIHP must have a written description of its QAPIP which specifies:* a. *An adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP;* b. *The components and activities of the QAPIP including those as required by the Quality Assessment and Performance Improvement Program Technical Requirement;* c. *The role for recipients of service in the QAPIP; and* d. *The mechanisms or procedures to be used for adopting and communicating process and outcome improvement.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	**HSAG Recommended Evidence:** • QAPIP program description **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 7-12; page 27-26	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. *The PIHP must submit the updated QAPIP description and associated work plan to MDHHS annually by February 28th. The report will include a list of the members of the Governing Body.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section I*	**HSAG Recommended Evidence:** • QAPIP program description • QAPIP work plan • Evidence of submission of the QAPIP documents **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 7-8, and page 27 • 02. FY2021 QAPIP Report with Attachments page 63, under Governance, Attachment 19-MSHN Governing Board • 03. QAPIP Submission-Email approval of date • 04. Confirmation MDHHS QAPIP Annual Submission	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. *The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:* a. *Oversight of QAPIP – There is documentation that the Governing Body has approved the overall QAPIP and an annual Quality Improvement (QI) plan.*	**HSAG Recommended Evidence:** • QAPIP program description • Governing Body charter • Minutes from Governing Body demonstrating approval of the QAPIP and quality improvement plan • Examples of concurrent QAPIP progress reports • Minutes from Governing Body demonstrating review of QAPIP progress reports and the annual QAPIP review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. *QAPIP progress reports – The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken, and the results of those actions.* c. *Annual QAPIP review – The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section II*	**Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 7, Section Governance/Board of Directors • 02. FY2021 QAPIP Report with Attachments • 05. 2022-03-01_Board _of_Directors_Meeting_Packet • 06. 2022-03-01_MSHN_Board Mtg_Minutes_Board Approved • 07. 2022-01-11_MSHN_Board_Meeting_Minutes • 08. 2022-01-11_MSHN_Board_Packet-QAPI Progress Report ➢ Population Health and Integrated Care page 32 and 34. ➢ Update/Performance Bonus Incentive Report FY21 page 32 and 43 ➢ Medicaid Event Verification Annual Report-page 33 and 34 • 09. 2021-11-02_Board Packet QAPI Progress Report ➢ Behavioral Health Department Report FY21Q3 page 59 ➢ Provider Network Department Report FY21Q3 page 59 • 10. 2022-05-03_Board Meeting Packet QAPI Progress Report ➢ Priority Measures FY22Q1 page 57 and 59 ➢ Compliance and Quality Department Report page 57-58 and 59	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP provided an executive summary of the QAPIP description, work plan, and evaluation to the Board of Directors, HSAG recommends the PIHP document any discussion and feedback from the Board of Directors. HSAG recognizes that the PIHP follows Robert's Rules of Order; however, HSAG strongly recommends that the PIHP document discussion and feedback from committees in some manner in order to ensure appropriate follow up. Additionally, while the PIHP provided information related to specific QAPIP activities to the Board of Directors, HSAG recommends that the PIHP designate a time on the agenda to review QAPIP activities and ensure it is clearly documented in the meeting minutes.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
5. *There is a designated senior official responsible for the QAPIP implementation.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section III*	**HSAG Recommended Evidence:** • QAPIP program description • Job description **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 8, under Chief Executive Officer 1st paragraph • 12. Chief Compliance and Quality Officer Job Description • 13. Quality Manager Job Description	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
6. *There is active participation of providers and individuals in the QAPIP processes.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section IV*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Meeting minutes demonstrating active participation of providers and PIHP members in the QAPIP processes **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan • 14. 202101028 QIC Meeting Snapshot • 15. 202111220 QIC Meeting Snapshot • 16. 20220224 QIC Meeting Snapshot • 17. RCAC Meeting Snapshot 2021_12_10 • 18. RCAC Meeting Snapshot 2021_10_08 • 19. 2022-02 Operations Council Key Decisions • 20. 2022-02-24 CLC_UMC Minutes • 21. MSHN Regional Medical Directors Meeting 1-21-2022 • 22. MSHN Regional Medical Directors Meeting 3-18-2022	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• 23. Org Chart w-council and committee	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While PIHP staff members confirmed that members and providers attend several committees, which was evidenced by the attendees lists in the meeting minutes, HSAG recommends that the PIHP capture the member and provider feedback in the minutes or other documents to ensure follow up.		
Required Actions: None.		
Basic Elements of QAPIPs		
7. The QAPIP must include mechanisms to assess both underutilization and overutilization of services. *42 CFR §438.330(b)(3)*	**HSAG Recommended Evidence:** • QAPIP program description • Evidence demonstrating assessment of underutilization and overutilization of services (e.g., meeting minutes, reports) **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 20, 26-28, • 02. FY2022 QAPIP Report with attachments Attachment 1 Act Utilization • 44. Penetration Rate Percent Changed Detail FY21 • 45. FY21 Q4 Compliled MCG Reviews Final • 25. MSHN UM Plan FY21-22 page 9, Section 7.a; page 12 Section 5.a; page 14, Section C.a • 20. 2022-2-24-CLC-UMC Minutes • 24. Minutes_UMC_CLC_November_2021 (ACT utilization)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
8. The QAPIP must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy. *42 CFR §438.330(b)(4)*	**HSAG Recommended Evidence:** • QAPIP program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Audit tools and results **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan • 02. FY2021 QAPIP Report with Attachments • 67. DMC clinical Chart Review tool sections 6 and 7. • 68. 2021 Specific Waiver Specific Tool • 64. Service Delivery CWP Policy • 65. Service Delivery System HSW Policy • 66. Service Delivery System HSW Annual Rec	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
9. For PIHPs providing long-term services and supports, the QAPIP must include: a. Mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan. *42 CFR §438.330(b)(5)(i)*	**HSAG Recommended Evidence:** • QAPIP program description • Critical incident policies and procedures • Critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 34,41 • 02. FY2022 QAPIP Report with Attachments page 50-52, 70-73, 84-86, 93-95	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	➢ Attachment 6 ➢ Attachment 7 • 46. Quality-Critical Incidents Policy • 47. Quality Incident Review for SUD Providers Policy • 30. MSHN Critical Incident Performance Report FY22Q1 • 31. MSHN Critical incident Performance Report SUDTP FY22Q1 • 32. MSHN Critical Incident Performance Report SUDTP FY22Q2 • 67. DMC Chart Review section 6, 7, 8, and 9.	
