Michigan Department of Health and Human Services (MDHHS)

*Behavioral Health and Developmental Disabilities Administration*

# 2017–2018 External Quality Review Compliance Monitoring Report *for* Prepaid Inpatient Health Plans

## Region 5—Mid-State Health Network

*December 2018*

HSAG HEALTH SERVICES ADVISORY GROUP

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# 1. Overview

## Background

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, its agent that is not a Medicaid prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO) must conduct a review to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance monitoring reviews of the PIHPs.

## Description of the External Quality Review Compliance Monitoring Review

HSAG performed a desk review of **Mid-State Health Network**'s documents and completed an on-site review that included reviewing additional documents and case files and conducting interviews with key **Mid-State Health Network** staff members. HSAG evaluated the degree to which **Mid-State Health Network** complied with federal Medicaid managed care regulations and the associated MDHHS contract requirements in the following eight of 17 performance categories:

- Standard VI—Customer Service
- Standard VII—Grievance Process
- Standard IX—Subcontracts and Delegation
- Standard X—Provider Network
- Standard XII—Access and Availability
- Standard XIV—Appeals
- Standard XV—Disclosure of Ownership, Control, and Criminal Convictions
- Standard XVII—Management Information Systems

For the 2017–2018 review period, MDHHS has elected to conduct a review of eight performance standards. The remaining nine standards will be reviewed during the 2018–2019 review period. Several modifications to the review process were made for this year's compliance monitoring review compared to previous years. These modifications are discussed in *Section 2—Methodology* of this report.

Following this overview (**Section 1**), this report includes:

- **Section 2**—A description of the methodology HSAG used to conduct the compliance monitoring review and to draft its findings report.
- **Section 3**—A summary of HSAG's findings regarding **Mid-State Health Network**'s performance results.
- **Section 4**—A statement regarding the performance improvement process.
- **Appendix A**—The completed review tool used to evaluate **Mid-State Health Network**'s compliance with each requirement contained within the standards.

## Overview of Findings

Table 1.1 presents the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (*N/A). Table 1.1 also presents **Mid-State Health Network**'s overall compliance score for each standard, the totals across the eight standards reviewed, and the total compliance score across all standards for the 2017–2018 compliance monitoring review. Refer to *Appendix A—Review of the Standards* for a detailed description of the findings.

**Table 1.1—Summary of 2017–2018 Compliance Monitoring Review Results**

| Standard | Total # of Applicable Elements | Number of Elements | | | Total Compliance Score |
|---|---|---|---|---|---|
| | | *Met* | *Not Met* | *N/A* | |
| Standard VI—Customer Service | 39 | 34 | 5 | 0 | **87%** |
| Standard VII—Grievance Process | 26 | 24 | 2 | 0 | **92%** |
| Standard IX—Subcontracts and Delegation | 11 | 10 | 1 | 0 | **91%** |
| Standard X—Provider Network | 12 | 12 | 0 | 1 | **100%** |
| Standard XII—Access and Availability | 19 | 18 | 1 | 0 | **95%** |
| Standard XIV—Appeals | 54 | 50 | 4 | 0 | **93%** |
| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | 14 | 14 | 0 | 0 | **100%** |
| Standard XVII—Management Information Systems | 14 | 14 | 0 | 0 | **100%** |
| **Total Compliance Score** | **189** | **176** | **13** | **1** | **93%** |

**Total # of Applicable Elements—**The total number of elements within each standard minus any elements that received designations of *NA*.
**Total Compliance Score—**Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

**Mid-State Health Network** achieved full compliance in three out of the eight standards reviewed. The remaining five standards have identified opportunities for improvement. **Mid-State Health Network** demonstrated compliance in 176 out of 189 elements, with an overall compliance score of 93 percent.

# 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 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The review standards are separated into 17 performance areas. MDHHS has elected to review the full set of standards over two review periods, as displayed in Table 2.1.

**Table 2.1—Division of Standards Over Review Periods**

| 2017–2018 | 2018–2019 |
|---|---|
| Standard VI—Customer Service | Standard I—Quality Assessment Performance Improvement Program (QAPIP) Plan and Structure |
| Standard VII—Grievance Process | Standard II—Performance Measurement and Improvement |
| Standard IX—Subcontracts and Delegation | Standard III—Practice Guidelines |
| Standard X—Provider Network | Standard IV—Staff Qualifications and Training |
| Standard XII—Access and Availability | Standard V—Utilization Management |
| Standard XIV—Appeals | Standard VIII—Enrollees' Rights and Protections |
| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | Standard XI—Credentialing |
| Standard XVII—Management Information Systems | Standard XIII—Coordination of Care |
| | Standard XVI—Confidentiality of Health Information |

This report presents the results of the 2017–2018 review period. MDHHS and the individual PIHPs use the information and findings from the compliance monitoring reviews to:

- Evaluate the quality and timeliness of and access to behavioral healthcare 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 compliance reviews of the PIHPs, HSAG developed standardized tools for use during the reviews. The content of the tools was based on applicable federal regulations and the requirements set forth in the contract agreement between MDHHS and the PIHPs. The review processes and scoring methodology used by HSAG in evaluating the PIHPs' compliance were consistent with the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1]

For each of the PIHP reviews, HSAG followed the same basic steps:

**Pre-on-site review** activities included:

- Scheduling the on-site review.
- Developing the compliance monitoring review tools (*Documentation Request and Evaluation Tool*, *Desk Audit Form, Customer Handbook Checklist, Provider Network Checklist, Grievance Audit Tool*, and *Appeal Audit Tool*).
- Preparing for and forwarding to each PIHP the compliance monitoring review tools and instructions for submitting the requested documentation.
- Hosting a training webinar for all PIHPs in preparation for the review.
- Generating the sample selection for the on-site grievance and appeal case files reviews.
- Conducting a desk review of all completed review tools and supporting documentation submitted by the PIHP. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PIHP's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Preparing and forwarding the on-site review agenda to the PIHP.

**On-site review** activities included:

- An opening session, with introductions and a review of the agenda for and logistics of HSAG's two-day review activities.
- A review of 10 grievance and 10 appeal case files.[2-2]
- A review of the online customer handbook and provider directory.
- Interview sessions with the PIHP's key administrative and program staff members.
- A closing session during which HSAG reviewed and summarized preliminary findings.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: April 18, 2018.

[2-2] For PIHPs that had fewer than 10 grievance or appeal case files during the review period, HSAG reviewed the total number of cases that were available.

Reviewers used the compliance monitoring review tools to document findings regarding PIHP compliance with the standards. Based on the evaluation of findings, reviewers noted compliance with each element. The *Documentation Request and Evaluation Tool* listed the score for each element evaluated.

HSAG evaluated and scored each element addressed in the compliance monitoring review as *Met* (*M*), *Not Met* (*NM*), or *Not Applicable* (*NA*). The overall score for each of the eight standards was determined by totaling the number of *Met* (1 point), *Not Met* (0 points), and *Not Applicable* (no value) elements, then dividing the summed score by the total number of applicable elements for that standard. The scoring methodology is displayed in Table 2.2.

**Table 2.2—Scoring Methodology[2-3]**

| Compliance Designation | Point Value | Definition |
|---|---|---|
| ***Met*** | Value = 1 point | ***Met*** indicates full compliance defined as *all* of the following:<br>• All documentation and data sources reviewed, including PIHP data and documentation, MDHHS data and documentation, file reviews, and systems demonstrations for a regulatory provision or component thereof are present and provide supportive evidence of congruence.<br>• Staff members provide to reviewers responses consistent with one another, with the data and documentation reviewed, and with the regulatory provisions. |
| ***Not Met*** | Value = 0 points | ***Not Met*** indicates noncompliance defined as *one or more* of the following:<br>• Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision.<br>• Staff members demonstrate little or no knowledge of processes or issues addressed by the regulatory provisions. |
| ***Not Applicable*** | No value | • The requirement does not apply to the PIHP line of business during the review period. |

Several modifications to the review methodology may affect the comparability of findings from the 2017–2018 review to prior review periods. These modifications include, but are not limited to the following:

- The *Documentation Request and Evaluation Tool* was revised to align with new and/or revised federal and contract requirements, where applicable.
- The number of performance areas increased from 15 to 17. Standard XVII—Management Information Systems was reviewed during the 2017–2018 review period and Standard XVI—Confidentiality of Health Information will be reviewed during the 2018–2019 review period.