PIHP Description of Process: The quality and appropriate of care is monitored through the number of and severity of critical incidents reported to the PIHP, key priority measures, and individuals clinical chart reviews.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendation:** Although the PIHP reviewed members individually through its person-centered planning process and audits to ensure quality and appropriateness of care, HSAG recommends that the PIHP develop a process to regularly monitor the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including assessment of care between care settings, on an aggregated level, and include the information in its QAPIP documents (i.e., description, work plan, and evaluation).		
Required Actions: None.		
Performance Measurement		
10. The QAPI program must include the collection and submission of performance measurement data. The PIHP must annually: a. Measure and report to the State on its performance, using the standard measures required by the State; b. Submit to the State data, specified by the State, which enables the State to calculate the PIHP's performance using the standard measures identified by the State; or	**HSAG Recommended Evidence:** • QAPIP program description • QAPIP work plan • Performance measures reports • Evidence of submission of performance measurement reports to the State **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 16, 28-29	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
c. Perform a combination of the activities described in sub-elements (a) and (b). *42 CFR §438.330(b)(2)* *42 CFR §438.330(c)* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section V* *Contract Schedule E—Reporting Requirements*	• 02. FY2021 QAPIP Report with attachments page 45, 65, 80-81, 89 ➢ Attachment 2 • 33. MMBPIS Summary Report FY22Q1 • 34. MMBPIS SUD Summary Report FY22Q1(Internal use only) • 35. MMBPIS Email Confirmation	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Performance Improvement Projects (PIPs)		
11. The QAPI program must include performance improvement projects (PIPs). a. The PIHP must conduct PIPs that focus on both clinical and nonclinical areas. b. *The PIHP must engage in at least two projects during the waiver renewal period.* i. *Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.* ii. *Nonclinical areas would include, but not be limited to, appeals, grievances, trends, and patterns of substantiated Recipient Rights complaints as well as access to, and availability of, services.* iii. *Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need*	**HSAG Recommended Evidence:** • Policies and procedures • QAPIP program description • QAPIP work plan • PIP documentation for all active PIPs (excluding HSAG-validated PIPs) **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 17, 28 • 02. FY2022 QAPIP Report with attachments page 90 Attachment 4 Attachment 5 • 63. PIP Start of Services within 14 days of Assessment (Ind. 3)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
for a specific service by, the organization's individuals; consumer demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed. *42 CFR §438.330(b)(1)* *42 CFR §438.330(d)(1)* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VII*		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
12. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. *42 CFR §438.330(d)(2)*	**HSAG Recommended Evidence:** • QAPIP program description • QAPIP work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 17, 28 • 36. Quality Performance Improvement Policy • 63. PIP Start of Services within 14 days of Assessment (Ind. 3)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP conducted an overall evaluation of the effectiveness of all interventions for the *Recovery Self-Assessment* PIP, HSAG recommends the PIHP document all interventions and evaluate the effectiveness of each intervention for clarity about how each specific intervention improved or did not improve the results of the PIP.		
Required Actions: None.		
13. The PIHP must report the status and results of each PIP to the State as requested, but not less than once per year. *42 CFR §438.330(d)(3)*	**HSAG Recommended Evidence:** • Evidence of annual submission of all PIPs to the State **Evidence as Submitted by the PIHP:** • 62. PIP Approval Submission for FY22- FY25 Email	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MDHHS has not required the PIPs to be submitted annually. MDHHS did require the Proposed PIP for the current cycle to be submitted for approval.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, HSAG will recommend that MDHHS update its contract to include the time period and format for reporting the status and results of each PIP conducted at least annually.		
Required Actions: None.		
Sentinel Events and Critical Incidents		
14. Participate in efforts by the State to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR § 441.302(h). a. *The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put individuals at risk of harm.* *42 CFR §438.330(b)(5)(ii)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Sentinel events and critical incidents policies and procedures **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP Plan page 18 bottom-19 top • 37. FY22 Medicaid Subcontract Delegation Grid • 46. Quality-Critical Incidents Policy • 47. Quality Incident Review for SUD Providers Policy • 48. Quality Sentinel Event Policy	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(K)(2)(a) *QAPIPs for Specialty PIHPs, Section VIII*	• 38. Critical Incident Review Tool	
PIHP Description of Process: The identification and review of adverse events (sentinel, critical, risk) is delegated to the CMHSP participants and the SUD Providers. Oversight is provided during the Delegated Managed Care Reviews using the Critical Incident Review Tool. The data is aggregated regionally and reviewed on a quarterly basis for regional action based on the individual provider issues that have been identified. Area that require additional development or improvement are included in the QAPIP Work Plan.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
15. *At a minimum, sentinel events as defined in the MDHHS contract must be reviewed and acted upon as appropriate.* a. *The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event.* b. *If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analysis of the event.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(A)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Tracking and reporting mechanisms • Three examples of the review of critical incidents/sentinel events (date of incident, date incident determined to be a root cause event, and date root cause analysis completed must be provided) **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 18 bottom-19 top • 48. Quality Sentinel Event Policy • 50. Critical Incident and Sentinel Event Reporting FY22 • Example 1, 2, 3, 4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The identification and review of sentinel events is delegated to the CMHSP participants and the SUD Providers. Oversight is provided during the Delegated Managed Care Reviews using the Critical Incident Review Tool. Any areas that do not meet the expectations result in a recommendation for further improvement/development or a finding which results in a corrective action plan. The corrective action plan is then followed up on during the interim review to ensure it was completed and effective.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP develop a RCA template for all CMHSPs and SUD providers to use so the PIHP can ensure all required components are included.		