[2-3] This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

- Case file review findings were used in conjunction with the PIHP's supporting documentation to determine compliance with scoring elements, when applicable.
- *Substantially Met* and *Partially Met* were removed from the scoring methodology.
- The number of scoring elements increased. While many requirements remained the same, HSAG divided prior requirements with multiple components into separate elements that were scored independently.

## Description of Data Obtained and Related Time Period

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management and monitoring reports.
- Provider manual and provider directory.
- Provider service and delegation agreements and contracts.
- Customer handbook and other written informational materials.
- Grievance and appeal records.
- Narrative and/or data reports across a broad range of performance and content areas.

Findings for the *Standard XII—Access and Availability* were derived from the Michigan Mission-Based Performance Indicator System (MMBPIS)—Access Domain, Performance Indicators 1 through 4b. The PIHPs routinely reported quarterly performance data to MDHHS. MDHHS provided data directly to HSAG for the three reporting quarters.

Interviews with PIHP staff (e.g., PIHP leadership, customer services staff, and grievances and appeals staff) provided additional information.

Table 2.3 lists the major data sources that HSAG used in determining the PIHP's performance in complying with requirements and states the time period to which the data applied.

**Table 2.3—Data Sources and Applicable Time Periods**

| Data Source | Time Period to Which the Data Applied |
|---|---|
| Desk review documentation | January 1, 2017, through March 31, 2018 |
| Interviews | January 1, 2017, through March 31, 2018 |
| MMBPIS | April 1, 2017, through December 31, 2017 |
| Grievance and appeal records | October 1, 2017, through December 31, 2017 |

# Standard VI—Customer Service

## *Performance Strengths*

While **Mid-State Health Network** maintained a customer service line and customer service specialist, most customer service functions were delegated to the Community Mental Health Services Programs (CMHSPs) and monitored during managed care site reviews. The CMHSPs each retained their own customer handbook, which mainly consisted of standardized language used throughout the region but also allowed for personalized text specific to each CMHSP. **Mid-State Health Network** had a regional Customer Service Committee to oversee customer service functions and requirements. Meeting minutes were thorough and documented collaborative discussions on topics such as educational materials, changes to federal and State requirements, updates to the customer handbook, policy, and reporting requirements.

## *Required Actions*

**Mid-State Health Network**'s customer handbook did not include each enrollee's right to use any hospital or other setting for emergency care, or information on how to report suspected fraud and abuse. Additionally, an error in the handbook identified that a standard appeal decision would be made within 60 calendar days instead of 30 calendar days. Lastly, several CMHSPs posted outdated versions of the customer handbook on their websites with one dating back to 2014. **Mid-State Health Network** must ensure its customer handbook contains all content required by its contract with MDHHS and 42 CFR 438.10(g).

Several deficiencies related to the provider directory requirements were identified. **Mid-State Health Network**'s behavioral health and substance use disorder (SUD) provider directories did not contain all required content including, but not limited to, cultural and linguistic capabilities (if they have completed cultural competency training) and any non-English languages they speak (including American Sign Language), whether the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new patients. Additionally, there was a lack of oversight of CMHSP compliance with provider directory requirements. Several of the CMHSPs had outdated local provider directories posted on their websites, with two dating back to 2015 and 2016. Details of the findings can be found in *Appendix A—Review of the Standards*. Prior to the on-site review, **Mid-State Health Network** began initiating actions to address deficiencies related to the provider directory. New draft policies and procedures have been developed as well as a new proposed format for the regional online directory with searchable fields.

### Recommendations

**Mid-State Health Network** should develop a formal process of monitoring the content posted on CMHSP websites. Specifically, ensuring the customer handbook, provider directory, and other enrollee informational materials are current and meet all federal and contractual requirements.

## Standard VII—Grievance Process

### Performance Strengths

**Mid-State Health Network** demonstrated appropriate processes for ensuring the individuals making grievance decisions were not involved in any previous level of review or decision making and staff members had the appropriate clinical expertise to review and resolve grievances when applicable. **Mid-State Health Network** also consistently acknowledged and resolved grievances in a timely manner. Additionally, the Notice of Grievance Resolution letters included the appropriate content, including the results of the grievance process and the date the grievance process was concluded. During the interview session, **Mid-State Health Network** staff members shared that **Mid-State Health Network** and representatives from each CMHSP attend a regular Customer Services Committee and any trends identified through a review of grievance data is discussed as a committee. **Mid-State Health Network** also shared its plan to implement standardized grievance templates for use by the **Mid-State Health Network** and each CMHSP**.**

### Required Actions

**Mid-State Health Network** did not demonstrate a clear process for who is responsible for receiving grievances and facilitating the resolution of grievances filed by enrollees accessing SUD services. During the interview session, **Mid-State Health Network** provided conflicting information about which entity (PIHP or SUD provider) is handling the SUD-related grievances. Additionally, the SUD is listed on the delegate reporting document; however, no grievances were submitted during the time period under review. **Mid-State Health Network** must identify the PIHP organizational unit approved and administratively responsible for accepting and facilitating the resolution of SUD-related grievances filed by enrollees or their authorized representatives.

The Customer/Consumer Service policy and procedure manual indicated **Mid-State Health Network**'s standards of customer service ensure materials are written at the fourth-grade reading level when possible. This policy also indicated enrollees are notified that oral interpretation is available for any language and written information is available in prevalent languages. Additionally, for enrollees with visual impairment, oral interpretation services are provided free of charge. While **Mid-State Health Network**'s policy complies with the requirements of 42 CFR 438.10, during the case file review, HSAG noted letters were not consistently written at a fourth-grade reading level and, at times, contained typographical and grammatical errors. In one instance, a Notice of Grievance Resolution letter also contained language pertaining to an appeal, which may be confusing to an enrollee. **Mid-State Health**

**Network** must ensure each Notice of Grievance Resolution letter complies with the requirements of 42 CFR 438.10 and meets the needs of those individuals with limited English proficiency and limited reading proficiency.

### *Recommendations*

**Mid-State Health Network** should conduct training with CMHSPs and SUD providers to ensure all expressions of dissatisfaction are being documented, tracked, and trended as grievances.

**Mid-State Health Network** should revise its grievance and appeal brochure to be less confusing to enrollees.

**Mid-State Health Network** should ensure all grievance-related documents reference the 90-day grievance resolution timeliness requirement instead of the 60-day requirement.

**Mid-State Health Network** should also consider implementing a formal quality review process of enrollee letters to ensure the letters comply with federal grievance requirements, are easy to understand, and are free of grammatical and spelling errors.

## Standard IX—Subcontracts and Delegation

### *Performance Strengths*

**Mid-State Health Network** maintained policies and procedures that described the processes for conducting the monitoring and oversight activities of its CMHSPs and SUD provider network. During the interview session, **Mid-State Health Network** staff members explained that a full evaluation is conducted once every two years, and during the interim year, a review of the previous year's non-compliant findings is completed along with a review of any new requirements. A review of selected annual audit findings confirmed **Mid-State Health Network** required and followed up on corrective actions for deficient findings.

Exhibit A of the subcontract between **Mid-State Health Network** and CMHSPs clearly outlined managed care functions and whether they were retained by **Mid-State Health Network** or delegated to the local CMHSPs. During the previous full compliance review, it was noted that the subcontracts did not include language regarding the revocation of delegation or use of other sanction to address inadequate performance of a delegated function on the part of the subcontractor. A review of the subcontracts verified they contained detailed provisions related to remedies and sanctions for contract non-compliance including revocation of delegated functions.

### Required Actions

**Mid-State Health Network**'s contract with its CMHSPs and SUD providers did not include the requirement that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. During the interview session, **Mid-State Health Network** staff members verbalized that contract language is being revised to include this requirement. Additionally, the contract indicated that access to books, documents, and records would be available for four years following the termination of the agreement, which conflicted with the 10-year requirement.

### Recommendations

During the interview session, **Mid-State Health Network** staff members discussed the intent to delegate grievance and appeal functions to its SUD providers, which are currently being managed by **Mid-State Health Network**'s customer service specialist. HSAG recommends that **Mid-State Health Network** reconsider this and retain all grievance and appeals functions for SUD providers. **Mid-State Health Network** staff members explained that its SUD provider network primarily consists of small "mom and pop" providers. It is unclear if these providers would be able to meet all requirements related to processing grievances and appeals, such as ensuring individuals who make decisions are not involved in any previous level of review or decision making, nor a subordinate of any such individual.

While the contract between **Mid-State Health Network** and the CMHSPs included provisions to allow MDHHS, the State of Michigan, or designated representatives to review, copy, and audit all contract/financial records, license, accreditation, certification, program reports, and clinical records to the full extent permitted by applicable federal and State law, **Mid-State Health Network** should add specific language related to fraud.

## Standard X—Provider Network

### Performance Strengths

**Mid-State Health Network** delegated many provider network management functions to the CHMSPs that were monitoring during the managed care site review. The Provider Network Management policy described the various mechanisms **Mid-State Health Network** used to monitor and oversee its provider network, which included a review of access and availability data, a needs assessment, a review of utilization data, and solicitation of stakeholder input. These activities were summarized in the annual Assessment of Network Adequacy report, which identified priority areas and recommendations.

**Mid-State Health Network** used a checklist that outlined the action steps to be taken when a decision has been made to terminate a provider contract. These steps included, but are not limited to, notification to internal departments as well as the State of Michigan, and coordinating with the utilization management department for a consumer referral plan.

### Required Actions

No corrective actions are required for this standard as **Mid-State Health Network** was found to be in compliance with all the requirements.

### Recommendations

While the Credentialing: Suspension and Revocation policy required immediate verbal notification followed by written notification to the Behavioral Health and Developmental Disabilities Administration in MDHHS when a decision has been made to terminate a provider contract, **Mid-State Health Network** should add the notification time frame requirement to its checklist to ensure MDHHS is notified within seven days of any changes to the composition of the provider network that negatively affects access to care provided as required by contract.

## Standard XII—Access and Availability

### Performance Strengths

**Mid-State Health Network** collected data on the performance indicators from each CMHSP in the region, compiled the data, and sent quarterly reports to MDHHS according to State specifications. Contract provisions and PIHP policies required CMHSPs to meet the performance indicator standards. Performance was monitored monthly by **Mid-State Health Network**'s Quality Improvement council, which required corrective actions as necessary.

MDHHS provided HSAG with MMBPIS data for the period from April 1, 2014, through December 31, 2014. **Mid-State Health Network**'s performance was evaluated and scored based on aggregated data across three reporting quarters.

Based on the aggregated data over three quarters, **Mid-State Health Network** demonstrated strong performance. **Mid-State Health Network**'s aggregated rates were at or above the contractually required minimum performance standard of 95 percent for 14 of the 15 measures reviewed. These included: children and adults receiving timely preadmission screenings for psychiatric inpatient care; provision of a face-to-face assessment within 14 days of a nonemergent request for service for all populations (mentally ill children and adults, developmentally disabled children and adults, and beneficiaries with a SUD); providing developmentally disabled adults and beneficiaries with a SUD needed, ongoing service within 14 days of a nonemergent assessment; and providing follow-up care within seven days of a discharge from a psychiatric inpatient or detox unit for children and adults.

### Required Actions

Of the 15 MMBPIS measures reviewed, one was below the required 95 percent threshold. **Mid-State Health Network** must ensure that developmentally disabled children start needed, ongoing services with a professional within 14 days of a nonemergent assessment.

### Recommendations

No additional recommendations for this standard were identified.

## Standard XIV—Appeals

### Performance Strengths

**Mid-State Health Network** delegated the responsibility for the appeals process to its network CMHSPs. The delegation grids in **Mid-State Health Network**'s contract with the CMHSPs specified the subcontractors' responsibilities related to the appeals process. **Mid-State Health Network**'s Medicaid Beneficiary Appeals/Grievances policy required subcontractors to maintain a local appeal procedure that complied with the MDHHS Grievance and Appeal Technical Requirement and thereby addressed the enrollee's right to a State Fair Hearing, the method to obtain a hearing, the right to file appeals, and the requirements and time frames for filing appeals. **Mid-State Health Network** provided template language for the appeal acknowledgement and resolution letters. Grievance logs and records were maintained by the subcontractors. **Mid-State Health Network** conducted annual on-site reviews to assess subcontractors' performance on the delegated appeals process functions, including a review of a sample of appeals records.

### Required Actions

During the case file review, **Mid-State Health Network** did not demonstrate that oral requests for appeal were followed by a written, signed appeal. **Mid-State Health Network** must obtain a written signed request for appeal following the acceptance of a non-expedited oral request for an appeal.

**Mid-State Health Network** did not consistently resolve appeals within 30 calendar days as indicated during the case file review. **Mid-State Health Network** must resolve appeals within 30 calendar days.

The appeal resolution letters reviewed during the case file review were written at a level higher than the required fourth-grade reading level. Further, many of the letters were excessively long and were written in the form of clinical progress notes rather than a formal notice of the appeal decision. **Mid-State Health Network**'s resolution letters must also be written in a way that is easily understood by those with limited English proficiency or limited reading proficiency.

The appeal resolution notice content, as demonstrated during the case file review, did not consistently include the date of the appeal resolution. **Mid-State Health Network** must ensure the date of the appeal resolution is documented in the system as well as included in the appeal resolution letter.

### *Recommendations*

No additional recommendations for this standard were identified.

## Standard XV—Disclosure of Ownership, Control, and Criminal Convictions

### *Performance Strengths*

**Mid-State Health Network**'s use of the Disclosure of Ownership and Controlling Interest Statement form is an effective method for capturing required disclosure information from providers during the credentialing and contracting processes. **Mid-State Health Network** also demonstrated effective monitoring processes to ensure no staff member or provider was excluded from participating in Medicare, Medicaid, and other federal healthcare programs.

### *Required Actions*

No corrective actions are required for this standard as **Mid-State Health Network** was found to be in compliance with all the requirements.

### *Recommendations*

No additional recommendations for this standard were identified.

## Standard XVII—Management Information Systems

### *Performance Strengths*

**Mid-State Health Network** provided assurances that its health information systems, as well as its CMHSPs' health information systems, had the capacity to collect, analyze, integrate, and report data to achieve its obligations under the contract with MDHHS. **Mid-State Health Network** used its Information Technology Council as a forum for sharing information related to encounters and other systems with its CMHSPs. Robust reports, including detailed utilization data, were also being shared with the utilization management and quality improvement teams to assist them in process improvement efforts.

## Required Actions

No corrective actions are required for this standard as **Mid-State Health Network** was found to be in compliance with all the requirements.

## Recommendations

No additional recommendations for this standard were identified.