Required Actions: None.		
16. *Individuals involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(B)*	**HSAG Recommended Evidence:** • Policies and procedures • QAPIP program description • Job description • Three examples of the review of critical incidents/sentinel events (credentials of the review staff must be provided) **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 18-19 • 48. Quality_Sentinel Event Policy 3rd bullet • 38. CMHSP Critical Incident Review Tool (Example MCN) • Example 1, 3, 4	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The identification and review of sentinel events is delegated to the CMHSP participants and the SUD Providers. Oversight is provided during the Delegated Managed Care Reviews using the Critical Incident Review Tool to ensure the staff involved in the root cause analysis and review include the appropriate scope of care. The qualifications of staff that are members of the committee/council to review the events is reviewed as well as any adhoc members that are included within the RCA process and/or meeting. Any areas that do not meet the expectations result in a recommendation for further improvement/development or a finding which results in a corrective action plan. The corrective action plan is then followed up on during the interim review to ensure it was completed and effective.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
17. *All unexpected deaths of Medicaid members, who at the time of their deaths were receiving specialty supports and services, must be reviewed and include:* a. *Screens of individual deaths with standard information (e.g., coroner's report, death certificate).* b. *Involvement of medical personnel in the mortality reviews.* c. *Documentation of the mortality review process, findings, and recommendations.* d. *Use of mortality information to address quality of care.* e. *Aggregation of mortality data over time to identify possible trends.* *Note: "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(C)*	**HSAG Recommended Evidence:** • Policies and procedures • QAPIP program description • Tracking and reporting mechanisms • Three examples of the review of critical incidents/sentinel events involving deaths **Evidence as Submitted by the PIHP:** • 37. FY22 Medicaid Subcontract Delegation Grid page 15 • 01. FY22 QAPIP page 18-19 • 46. Quality-Critical Incidents Policy page 2 • Examples Sentinel_Crticial Events 1,2,3,4 • Examples Analysis Sentinel Critical Risk (Example FY22Q1 Death Report (mortality review)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The identification and review of sentinel events is delegated to the CMHSP participants and the SUD Providers. The analysis of local mortality data is completed at the local level.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
18. *Following immediate event notification to MDHHS, the PIHP submits information on relevant events through the Critical Incident Reporting System.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(D)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Critical Incident Reporting System oversight and reporting demonstration **Evidence as Submitted by the PIHP:**	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	01. QAPIP Plan 18-19 47. Quality Incident Review for SUD Policy 49. Critical Incident 2.26.2021	
PIHP Description of Process: All immediate reportable events are sent directly to the PIHP for reporting within 48 hours of notification. The CMHSPs enter all critical events, including immediate reportable events, into the critical incident reporting system for submission by the PIHP to MDHHS within the required timelines.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
19. *The PIHP reports the following five specific reportable events through the Critical Incident Reporting System:* a. *Suicide* b. *Non-suicide death* c. *Emergency medical treatment due to injury or medication error* d. *Hospitalization due to injury or medication error* e. *Arrest of the individual* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(E)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Critical Incident Reporting System oversight and reporting demonstration **Evidence as Submitted by the PIHP:** 01. QAPIP Plan page 18-19 46. Quality-Critical Incidents Policy 30. MSHN Critical Incident Performance Report FY22Q1 32. MSHN Critical Incident Performance Report SUDTP FY22Q2 31. MSHN Critical incident Performance Report SUDTP FY22Q1 49. Critical Incidents Work Flow 2.26.2021	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process:		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
20. *The QAPIP must describe how the PIHP will analyze, at least quarterly, the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(E)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Tracking and reporting mechanisms • Three examples of quarterly analysis of critical incidents, sentinel events, and risk events **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP Plan page 18-19 • 02. FY21 QAPIP Report with attachments Attachment 6, 7 • 46. Quality-Critical Incidents Policy • 47. Quality Incident Review for SUD Providers Policy • 30. MSHN Critical Incident Performance Report FY22Q1 • 32. MSHN Critical Incident Performance Report SUDTP FY22Q2 • 31. MSHN Critical Incident Performance Report SUDTP FY22Q1 • Examples CMHSP Analysis Sentinel Critical Risk	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
21. *The PIHP's QAPIP has a process for analyzing additional critical incidents that put individuals at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. These events minimally include:*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Three examples of the analysis of critical incidents that put individuals at risk of harm	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
a. *Actions taken by individuals who receive services that cause harm to themselves.* b. *Actions taken by individuals who receive services that cause harm to others.* c. *Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(F)*	**Evidence as Submitted by the PIHP:** • FY2022 QAPIP Plan 18, 19 • 37. FY22 Medicaid Subcontract Delegation Grid Quality Section page15 • 39. Delegated Managed Care Review (Standard 13.2. Example-MCN) • Examples Analysis Sentinel_Crticial	
PIHP Description of Process: The identification and review of risk events is delegated to the CMHSP participants. Oversight is provided during the Delegated Managed Care Reviews using the Critical Incident Review Tool. Any areas that do not meet the expectations result in a recommendation for further improvement/development or a finding which results in a corrective action plan. The corrective action plan is then followed up on during the interim review to ensure it was completed and effective. Examples are provided of the local analysis completed by the CMHSPs.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