# 4. Performance Improvement Process

**Mid-State Health Network** is required to submit to MDHHS a corrective action plan for all elements scored as *Not Met*. The corrective action plan must be submitted within 30 days of receipt of the final report. For each element that requires correction, the plan should identify the interventions intended to assist in achieving compliance with the requirement(s), the individual(s) responsible, and the timeline. HSAG has prepared a customized template to facilitate **Mid-State Health Network**'s submission and MDHHS' review of corrective actions. The template includes each requirement for which HSAG assigned a performance score of *Not Met* and, for each such requirement, HSAG's findings and required actions to bring the organization's performance into full compliance.

| Standard VI—Customer Service | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. Designated Unit**<br><br>MDHHS Contract Part IIA-6.3<br>Attachment P6.3.1 | | |
| a. The PIHP has a designated unit called "Customer Services", with a minimum of one full-time equivalent (FTE) performing the customer services function, within the customer services unit or elsewhere within the PIHP.<br><br>Attachment P6.3.1(1-2) | Customer Service and Rights Specialist Job Description<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>Example: CMH for Central Michigan Handbook, pgs. 11-25 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Mid-State Health Network (MSHN) employs a full-time equivalent (FTE) Customer Service & Rights Specialist to perform customer service functions. The position responsibilities are to ensure regional compliance with federal and state requirements regarding customer service, enrollee rights and protections, grievance and appeal standards and performance indictor standards. The individual manages customer inquiries, facilitating communication and action in response to inquiries, and networks with the CMHSP and SUDSP customer service to bring resolution to the customer inquiry. MSHN also delegates customer service as defined in the MSHN FY2018 Medicaid Subcontracting Agreement Exhibit A Delegation Grid – Customer Service. MSHN's Customer Service Policy reference's the requirements for the provider network. The regional handbook includes the regional and local customer service contact information for MSHN and each CMHSP within the region. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard VI—Customer Service | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **2. Phone Access**<br>Attachment P6.3.1 | | |
| a. The PIHP has a designated toll-free customer services telephone line and access to alternative telephonic communication methods (e.g., Relays, a TTY number, etc.).<br>Attachment P6.3.1(3) | Example: CMH for Central Michigan Handbook, pgs. 8, 11-25<br><br>Customer Service Line Website Screenshot<br><br>Customer Service – Customer Service Handbook Policy<br><br>MSHN CMHSP Delegated Functions Audit: Standards #1 (Customer Services) and #3 (24/7/365 Access) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The customer services numbers are displayed in agency brochures and public information material.<br>Attachment P6.3.1(3) | Example: CMH for Central Michigan Handbook, pgs. 12-25<br><br>Customer Service Line Website Screenshot<br><br>Customer Service – Customer Service Handbook Policy<br><br>MSHN CMHSP Delegated Functions Audit: Standards #1 (Customer Services) and #3 (24/7/365 Access) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. The PIHP ensures that the customer services telephone line is answered by a live voice during business hours. Telephone menus are not acceptable.<br>Attachment P6.3.1(4) | Example: CMH for Central Michigan Handbook, pgs. 27<br><br>Customer Service – Customer Service Handbook Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | MSHN CMHSP Delegated Functions Audit: Standards #1 (Customer Services) and #3 (24/7/365 Access) | |
| d. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.<br><br>Attachment P6.3.1(4) | Example: CMH for Central Michigan Handbook, pgs. 27<br><br>Customer Service – Customer Service Handbook Policy<br><br>MSHN CMHSP Delegated Functions Audit: Standards #1 (Customer Services) and #3 (24/7/365 Access) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN maintains a dedicated Customer Service Line answered live by the Customer Service & Rights Specialist to receive customer service inquires. When the Customer Service & Rights Specialist is away a MSHN administrative professional answers calls and routes customer service inquires to the Director of Compliance, Customer Service & Quality. The regional handbook includes the regional and local customer service contact information for MSHN and each CMHSP within the region. MSHN delegates Customer Service functions to the Provider Network and provides monitoring and oversight through the delegated managed care site review. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **3. Hours of Operation**<br><br>Attachment P6.3.1 | | |
| a. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized.<br><br>Attachment P6.3.1(5) | Example: CMH for Central Michigan Handbook, pgs. 12-25<br><br>Customer Service Line Website Screenshot<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. The customer services unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.<br>Attachment P6.3.1(5) | Example: CMH for Central Michigan Handbook, pgs. 12-25<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN developed, and reviews annually through the Customer Services Committee, the regional handbook that includes regional and local contact information for MSHN and each CMHSP within the region. MSHN delegates Customer Service functions to the Provider Network as evidenced by the Delegation Grid. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **4. Customer Handbook**<br>42 CFR 438.10(g)<br>Attachment P6.3.1 | | |
| a. The customer handbook includes: | | |
| i. The state-required topics (See P.6.3.1.1.A) including Templates #1-#12, other required contract topics, and all CFR requirements specified in 438.10(g) – refer to the Customer Handbook Checklist.<br>42 CFR438.10(g)(2)<br>Attachment P6.3.1(6) | Mid-State CS Manual Approval Letter 01.26.2018<br><br>Example: CMH for Central Michigan Handbook, pgs. 6-7, 87<br><br>Customer Service - Customer Service Policy | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| ii. The Medicaid coverage name and the State's description of each services.<br>Attachment P6.3.1(7) | Example: CMH for Central Michigan Handbook, pgs. 56-65 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| iii. The date of the publication and revision(s).<br>Attachment P6.3.1(8) | Example: CMH for Central Michigan Handbook, back cover | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iv. Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area, including plan or program name, locations, and telephone numbers.<br>Attachment P6.3.1(10) | Example: CMH for Central Michigan Handbook, pgs. 68-69<br><br>CS_Customer_Handbook Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The PIHP or delegate entity must provide each customer a customer handbook within a reasonable time after receiving notice of the beneficiary's enrollment. This may be provided by:<br>42 CFR 438.10(g)<br>Attachment P6.3.1 | | |
| i. Mailing a printed copy to the customer's mailing address.<br>42 CFR 438.10(g)(3)(i)<br>Attachment P6.3.1(9)(a) | CS_Customer_Consumer_Service Policy<br><br>CS_Customer_Handbook Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 10 & 30 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| ii. Emailed after obtaining the customer's agreement to receive information by email.<br>42 CFR 438.10(g)(3)(ii)<br>Attachment P6.3.1(9)(b) | CS_Customer_Consumer_Service Policy<br><br>CS_Customer_Handbook Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Example: CMH for Central Michigan Handbook, pg. 10 & 30 | |
| iii. If the PIHP posts the information on the website and advises the customer in paper or electronic form that the information is available on the internet provided that persons with disabilities who cannot access the information online are provided auxiliary aids and services upon request at no cost.<br><br>42 CFR 438.10(g)(3)(iii)<br>Attachment P6.3.1(9)(c) | CS_Customer_Consumer_Service Policy<br><br>CS_Customer_Handbook Policy<br><br>Example: CMH for Central Michigan Handbook pg. 10 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The MSHN Customer Handbook contains the elements required as part of the contract attachment P.6.3.1. The handbook was submitted for review this year to MDHHS, who provided an approval letter stating the handbook was consistent with the Customer Services Standards (contract attachment P.6.3.1) and was approved for use with the beneficiaries. The Customer Handbook Policy and the Customer Service Policy also identify the standards that must be followed by the PIHP and the Provider Network regarding customer services and the consumer handbook. It is also a regional practice to provide the consumer handbook at intake into service, and annually thereafter, typically as part of the Person Centered Planning Process. | | |
| **HSAG Findings** | | |
| The PIHP's customer handbook did not include the enrollee's right to use any hospital or other setting for emergency care or information on how to report suspected fraud or abuse. Additionally, an error in the handbook indicated a standard appeal decision would be made within 60 calendar days instead of 30 calendar days. Lastly, several CMHSPs posted outdated versions of the customer handbook on their websites. The PIHP should consider developing a formal process of monitoring the customer handbook and other informational materials that are posted online by the CMHSPs.<br>**Required Actions:** The PIHP must include in the customer handbook the enrollee's right to use any hospital or other setting for emergency care and information on how to report suspected fraud or abuse. The PIHP must also correct the timeframe for standard appeal decisions. | | |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **5. Provider Listing**<br>42 CFR 438.10(h)<br>Attachment P6.3.1 | | |
| a. The PIHP or delegate unit shall maintain a current listing of all providers, practitioners and organizations with whom the PIHP has contracts – refer to the Provider Directory Checklist.<br>42 CFR 438.10(h)(1)(i-viii)<br>Attachment P6.3.1(11) | Example: CMH for Central Michigan Handbook, pg. 10<br>MSHN Website, via link: http://midstatehealthnetwork.org/provider-network/<br>MSHN website screenshot: SUD Providers<br>MSHN website screenshot: Behavioral Health Providers<br>CS_Customer_Handbook Policy<br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| b. The PIHP must make this available in paper form upon request and electronic form such as the PIHP, CMHSP, or network provider's website as applicable.<br>42 CFR 438.10(h)(1)<br>Attachment P6.3.1(11) | Example: CMH for Central Michigan Handbook, pg. 10<br>CS_Customer_Handbook Policy<br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| c. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.<br>Attachment P6.3.1(11) | Example: CMH for Central Michigan Handbook, pg. 30<br>CS_Customer_Handbook Policy<br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| d. The provider directory must be made available in paper form upon request and electronic form. It must also be made available on the PIHP's website in a machine readable file and format.<br>42 CFR 438.10(h)(1,4)<br>Attachment P6.3.1(12) | Example: CMH for Central Michigan Handbook, pg. 10<br><br>CS_Customer_Handbook Policy<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| e. The paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.<br>42 CFR 438.10(h)(3)<br>Attachment P6.3.1(13) | Example: CMH for Central Michigan Handbook, pg. 10<br><br>MSHNProviderChoiceListing v.4.24.18<br><br>CS_Customer_Handbook Policy<br><br>CS_Customer_Consumer_Service Policy<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Provider Directory Policy | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| f. If the PIHP provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days.<br>Attachment P6.3.1(14) | Example: CMH for Central Michigan Handbook, pg. 10<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The provider listing is given to the consumer, at least annually, as part of the consumer handbook. The provider listing is also updated monthly for any needed revisions and an electronic copy is available on MSHN's website and each CMHSP's website. The Provider Directory Policy also identifies that the directory must be updated at least monthly and electronic directories must be updated no later than 30 calendar days after the PIHP receives updated provider information. A hard copy of the handbook, as well as any other customers information, will be made available at no cost to the beneficiary upon request. MSHN delegates Customer Service functions to the Provider Network as evidenced in the Delegation Grid. | | |