22. *Following immediate event notification to MDHHS, the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid member whose death occurred within one year of the individual's discharge from a State-operated service.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section VIII(F)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Tracking mechanism/documentation • Three examples of written reports of member deaths/notification to MDHHS **Evidence as Submitted by the PIHP:** • 01. QAPIP Plan page 18 highlighted. • 49. Critical Incidents Work Flow 2.26.2021	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Examples Sentinel Critical Event 1, 2, 3 • Example Analysis Sentinel Critical Risk/Example of Risk Event Discharge from State Facility	
PIHP Description of Process: No deaths occurred for an individual within one year of a discharge from the State operated service. An example is provided of the form used to collect and analyze the information.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, PIHP staff members confirmed they were not made aware of any deaths of members that occurred within one year of being discharged from a state-operated service. **Recommendations:** During the site review, PIHP staff members indicated that they are not notified of a member's death if the member was discharged from a state-operated service prior to the member's death. However, HSAG recommends that the PIHP develop a process to ensure that when notified through any sources (e.g., contracted provider, family member, MDHHS) of a member's death, and after immediate notification to MDHHS, the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid member whose death occurred within one year of the individual's discharge from a state-operated service in the event the PIHP is ever notified of a death in these circumstances.		
Required Actions: None.		
Behavior Treatment Review		
23. *The QAPIP quarterly reviews analyses of data from the Behavior Treatment Review Committee where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.* a. *Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and have been approved during person-centered planning by the member or his/her guardian, may be used with members.* b. *Data shall include numbers of interventions and length of time the interventions were used per individual.*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • QAPIP program description • Quarterly reviews of data from the Behavior Treatment Review Committee **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP Plan page 22, 34, 35 • 51. Quality BTP Review Procedure section D and E. • 52. Quality CMHSP Participant Monitoring Procedure page 1. B-6, C-2 • 40. MSHN Behavior Treatment Review Data FY22Q2	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(K)(2)(a) *QAPIPs for Specialty PIHPs, Section IX*	• 53. (Example-BABH) FY22Q1 Behavior Treatment Summary • 54. MSHN Behavior Intervention Description of Project Study • 55. BTPR Data Collection FY22 Final 032302022 • 39. Delegated Managed Car Review (Example MCN) Standard 9.1, 9.2, 13.4.	
PIHP Description of Process: Behavior Treatment Data Collection is delegated to the CMHSP Participants. A subset of the data is submitted to the PIHP for quarterly analysis and regional action for improvements through the regional Quality Improvement Council(QIC), regional Clinical Leadership Committee(CLC), and the regional Behavior Treatment work group. Adherence to the Behavior Treatment Standards are monitored during the Delegated Managed Care Site Review.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Assessments of Member Experience		
24. *The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services.* a. *These assessments must be representative of the individuals served and the services and supports offered.* b. *The assessments must address the issues of the quality, availability, and accessibility of care.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(A)*	**HSAG Recommended Evidence:** • QAPIP program description • QAPIP work plan • Quantitative and qualitative assessments of member experience **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP Plan page 17, 30, 31 • 02. FY22 QAPIP Report with attachments page 53(document), and ➢ Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21 ➢ Attachment 9 Member Satisfaction Annual Report ➢ Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Satisfaction Surveys are completed annually. The data is separated by program for follow up specific to population groups such as case management/supports coordination, outpatient therapy for both children and adults. MSHN combines the data for a regional analysis to determine any regional action for improvement needed. If specific action is identified through a causal factor analysis it is identified under the interventions/recommendations.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
25. *As a result of the assessments, the PIHP:* a. *Takes specific action on individual cases as appropriate;* b. *Identifies and investigates sources of dissatisfaction;* c. *Outlines systemic action steps to follow up on the findings;* d. *Informs practitioners, providers, recipients of service, and the Governing Body of assessment results; and* e. *Ensures the incorporation of individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.* f. *Evaluates the effects of activities implemented to improve satisfaction.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(B-D)*	**HSAG Recommended Evidence:** • QAPIP program description and evaluation • Quantitative and qualitative assessments review and analysis • Assessment results notifications to stakeholders **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP Plan page 17, 30, 31 • 02. FY22 QAPIP Report with attachments page 53(document), and ➢ Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21 ➢ Attachment 9 Member Satisfaction Annual Report ➢ Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments • 69. CMHSP Example (BABH) 2021 MHSIP-YSS Summary Report • 14. 20210128 QIC Meeting Snapshot • 18. RCAC Meeting Snapshot 2021_10_08 • 70. Provider Meeting Agenda September 2021	☐ Met ☒ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Each CMHSP/SUD provider follows up on individual cases of dissatisfaction, and individual comments provided on the satisfaction survey. MSHN combines the data for a regional analysis to determine any regional action for improvement needed. If specific action is identified through a causal factor analysis it is identified under the interventions/recommendations.		
HSAG Findings: The PIHP provided evidence that supported it identified and investigated sources of dissatisfaction, outlined systemic action steps to improve satisfaction, informed stakeholders of the results of the member satisfaction survey, and included members receiving LTSS in the review and analysis. However, evidence reviewed did not demonstrate that the PIHP evaluated the effects of activities implemented to improve satisfaction, and PIHP staff members confirmed this. **Recommendations:** Although the PIHP's member newsletter indicated that members were able to obtain information related to the QAPIP on the website, HSAG recommends that the PIHP notify members specifically of the results of the member satisfaction survey.		
Required Actions: As a result of the member satisfaction assessments, the PIHP must evaluate the effects of activities implemented to improve satisfaction.		
Service Verification		
26. *The written description of the PIHPs QAPIP must address how it will verify whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors.* a. *The PIHP must submit to the State for approval its methodology for verification.* b. *The PIHP must annually submit its findings from this process and provide any follow-up actions that were taken because of the findings.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section XII(A-B)*	**HSAG Recommended Evidence:** • QAPIP program description • QAPIP program evaluation • Methodology for verification of services/submission to MDHHS • Annual report of findings **Evidence as Submitted by the PIHP:** • 01. FY2022 QAPIP Plan page 24, 32 • 02. FY22 QAPIP Report with attachments page 56-57(document), and ➢ Attachment 12.	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
QAPIP Reviews, Analysis, and Evaluation		
27. The PIHP must develop a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation must include: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. d. *The annual effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for members as a result of QAPI activities and interventions carried out by the PIHP.* e. *The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives.* *42 CFR §438.330(e)(2)* *Contract Schedule A—1(K)(3)(a)*	**HSAG Recommended Evidence:** • QAPIP program evaluation • Evidence of QAPIP program evaluation annual submission to MDHHS **Evidence as Submitted by the PIHP:** • 02. FY22 QAPIP Report with attachments • 03. QAPIP Submission-Email approval of date • 04. Confirmation MDHHS QAPIP Annual Submission	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: Although the PIHP's QAPIP evaluation included the performance measures on which it was required to report, the outcomes and trended results of each PIP, analysis of the quality of care, and trends in service delivery and health outcomes over time, the evaluation did not include the results of any efforts to support community integration for members using LTSS.		
Required Actions: The QAPIP evaluation must include the results of any efforts to support community integration for members using LTSS.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
28. *Information on the effectiveness of the PIHP's QAPIP must be provided annually to network providers and to members upon request.* *Contract Schedule A—1(K)(3)(a)*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Annual effectiveness review submitted to providers/members **Evidence as Submitted by the PIHP:** https://midstatehealthnetwork.org/stakeholders-resources/quality-compliance/compliance-reports 29. Website Screen Shots 41. CMHSP QAPIP Distribution 42. MSHN Newsletter (Constant Contact) Email Distribution 43. SUD Providers QAPIP Distribution	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Staffing		
29. *The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services.* a. *The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section XII*	**HSAG Recommended Evidence:** • Policies and procedures • QAPIP program description • Job descriptions **Evidence as Submitted by the PIHP:** • 02. FY22 QAPIP Plan page 23, 24 • 61. PNM Provider Network Management Policy page 2-3 • 57. HR Personnel Manual page 6-7 • 58. Office Assistant Receptionist Job Description	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
30. *Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:* a. *Educational background* b. *Relevant work experience* c. *Cultural competence* d. *Certification, registration, and licensure as required by law* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section XII(A)*	**HSAG Recommended Evidence:** • Policies and procedures • QAPIP program description • Job descriptions **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP page 23 • 61. PNM Provider Network Management Policy • 57. HR Personnel Manual pages 6-7 • 56. Chief Behavioral Health Officer Job Description	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard XIII—Quality Assessment and Performance Improvement Program						
Met	=	28	X	1	=	28
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	30	**Total Score**		=	28
Total Score ÷ Total Applicable					=	93%

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
File Reviews		
13. The PIHP complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. *42 CFR §438.214(e)* *Credentialing and Re-credentialing Processes*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The initial credentialing file review identified the following deficiencies: • For one case, no attestation regarding felony convictions was present in the file. • For four cases, evidence that the provider was given written notification of the credentialing decision was not found in the file. • For one case, the credentialing process occurred outside the 90-day time frame requirement. • For one case, a completed National Practitioner Data Bank (NPDB) query was present in the file; however, it was dated over 180 days prior to the credentialing decision date, outside of the PIHP's verification time limit required by policy. • For one case, no NPDB query was present in the file. In lieu of the query, the PIHP or its delegated entity must verify a minimum five-year history of professional liability claims resulting in judgment or settlement, disciplinary status with regulatory board or agency, and Medicare/Medicaid sanctions. Although the files contained reports from the Office of Inspector General (OIG), MDHHS sanctions list, VerifyComply, and Licensing and Regulatory Affairs (LARA), no verification of a minimum five-year history of professional liability claims resulting in judgment or settlement was present in the file. **Recommendations:** Although PIHP staff members stated that the LARA is utilized to verify graduation from an accredited school as this is a requirement for certain licenses, HSAG recommends the PIHP obtain verification of graduation from an accredited school directly from the source (e.g., university,		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
clearinghouse). Alternatively, the PIHP should maintain evidence that LARA performs primary source verification (PSV) for graduation from an accredited school and the provider types for which this applies.		