| **HSAG Findings** | | |
| The PIHP's behavioral health provider directory did not include the following:<br>• Telephone number(s).<br>• Website URL (if appropriate).<br>• Cultural and linguistic capabilities (if they have completed cultural competency training) and any non-English languages they speak (including American Sign Language).<br>• Whether the provider's office/facility has accommodations for people with physical disabilities.<br>• Whether they are accepting new patients.<br><br>The PIHP's SUD provider directory did not include the following:<br>• Cultural and linguistic capabilities (if they have completed cultural competency training) and any non-English languages they speak (including American Sign Language). The paper version of the SUD provider directory included languages spoken; however, the online version did not.<br>• Whether the provider's office/facility has accommodations for people with physical disabilities.<br>• Whether they are accepting new patients.<br><br>Neither directory included independent PCP facilitators. During the interview session, PIHP staff members explained that it typically utilized single case agreements for independent facilitators due to high turnover. In response to the finding that the directories do not specify whether the provider is accepting new patients, PIHP staff members verbalized that its providers are required by the State to accept all enrollees and are prohibited from turning them away. Additionally, documentation did not support there was a process to ensure the CMHSP local provider directories included all required content, were available in a machine-readable format, and were updated monthly or within 30 calendar days after receiving updated provider information. While the local provider directories were posted on the CMHSP websites, several were outdated versions. Prior to the onsite review, the PIHP had developed draft policies | | |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| and procedures to address several of these deficiencies. During the interview session, the PIHP further explained they are in the process of developing a new online regional provider directory with the intent to no longer have local provider directories maintained by the CMHSPs. The CMHSPs would be required to upload a current copy of their directory into the PIHPs information system monthly. The proposed data fields of the new directory included the required demographic information.<br><br>**Required Actions:** The PIHP must ensure the provider directory includes all content required by contract and 42 CFR 438.10(h). The PIHP must ensure that any independent PCP facilitators with whom the PIHP or CMHSPs contract with are included in the directory. The PIHP must have a process to ensure the directory reflects providers who are not accepting new enrollees, for example when the provider is at capacity. Additionally, the PIHP must ensure the paper provider directory is updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information. Lastly, if the CMHSPs retain their own local provider directory, the PIHP must implement mechanisms to ensure they are compliant with all State and federal requirements. | | |
| **6. Access to Information**<br>The customer services unit has access to information about the PIHP, including:<br><br>Attachment P6.3.1 | | |
| a. CMHSP affiliate annual report.<br><br>Attachment P6.3.1(15) | Example: CMH for Central Michigan Handbook, pg. 2 & 10<br><br>MSHN Website, via link:<br>http://midstatehealthnetwork.org/provider-network/<br><br>CMHSP Provider Network Website Screenshot<br><br>Example: CMH for Central Michigan annual report webpage screenshot | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. Current organizational chart.<br><br>Attachment P6.3.1(15) | Example: CMH for Central Michigan Handbook, pg. 2<br><br>MSHN Website, via link:<br>http://midstatehealthnetwork.org/provider-network/<br><br>MSHN Network Org Chart 2018<br><br>MSHN Org Chart 2018 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. CMHSP board member list.<br><br>Attachment P6.3.1(15) | Example: CMH for Central Michigan Handbook, pg. 2<br><br>MSHN Website, via link:<br>http://midstatehealthnetwork.org/provider-network/<br><br>http://www.midstatehealthnetwork.org/board/<br><br>Example: CMHCM Board Member List Webpage Screenshot<br><br>Example: MSHN Board Member List Webpage Screenshot | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Meeting schedule, and minutes.<br><br>Attachment P6.3.1(15) | Example: CMH for Central Michigan Handbook, pg. 2<br><br>MSHN Website, via link:<br>http://midstatehealthnetwork.org/provider-network/<br><br>http://www.midstatehealthnetwork.org/board/ | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Example: MSHN board meeting schedule webpage screenshot<br><br>Example: MSHN board meeting minutes webpage screenshot | |
| e. Customer services provides this information in a timely manner to individuals upon their requests.<br><br>Attachment P6.3.1(15) | Example: CMH for Central Michigan Handbook, pg. 10 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| CMHSP Annual Reports, board member listings, schedules and meeting minutes are available upon request and on the CMHSP websites. MSHN also has their board member list, schedule of meetings and meeting minutes located on their website. The MSHN consumer handbook also contains information about the PIHP and each CMHSP. Please refer to the handbook and the MSHN Website as an example of evidence, as well as CMHSP websites, provider listings, MSHN Board and Council meeting agenda and minutes. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **7. Assistance with Grievances and Appeals**<br><br>MDHHS Contract Part IIA-6.3<br>Attachment P6.3.1 | | |
| a. Upon request, the customer services unit assists beneficiaries with the grievance, appeals, and local dispute resolution processes and coordinates, as appropriate, with the Fair Hearing Officer and the local Office of Recipient Rights. | Example: CMH for Central Michigan Handbook, pg. 33-36<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| Attachment P6.3.1(16) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The MSHN consumer handbook includes both regional and local contact information regarding customer services. Please see the handbook as an example of compliance with this standard. In addition the Customer Services Medicaid Enrollee Appeal and Grievances Policy outlines the process to resolve complaints and notification of the right to file appeals and grievances and administrative hearings. MSHN delegates Customer Service functions to the Provider Network as evidenced in the Delegation Grid. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |
| **8. Training**<br>Customer services staff receives training to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained, in at least the following areas:<br>Attachment P6.3.1 | | |
| **Working Knowledge About:** | | |
| a. The populations served (serious mental illness, serious emotional disturbance, developmental disability, and substance use disorder) and eligibility criteria for various benefit plans (e.g., Medicaid, Healthy Michigan Plan, MIChild).<br>Attachment P6.3.1(17)(a) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pgs. 56-70 | |
| b. Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services.<br><br>Attachment P6.3.1(17)(b) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pgs. 56-70 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| c. Grievance and appeals, fair hearings, local dispute resolution processes, and recipient rights.<br><br>Attachment P6.3.1(17)(g) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pgs. 33-36, 49-51 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid health plans, fee-for-service practitioners, and the Department of Human Services.<br><br>Attachment P6.3.1(17)(i) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pgs. 56-70 | |
| **Knowledge Where to Obtain Information About:** | | |
| e. Person-centered planning.<br><br>Attachment P6.3.1(17)(c) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pgs. 38-39 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| f. Self-determination.<br><br>Attachment P6.3.1(17)(d) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 40 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| g. Recovery and resiliency.<br><br>Attachment P6.3.1(17)(e) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 43 | |
| h. Peer specialists.<br><br>Attachment P6.3.1(17)(f) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 60 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| i. Limited English proficiency and cultural competency.<br><br>Attachment P6.3.1(17)(h) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 8, 82 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| j. The organization of the public mental health system.<br><br>Attachment P6.3.1(17)(j) | FY18 Medicaid Subcontract Agreement: pgs. 9 – 10 (X. C - D.)<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 10 | |
| k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections.<br><br>Attachment P6.3.1(17)(k) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VI—Customer Service | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies).<br><br>Attachment P6.3.1(17)(l) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 88 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP).<br><br>Attachment P6.3.1(17)(m) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>FY18 SUD Provider Contract: Pg. 14 (Section II.C.6)<br><br>Customer Service - Customer Service Policy<br><br>MSHN Training Grid 2018<br><br>SUD – Staff Training Site Review Tool<br><br>CMHSP – Staff Training Site Review Tool<br><br>Example: CMH for Central Michigan Handbook, pg. 51 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates the Customer Service training requirements to the Provider Network and provides monitoring and oversight as part of the Delegated Managed Care Site Reviews. Training requirements are also included within the provider network contracts. The MSHN Consumer Handbook provides additional information outlined within this standard. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Results—Standard VI | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 34 | X | 1.0 | = | 34 |
| Not Met | = | 5 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | |
| Total Applicable | = | 39 | Total Score | | = | 34 |
| Total Score ÷ Total Applicable | | | | | = | 87% |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. General Requirement**<br>42 CFR 438.402<br>MDHHS Contract Part II A-6.3.1<br>Attachment P6.3.1.1 | | |
| a. The PIHP has a grievance system in place for Enrollee's that complies with Subpart F of Part 438.<br>42 CFR 438.402(a)<br>MDHHS Contract Part II A-6.3.1<br>Attachment P6.3.1.1(III) | MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I. (Pg. 28)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services & Utilization Management Sections (Pgs. 1-3 & 17)<br><br>MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19<br><br>CS_Customer_Consumer_Service Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>MSHN CMHSP Delegated Functions Site Review Tool<br><br>MSHN SUD Delegated Functions Site Review Tool | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN has an established process in place that is compliant with the MDHHS contract attachment P.6.3.1.1. MSHN utilizes the Consumer Handbook to provide information to enrollees on their rights for appeals, grievances and Medicaid Fair Hearings. MSHN provides information to the provider network through the referenced policies/procedures and includes the requirement for providers to comply with the State standards as part of their contract with MSHN. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| HSAG has determined the PIHP is compliant with this element. | | |