Required Actions: The PIHP must comply with, and ensure delegates performing credentialing activities comply with, all initial credentialing requirements as outlined in its contract with MDHHS.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
14. The PIHP complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PNM_Credentialing_-_Individual_Practitioner_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The recredentialing file review identified the following deficiencies: • For two cases, no attestation regarding felony convictions was present in the file. • For three cases, documentation was not provided to support that member concerns, grievances, appeal information, or quality issues were evaluated. • For one case, the recredentialing process occurred outside the two-year time frame requirement. • For one case, a completed NPDB query was present in the file; however, it was dated after the recredentialing decision date. • For one case, no evidence was found in the file that the provider was verified for Medicare/Medicaid sanctions; state sanctions; or limitations on licensure, registration, or certification.		
Required Actions: The PIHP must comply with, and ensure delegates performing recredentialing activities comply with, all recredentialing requirements as outlined in its contract with MDHHS.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
15. The PIHP complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**- HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Credentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • Credentialing Committee Minutes – June 2020	☐ Met ☒ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Credentialing Committee Minutes – 9.29.21	
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The initial organizational credentialing file review identified the following deficiencies: • For three cases, evidence that the provider was given written notification of the credentialing decision was not found in the file. • For two cases, the credentialing process occurred outside the 90-day time frame requirement. • For one case, no evidence that the provider was validated to be approved by an accredited body, or for those providers that are not accredited, that an on-site quality assessment or alternative quality assessment was conducted. • For one case, no evidence that the provider was validated to not be excluded from Medicaid or Medicare participation was present in the file. In follow up, the PIHP submitted a VerifyComply report that included this provider was reviewed for exclusions; however, it was dated a month after the credentialing decision date.		
Required Actions: The PIHP must comply with, and ensure delegates performing credentialing activities comply with, all initial organizational credentialing requirements as outlined in its contract with MDHHS.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
16. The PIHP complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. *42 CFR §438.214* *Credentialing and Re-credentialing Processes*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • PNM_Credentialing_Recredentailing_Policy • PN_Provider_Network_-_Credentialing_-_Organizational_Providers_Procedure • Credentialing Committee Minutes – June 2020 • Credentialing Committee Minutes – 9.29.21	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: MSHN includes the requirement in the PNM Credentialing Recredentialing Policy and as outlined in the CMHSP (Medicaid Subcontracting Agreement and the SUD (SUD Treatment) contract. MSHN monitors compliance with the requirement using the DMC Review Tool Credentialing Section. MSHN's Credentialing Committee reviews Organization credentialing and recredentialing along with MSHN's LIP credentialing and recredentialing.		
HSAG Findings: The organizational recredentialing file review identified the following deficiencies: • For two cases, no evidence that the provider was validated to not be excluded from Medicaid or Medicare participation was present in the file. In follow up, the PIHP submitted a VerifyComply report that included this provider was reviewed for exclusions; however, it was dated a month after the credentialing decision date. • For one case, although a certification of accreditation was present in the file, it had an expiration date prior to the credentialing decision date. No evidence was submitted to support that the provider had an active accreditation at the time of the credentialing decision, or that an on-site quality assessment or alternative quality assessment was conducted.		
Required Actions: The PIHP must comply with, and ensure delegates performing credentialing activities comply with, all organizational recredentialing requirements as outlined in its contract with MDHHS.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Notice of Privacy Practices		
11. The PIHP's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the PIHP, and of the member's rights and the PIHP's legal duties with respect to PHI. a. The PIHP must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The PIHP must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). *45 CFR §164.520(a)(1)* *45 CFR §164.520(b)(1)(i-viii)* *45 CFR §164.520(c)(1-3)*	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form **Evidence as Submitted by the PIHP:** • Policies/Procedures ○ Confidentiality and Notice of Privacy Policy ○ Consent to Share Information Policy • Training Materials ○ 2022 MSHN Compliance Plan (pgs. 9, 10, 12 -13) ○ MSHN Compliance Plan Acknowledgment Form ○ MSHN PIHP Compliance Training – January 1, 2022 – Relias (pgs. 31 -33) • MSHN Privacy Notice (Pgs. 4 - 5) • Consent to Share Behavioral Health Information Form	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The HIPAA Notice of Privacy Practices did not include a description of the types of uses and disclosures that require an authorization under 45 CFR §164.508(a)(2)-(a)(4), including psychotherapy notes, marketing, and the sale of PHI. Additionally, although the notice included a statement that individuals may complain to the local agency, the PIHP, and to the Secretary if they believe their privacy rights have been violated and also included organizations, addresses, and telephone numbers, the notice did not include a statement that the individual will not be retaliated against for filing a complaint, nor did the notice contain the name or title of the person to contact for further information as required by 45 CFR §164.530(a)(1)(ii). Finally, the notice did not include the right of an individual, including an individual who has agreed to receive the notice electronically, to obtain a paper copy of the notice from the PIHP upon request. Also, although the PIHP indicated that a Notice of Privacy Practices is required to be part of the new client packet at intake, and also stated that the Notice of Privacy Practices is supposed to be provided as part of the annual person-centered planning process and posted at the service location, the PIHP did not provide evidence that this is occurring or provide other evidence to support that members receive a Notice of Privacy Practices upon enrollment, at least every three years, and when there is a material change to the notice.		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Federal rule under 45 CFR §164.520(b)(1)(i-viii) requires the Notice of Privacy Practices to specifically include a statement indicating, "*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully*." The PIHP's Notice of Privacy Practices indicated, "*…describes how health information….*" Although not noted as a deficiency, HSAG recommends the PIHP consider updating the statement to mirror the statement required under federal rule.		
Required Actions: The PIHP must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). The PIHP must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3).		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Grievances		
4. The PIHP must acknowledge receipt of each grievance. *42 CFR §438.406(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(e)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 13 • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. 37 • MSHN Notice of Grievance Receipt	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the grievance was not acknowledged until nearly six weeks after the grievance was filed, which does not meet the intent of an acknowledgement. Although MDHHS does not define a time frame requirement in contract, HSAG considers six weeks for an acknowledgement excessive. Additionally, the PIHP's grievance training materials required acknowledgement letters to be sent within three days. **Recommendations:** HSAG recommends that the PIHP enhance quality assurance (QA) processes to ensure grievance acknowledgement letters are grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member. Additionally, the grievance and appeal resolution process training document required written acknowledgment of the grievance to be mailed within three business days. However, this standard was not defined in policy. As such, HSAG recommends that the PIHP update its policy accordingly.		
Required Actions: The PIHP must acknowledge receipt of each grievance.		
PIHP Corrective Action Plan		
Root Cause Analysis:		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Timely Resolution and Notification of Grievances		
6. The PIHP must resolve each grievance, and provide *written* notice *of resolution*, as expeditiously as the member's health condition requires, within MDHHS timeframes that may not exceed the timeframes specified in 42 CFR §438.408. a. The PIHP must resolve the grievance and send notice to the affected parties within ninety (90) calendar days from the day the PIHP receives the grievance. b. The notice must meet the standards described at 42 CFR §438.10. *42 CFR §438.408(a)* *42 CFR §438.408(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(v); (L)(2)(k)* *Appeal and Grievance Resolution Processes Technical Requirement—VII(D)(1); VII(D)(3)(a)*	**HSAG Recommended Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 14 • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. 37 • MSHN Notice of Grievance Resolution	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the grievance was not resolved within 90 calendar days (resolved in 98 days). After the site review, PIHP staff members acknowledged that the resolution letter was not sent out timely due to staff error.		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP enhance QA processes to ensure grievance resolution notices are professional, grammatically correct, free of errors, have abbreviations spelled out with first use, and are written to the member. Additionally, HSAG recommends that the PIHP require each grievance resolution notice, or a certain percentage of grievance resolution notices, be assessed for professionalism and reading grade level prior to mailing. The reading grade level must be written at the 6.9 reading grade level.		
Required Actions: The PIHP must resolve each grievance and provide written notice of resolution to the affected parties within 90 calendar days from the day the PIHP receives the grievance.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
Handling of Appeals		
16. The PIHP must acknowledge receipt of each appeal. *42 CFR §438.406(b)(1)* *42 CFR §438.228* *Contract Schedule A—1(L)(2)(e)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(B)(2)*	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 38\9 • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 10 • MSHN Notice of Grievance Receipt • MSHN FY 2022 MEDICAID SUBCONTRACTING AGREEMENT – Gratiot, pg. 37	☐ Met ☒ Not Met ☐ NA

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the appeal was not acknowledged until 44 days after receipt of the appeal request, which was 14 days after the resolution due date. Although MDHHS does not define a time frame requirement in contract, HSAG considers 44 days for an acknowledgement excessive. **Recommendations:** HSAG recommends that the PIHP define a time frame in which members are mailed the written acknowledgement of the appeal (e.g., within three business days of receipt of the appeal). Additionally, HSAG recommends that the PIHP enhance QA processes to ensure appeal acknowledgement letters are grammatically correct, free from errors, have abbreviations spelled out with first use, and are written to the member. Further, the acknowledgment letters informed members that they may request continuation of benefits within 10 calendar days from the date of the acknowledgement notice. However, this is inaccurate as a member must request continuation of benefits within 10 calendar days of the notice of the ABD, not from the appeal acknowledgement letter. The acknowledgement letter also informed members that a request for an SFH must be received within 10 calendar days of the acknowledgement letter notice. However, as the appeal is not yet completed, the member does not have access to an SFH. As this language was template language included in MDHHS' letter template, HSAG recommends that the PIHP consult with MDHHS to have this template revised accordingly. HSAG will also recommend that MDHHS revise or remove this language in the letter template.		
Required Actions: The PIHP must acknowledge receipt of each appeal.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Resolution and Notification of Appeals		
21. The PIHP must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than thirty (30) calendar days from the day the PIHP receives the appeal. *42 CFR §438.408(a)* *42 CFR §438.408(b)(2)* *42 CFR §438.228* *Contract Schedule A—1(L)(1)(e)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(1)*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 11 • MSHN Adverse Benefit Determination Notice • MSHN Notice of Appeal Receipt	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the standard appeal was not resolved with 30 calendar days (resolved in 45 calendar days).		
Required Actions: The PIHP must resolve standard appeals and send notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the PIHP receives the appeal.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted	

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	☐ Accepted With Recommendations ☐ Not Accepted	
25. In the case that the PIHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process. The member may initiate a State fair hearing. *42 CFR §438.408(c)(3)* *42 CFR §438.408(f)(1)(i)* *42 CFR §438.228* *Contract Schedule A—1(L)(7)(c)(i)* *MDHHS Appeal and Grievance Resolution Processes Technical Requirement—III*	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • MSHN_ FY22 Member Handbook.GRATIOT, pg. 39 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_ draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 5 • MSHN Adverse Benefit Determination Notice	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which the appeal was not resolved timely and, when it was realized that the time frame expired (which was 14 days after the appeal time frame expired), the appeal process was continued. However, once the appeal time frame has expired, the appeal process is deemed exhausted (i.e., appeal denied), and members must be informed of their SFH rights for untimely appeal resolutions.		