| **2. Information to Subcontractors and Providers**<br>The PIHP provides information about the grievance system to all providers and subcontractors at the time they enter into a contract. The information includes:<br>42 CFR 438.414<br>42 CFR 438.10<br>MDHHS Contract Part II A-7.0(4) | | |
| a. The right to file grievances.<br>42 CFR 438.10(g)(2)(xi)(A) | Example: CMH for Central Michigan Handbook, pg. 33<br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br>CS- Reporting Medicaid Appeals Grievances RR Procedure<br>MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I. (Pg. 28) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services & Utilization Management Sections (Pgs. 1-3 & 17)<br><br>MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19 | |
| b. The requirement and timeframes for filing a grievance.<br><br>42 CFR 438.10(g)(2)(xi)(B) | MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I. (Pg. 28)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services & Utilization Management Sections (Pgs. 1-3 & 17)<br><br>MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. The availability of assistance in the filing process.<br><br>42 CFR 438.10(g)(2)(xi)(C) | MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I. (Pg. 28)<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services & Utilization Management Sections (Pgs. 1-3 & 17) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure | |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN provides information to the provider network through the referenced policies/procedures and includes the requirement for providers to comply with the State standards as part of their contract with MSHN. The identified evidence outlines the rights for filing appeals and grievances as well as the timeframes for doing so and how to request assistance. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| HSAG has determined the PIHP is compliant with these elements. | | |
| **3. General**<br>42 CFR 438.402<br>Attachment P6.3.1.1 | | |
| a. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.<br><br>Attachment P6.3.1.1(VII)(B)(1) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure<br><br>MSHN Form Templates: | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | • MSHN FY18 Notice of Receipt Grievance Template<br>• MSHN FY18 Notice of Disposition Grievance Template | |
| b. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative.<br><br>42 CFR 438.402(c)(2)(i)<br>Attachment P6.3.1(VII)(B)(2) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure<br><br>Grievance and Appeal Brochure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. The enrollee may file a grievance either orally or in writing.<br><br>42 CFR 438.402(c)(3)(i) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>Grievance and Appeal Brochure<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within 90 calendar days of the date of the request.<br><br>42 CFR 438.400(b)(5)<br>42 CFR 438.408(b)(1)<br>Attachment P6.3.1(VII)(B)(3) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure<br><br>Grievance and Appeal Brochure<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Disposition Grievance | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| e. The Grievance System must provide Enrollees: | | |
| i. The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints. | Example: CMH for Central Michigan Handbook, pg. 33 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| ii. With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file Grievance to the PIHP.<br>42 CFR 438.402(c)(1)(ii)<br>Attachment P6.3.1.1(III) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Receipt Grievance | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iii. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so.<br>42 CFR 438.402(c)(1)(ii)<br>Attachment P6.3.1.1(III) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Receipt Grievance | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iv. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.<br>Attachment P6.3.1.1(III) | Example: CMH for Central Michigan Handbook, pg. 51 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes the Consumer Handbook to provide information regarding consumer rights involving grievances. MSHN has also developed standardized Notices for Receipt and Disposition of grievances that are used region wide. MSHN's policy/procedure for appeals and grievances is in compliance with the MDHHS contract requirements. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **HSAG Findings** | | |
| The PIHP did not demonstrate a clear process for who is responsible for receiving grievances and facilitating the resolution of grievances filed by enrollees accessing SUD services. During the interview session, the PIHP provided conflicting information about which entity (PIHP or SUD provider) is handling the SUD-related grievances. Additionally, the SUD is listed on the delegate reporting document; however, no grievances were submitted during the time period under review.<br><br>**Required Action:** The PIHP must identify the PIHP organizational unit approved and administratively responsible for accepting and facilitating resolution of SUD-related grievances filed by enrollees or their authorized representatives. | | |
| **4. The PIHP Responsibility When Enrollee Files a Grievance**<br><br>42 CFR 438.406<br>Attachment P6.3.1.1 | | |
| a. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. 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<br><br>42 CFR 438.406(a)<br>Attachment P6.3.1.1(VII)(C)(1) | Example: CMH for Central Michigan Handbook, pg. 8 -9 & 33<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Receipt Grievance | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Acknowledge receipt of the grievance.<br><br>42 CFR 438.406(b)(1)<br>Attachment P6.3.1.1(VII)(C)(2) | Example: CMH for Central Michigan Handbook, pg. 33<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Receipt Grievance | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| c. Maintain a record of grievances for review by the State as part of its quality strategy.<br><br>Attachment P6.3.1.1(VII)(C)(3) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I. (Pg. 28)<br><br>MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19<br><br>Customer Service - Customer Service Policy<br><br>CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>CS- Reporting Medicaid Appeals Grievances RR Procedure<br><br>**MSHN submitted a copy of the grievance and appeal log that contained the information recorded by each provider that was in compliance with state standards. | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action.<br><br>Attachment P6.3.1.1(VII)(C)(4) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I (Pg. 28)<br><br>MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19<br><br>Customer Service - Customer Service Policy<br><br>MSHN FY18 QAPIP (Pg. 14) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Utilization Management Policy<br><br>2017-2018 Grievance Review Template<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Disposition Grievance | |
| e. Coordinates as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.<br><br>Attachment P6.3.1(13) | FY18 Medicaid Subcontract Exhibit A Delegation Grid - Customer Services<br><br>MSHN FY 2018 Medicaid Subcontracting Agreement: Section XXI.I (Pg. 28)<br><br>MSHN FY 2018 SUD Provider Contract: Pgs. 13, 14 & 19<br><br>Customer Service - Customer Service Policy<br><br>MSHN Delegated Managed Care Review: Section 2.0 (Enrollee Rights and Protections)- 2.2 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes standardized templates for the receipt and disposition of a grievance. MSHN and its provider network maintain logs of grievances in accordance with the requirements as evidenced by the grievance log submitted to HSAG. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| HSAG has determined the PIHP is compliant with these elements. | | |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **5. Individuals Making Decisions**<br>Ensure that the individual(s) who make the decisions on the Grievance:<br>42 CFR 438.406<br>Attachment P6.3.1.1 | | |
| a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual.<br>42 CFR 438.406(b)(2)(i)<br>Attachment P6.3.1.1(VII)(C)(5)(a) | Example: CMH for Central Michigan Handbook, pg. 34<br>2017-2018 Grievance Review Template | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.<br>42 CFR 438.406(b)(2)(ii)(B-C)<br>Attachment P6.3.1.1(VII)(C)(5)(b) | Example: CMH for Central Michigan Handbook, pg. 34<br>FY18 Medicaid Subcontract Exhibit A Delegation Grid – VII. Provider Network (Pg. 13)<br>MSHN FY18 QAPIP (Pg. 13 -14)<br>Utilization Management Policy<br>2017-2018 Grievance Review Template | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.<br>42 CFR 438.406(b)(2)(iii)<br>Attachment P6.3.1.1(VII)(C)(5)(c) | Example: CMH for Central Michigan Handbook, pg. 34 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. As part of the site review. MSHN reviews a sample of grievances to ensure that standards are met. MSHN's QAPIP also identifies the requirement for decision makers to have the appropriate level of expertise. | | |
| **HSAG Findings** | | |
| HSAG has determined the PIHP is compliant with these elements. | | |
| **6. Timing of Grievance Resolution**<br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. Provide the Enrollee a written notice of resolution not to exceed 90 calendar days from the day the PIHP received the Grievance.<br>42 CFR 438.408(b)(1)<br>Attachment P6.3.1.1(VII)(D)(1) | MSHN FY18 Notice of Grievance Resolution<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>2017-2018 Grievance Review Template | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes a standardized template for notice of grievance resolution which contains this information. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. MSHN reviews a sample of grievances to ensure that standards are met. | | |
| **HSAG Findings** | | |
| HSAG has determined the PIHP is compliant with this element. | | |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **7. Format of Notice of Grievance Resolution**<br><br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).<br><br>42 CFR 438.10<br>42 CFR 438.408(d)(1)<br>Attachment P6.3.1.1(VII)(D)(2)(a) | MSHN FY18 Notice of Grievance Resolution<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>Customer Service - Customer Service Policy | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes a standard template for the notice of grievance resolution. The notice follows the template requirement identified in contract attachment P6.3.1. | | |
| **HSAG Findings** | | |
| The Customer/Consumer Service policy and procedure manual indicated the PIHP's standards of customer service ensure materials are written at the fourth-grade reading level when possible. This policy also indicates enrollees are notified that oral interpretation is available for any language and written information is available in prevalent languages. Additionally, for enrollees with visual impairment, oral interpretation services are provided free of charge. While the PIHP's policy complies with the requirements of this element, during the case file review, HSAG noted letters were not consistently written at a fourth-grade reading level and, at times, contained typographical and grammatical errors. In one instance, a Notice of Grievance Resolution letter also contained language pertaining to an appeal, which may be confusing to an enrollee.<br><br>**Required Action:** The PIHP must ensure each Notice of Grievance Resolution letter complies with the requirements of 42 CFR 438.10 and meets the needs of those individuals with limited English proficiency and limited reading proficiency. | | |