Required Actions: For untimely appeal resolutions, the PIHP must ensure that the appeal is deemed exhausted, and members are provided immediate access to their SFH rights.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
27. For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice. *42 CFR §438.408(d)(2)(ii)* *42 CFR §438.228* *42 CFR §438.228* *Contract Schedule A—1(L)(8)(b)(iv)* *Appeal and Grievance Resolution Processes Technical Requirement—VI(C)(4)(a)*	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of oral notice for an expedited appeal resolution • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY20 • CS_Medicaid_Enrollee_Appeals_Grievances_Policy_FY22_draft • Appeal-and-Grievance-Resolution-Processes-Technical-Requirement, pg. 12	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified one record in which there was no documentation to confirm the member was provided oral notice of the expedited appeal resolution. After the site review, the PIHP provided an email communication between staff members in response to the case file review findings that suggested the member was seen in person and that a staff member later contacted the member via telephone with the determination. However, documentation of these contacts was not included in the appeal case file at the time of the appeal resolution determination.		
Required Actions: For notice of an expedited appeal resolution, the PIHP must make reasonable efforts to provide oral notice.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface (API)		
7. The PIHP must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCO. Information must be made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed. b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments. c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the MCO. e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. *42 CFR §438.242(b)(5)* *42 CFR §431.60*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the PIHP:** • 7a_Payer Data Exchange - PCE User Manual • 7b_PIX_9_3_API_Documentation • https://fhir.pcesecure.com:9443/PCEFhirServer/MSH/Organization • https://fhir.pcesecure.com:9443/PCEFhirServer/MSH/Practitioner?name=a	☐ Met ☒ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: REMI provide access to the required data as data becomes available. There is no delay from receipt or entry of data to when it becomes available. Consumers must request and register for data to be made available.		
HSAG Findings: The PIHP had not implemented a Patient Access API that meets the requirements of 42 CFR §431.60 (member access to and exchange of data). **Recommendations:** As the PIHP implements a CAP to address this deficiency, HSAG recommends the PIHP thoroughly review all published guidance to ensure its Patient Access API meets CMS' implementation guidelines (e.g., https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index). Additionally, while the Payor-to-Payor API was not included as part of this year's compliance review, HSAG recommends that the PIHP familiarize itself with CMS' technical guidelines and proceed with its implementation.		
Required Actions: The PIHP must implement a Patient Access API that meets all requirements under 42 CFR §431.60 (member access to and exchange of data) and complies with the implementation guidelines required by CMS.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Assessments of Member Experience		
25. *As a result of the assessments, the PIHP:* a. *Takes specific action on individual cases as appropriate;* b. *Identifies and investigates sources of dissatisfaction;* c. *Outlines systemic action steps to follow up on the findings;* d. *Informs practitioners, providers, recipients of service, and the Governing Body of assessment results; and* e. *Ensures the incorporation of individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.* f. *Evaluates the effects of activities implemented to improve satisfaction.* *Contract Schedule A—1(K)(2)(a)* *QAPIPs for Specialty PIHPs, Section X(B-D)*	**HSAG Recommended Evidence:** • QAPIP program description and evaluation • Quantitative and qualitative assessments review and analysis • Assessment results notifications to stakeholders **Evidence as Submitted by the PIHP:** • 01. FY22 QAPIP Plan page 17, 30, 31 • 02. FY22 QAPIP Report with attachments page 53(document), and ➢ Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21 ➢ Attachment 9 Member Satisfaction Annual Report ➢ Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments • 69. CMHSP Example (BABH) 2021 MHSIP-YSS Summary Report • 14. 20210128 QIC Meeting Snapshot • 18. RCAC Meeting Snapshot 2021_10_08 • 70. Provider Meeting Agenda September 2021	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: Each CMHSP/SUD provider follows up on individual cases of dissatisfaction, and individual comments provided on the satisfaction survey. MSHN combines the data for a regional analysis to determine any regional action for improvement needed. If specific action is identified through a causal factor analysis it is identified under the interventions/recommendations.		
HSAG Findings: The PIHP provided evidence that supported it identified and investigated sources of dissatisfaction, outlined systemic action steps to improve satisfaction, informed stakeholders of the results of the member satisfaction survey, and included members receiving LTSS in the review and analysis. However, evidence reviewed did not demonstrate that the PIHP evaluated the effects of activities implemented to improve satisfaction, and PIHP staff members confirmed this.		

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Although the PIHP's member newsletter indicated that members were able to obtain information related to the QAPIP on the website, HSAG recommends that the PIHP notify members specifically of the results of the member satisfaction survey.		
Required Actions: As a result of the member satisfaction assessments, the PIHP must evaluate the effects of activities implemented to improve satisfaction.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
QAPIP Reviews, Analysis, and Evaluation		
27. The PIHP must develop a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation must include: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. d. *The annual effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for members as a result of QAPI activities and interventions carried out by the PIHP.*	**HSAG Recommended Evidence:** • QAPIP program evaluation • Evidence of QAPIP program evaluation annual submission to MDHHS **Evidence as Submitted by the PIHP:** • 02. FY22 QAPIP Report with attachments • 03. QAPIP Submission-Email approval of date • 04. Confirmation MDHHS QAPIP Annual Submission	☐ Met ☒ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
e. *The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives.* *42 CFR §438.330(e)(2)* *Contract Schedule A—1(K)(3)(a)*		
PIHP Description of Process: N/A		
HSAG Findings: Although the PIHP's QAPIP evaluation included the performance measures on which it was required to report, the outcomes and trended results of each PIP, analysis of the quality of care, and trends in service delivery and health outcomes over time, the evaluation did not include the results of any efforts to support community integration for members using LTSS.		
Required Actions: The QAPIP evaluation must include the results of any efforts to support community integration for members using LTSS.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	