| Standard VII—Enrollee Grievance Process | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **8. Content of Notice of Grievance Resolution**<br>The notice of Grievance resolution must include:<br>42 CFR 438.408(d)(1)<br>Attachment P6.3.1.1 | | |
| a. The results of the grievance process.<br>Attachment P6.3.1.1(VII)(D)(2)(b)(i) | MSHN FY18 Notice of Grievance Resolution | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The date the grievance process was concluded.<br>Attachment P6.3.1.1(VII)(D)(2)(b)(ii) | MSHN FY18 Notice of Grievance Resolution | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than 90-days from the date of the Grievance<br>Attachment P6.3.1.1(VII)(D)(2)(b)(iii) | MSHN FY18 Notice of Grievance Resolution | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Instructions on how to access the State Fair Hearing process, if applicable.<br>Attachment P6.3.1.1(VII)(D)(2)(b)(iv) | MSHN FY18 Notice of Grievance Resolution | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes a standard template for the notice of grievance resolution. The notice follows the template requirement identified in contract attachment P6.3.1 and contains all the elements identified in this section. | | |
| **HSAG Findings** | | |
| HSAG has determined the PIHP is compliant with these elements. | | |

| Results—Standard VII | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 24 | X | 1.0 | = | 24 |
| Not Met | = | 2 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | 0 |
| Total Applicable | = | 26 | Total Score | | = | 24 |
| Total Score ÷ Total Applicable | | | | | = | 92% |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. Delegation**<br><br>42 CFR 438.230<br>MDHHS Contract Part I-38.0 | | |
| a. The PIHP shall be held solely and fully responsible to execute all provisions of contract, whether or not said provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor.<br><br>42 CFR 438.230(b)(1)<br>MDHHS Contract Part I-38.0 | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 3<br>• Pg. 8, Section IX (A)<br><br>FY18 Medicaid Subcontract Delegation Grid<br><br>FY2018 SUD Contract | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Since MSHN has been established, compliance with delegated functions are monitored through the desk review and on-site review. Delegation agreements are included in the Medicaid Subcontracting Agreements 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. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **2. Written Contract**<br>Each contract or written arrangement must specify:<br><br>42 CFR 438.230<br>MDHHS Contract Part I-38.0 | | |
| a. The delegated activities or obligations, and related reporting responsibilities.<br><br>42 CFR 438.230(c)(1)(i) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 8 Section IX (A)<br>• Pg. 74, Exhibit G<br><br>FY 18 Medicaid Subcontract Delegation Grid<br><br>FY18 SUD Provider Reporting Requirements<br><br>FY18 SUD Treatment Contract<br>• Pg. 15, II (C) (14)<br>• Pg. 17, II (C) (22)<br>• Pg. 33, Attachment A (11)<br>• Pg. 38, Attachment C (4) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the PIHP's contract obligations.<br><br>42 CFR 438.230(c)(1)(ii) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 8, Section IX (A-B)<br>• Pg. 22, Section XVII (A)<br>• Pg. 74, Exhibit G<br><br>FY 18 Medicaid Subcontract Delegation Grid; | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | FY18 SUD Provider Reporting Requirements<br><br>MSHN HCPCS/CPT Code Grid<br><br>FY18 SUD Treatment Contract<br>• Pg. 15, II (C) (14)<br>• Pg. 17, II (C) (22)<br>• Pg. 33, Attachment A (11)<br>• Pg. 38, Attachment C (4) | |
| 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 subcontractor has not performed satisfactorily.<br><br>42 CFR 438.230(c)(1)(iii) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 36, Section XXX (D)<br><br>FY18 SUD Treatment Contract<br>• Pg. 30, (Section I (h)<br><br>MSHN Contract Compliance Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| 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. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **3. Agree to Comply**<br><br>42 CFR 438.230<br>MDHHS Contract Part I-38.0 | | |
| a. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions.<br><br>42 CFR 438.230(c)(2) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 25, Section XIX (A-F)<br><br>FY18 SUD Treatment Contract<br>• Pg. 14, Section II (C)(4)<br>• Pg. 18, II (C)(22)(d)<br>• Pg. 22, VI (B)(1) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Contracts include language specific to agreement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions as noted above. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |
| **4. Monitoring of Delegates**<br><br>42 CFR 438.230<br>MDHHS Contract Part I-38.0<br>Attachment P7.9.1 | | |
| a. The PIHP annually monitors its provider network(s), including any affiliates or subcontractors to which it has delegated managed care functions, including service and support provision. | FY18 Medicaid Subcontract Delegation Grid, Pg. 6<br><br>Provider Network Management Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| Attachment P7.9.1(XV) | Monitoring and Oversight Policy<br>• CMHSP Participant Monitoring & Oversight Procedure<br>• Monitoring and Oversight of SUD Providers<br>• MSHN Delegated Functions Audit 2017<br>• MSHN Delegated Functions Audit (2018 New Standards)<br><br>MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Page 24, Section XVIII (A-D)<br><br>SUD Treatment Contract<br>• Pg. 13, (Section II (C)(1)<br>• Pg. 14, II (C)(9) | |
| b. The PIHP shall review and follow up on any provider network monitoring of its subcontractors.<br>Attachment P7.9.1(XV) | FY18 Medicaid Subcontract Delegation Grid, Pg. 12<br><br>Provider Network Management Policy<br><br>Monitoring and Oversight Policy<br>• CMHSP Participant Monitoring & Oversight Procedure<br>• Monitoring and Oversight of SUD Providers<br>• Pg. 8/41/44, MSHN Delegated Functions Audit 2017 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | SUD Treatment Contract<br>• Pg. 13, (Section II (C)(1)<br>• Pg. 14, II (C)(9) | |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The MSHN CMHSP Participant Monitoring & Oversight Procedure and Monitoring and Oversight of SUD Providers Procedure and Monitoring and Oversight Policy describes the role of the PIHP in monitoring the provider network and procedure utilized to monitor the provider network. The Delegated Functions Audit tool has been provided to demonstrate the standards reviewed to ensure CMHSPs are monitoring subcontractors. In 2016, MSHN added contract language to the SUD contract where providers must obtain approval from MSHN in order to subcontract. At this time, it is not a practice for SUD providers to subcontract SUD services. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **5. Right to Audit**<br>The subcontractor agrees that:<br>42 CFR 438.230 | | |
| a. MDHHS, CMS, the HHS Inspector General, the Controller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PIHP's contract with MDHHS.<br>42 CFR 438.230(c)(3)(i) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 24, Section XVIII (A-D)<br><br>FY18 SUD Treatment Contract<br>• Pg. 13, Section II (C)(1)<br>• Pg. 14, II (C)(9)<br>• Pg. 17, II (C)(22)(c) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. The subcontractor makes 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 enrollees.<br>42 CFR 438.230(c)(3)(ii) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Page 24, Section XVIII (A-D)<br><br>SUD Treatment Contract<br>• Pg. 13, (Section II (C)(1) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. The right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.<br>42 CFR 438.230(c)(3)(iii) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 24, Section XVIII. B<br><br>FY18 SUD Treatment Contract<br>• Pg. 14, II (C)(9)<br><br>IT Record Retention Policy | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| d. If MDHHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, MDHHS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.<br>42 CFR 438.230(c)(3)(iv) | Medicaid Subcontract<br>• Pg. 24, Section XVIII. A-D<br><br>FY18 SUD Treatment Contract<br>• Pg. 17, (Section II (C)(22) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Contracts include language specific to standards a, b, c, and d. Please refer to the Medicaid Subcontract and SUD treatment contract as noted above. Contracts also refer to the record retention guidelines: General Schedule #20 for record retention requirements (refer to sources noted above). Record retention expectations are also stated in the Record Retention Policy. | | |

| Standard IX—Subcontracts and Delegation | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| With regard to standard 5.c. the MDHHS/PIHP contract does not specify that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. MSHN contracts do not include the 10 year requirement; however we are currently revising contract language for FY19 and will include revisions to specify the 10 year timeframe. | | |
| **HSAG Findings** | | |
| The contract between the PIHP and CMHSPs did not include the requirement that the right to audit exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. During the interview session, PIHP staff members verbalized that contract language is being revised to include this requirement. Additionally, the contract indicated that access to books, documents, and records would be available for four years following the termination of the agreement, which conflicted with the 10-year requirement.<br><br>**Required Actions:** The PIHP must proceed with revising the FY 2019 contract language to include the 10-year requirement. The PIHP should also consider a contract amendment to the FY 2018 contract. The PIHP must ensure its contract does not contain conflicting information. | | |

| Results—Standard IX | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 10 | X | 1.0 | = | 10 |
| Not Met | = | 1 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | |
| Total Applicable | = | 11 | Total Score | | = | 10 |
| Total Score ÷ Total Applicable | | | | | = | 91% |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. Provider Written Agreement**<br><br>42 CFR 438.206<br>MDHHS Contract Part II A-7.0 | | |
| a. The PIHP is responsible for maintaining and continually evaluating an effective provider network supported by written agreements to fulfill the obligations of its contract.<br><br>42 CFR 438.206(b)(1)<br>MDHHS Contract Part II A-7.0 | Provider Network Management Policy<br>• A. 1. Network Monitoring and Oversight<br>• B. 1. Network Adequacy/Sufficiency<br><br>MSHN FY 2018 Medicaid Subcontracting Agreement<br><br>FY18 SUD Treatment Contract<br><br>MSHN Provider Assessment of Network Adequacy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The contract tracking sheet is a list of all contracts with CMHSPs and SUD providers. Copies of the Medicaid Subcontract and SUD contract demonstrate written agreements with providers. Provider Network Policy and Network Adequacy/Sufficiency Procedures outline policies and procedures for maintaining its network. The Provider Assessment of Network Adequacy demonstrates MSHNs annual evaluation of its network and sufficiency in meeting its contractual obligations under the Master Agreement. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **2. Sufficiency of Agreements**<br>42 CFR 438.206 | | |
| a. Written agreements provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.<br>42 CFR 438.206(b)(1) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 25/26, Section XX (A-D)<br><br>FY18 SUD Treatment Contract<br>• Pg. 22, (Section VI (B)(2)<br><br>CS- Information Accessibility – Limited English Proficiency Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Both the Medicaid Subcontract and SUD contract include language specific to access to all services for all enrollees including those with LEP or physical or mental disabilities. MSHNs Information Accessibility – LEP policy addresses this as well. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |
| **3. Liability for Payment**<br>42 CFR 438.106 | | |
| a. The PIHP's providers may not bill individuals for the difference between the provider's charge and the PIHP's payment for services.<br>42 CFR 438.106(b)(2)<br>MDHHS Contract Part II A-7.8.2.2 | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 18, Section XIV (H)(1-3)<br><br>FY18 SUD Treatment Contract<br>• Pg. 11, (Section II (B)(5) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | • Pg. 12, II (B)(6)<br>• Pg. 20, IV (I) | |
| b. Providers shall not seek nor accept any additional payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the services directly.<br>42 CFR 438.106(c)<br>MDHHS Contract Part II A-7.8.2.2 | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 18, Section XIV (H)(1-3)<br><br>FY18 SUD Treatment Contract<br>• Pg. 11, (Section II (B)(5)<br>• Pg. 12, II (B)(6)<br>• Pg. 20, IV (I) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Medicaid Subcontract and SUD contract include language specific to liability for payment. Specific sections within the contracts are noted above. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **4. Reason for Decision to Decline**<br>42 CFR 438.12<br>MDHHS Contract Part I-37.0 | | |
| a. Must give those providers not selected for inclusion in the network written notice of the reason for its decision.<br>42 CFR 438.12(a)(1)<br>MDHHS Contract Part I-37.0<br>Attachment P7.1.1(H) | Credentialing: Suspension and Revocation Procedure<br><br>Example of letter to provider<br>• Pinnacle Recovery Services | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Credentialing: Suspension and Revocation Procedure indicates the requirement to provide written notice. Also provided is an example of a letter sent to a prospective provider with the basis for not approving the provider to join MSHNs panel. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |
| **5. Network Changes**<br>The PIHP submits supporting documentation to MDHHS that demonstrates that it has the capacity to serve the expected enrollment in its service area:<br>42 CFR 438.207<br>Attachment P7.7.1.1 | | |
| a. On an annual basis.*<br>42 CFR 438.207(c)(2)<br>*Effective for contracts beginning on or after July 1, 2018. | Provider Network Adequacy Assessment<br><br>Provider Network Management Policy<br>• Section B.3 | ☐ Met<br>☐ Not Met<br>☒ Not Applicable |
| b. The PIHP shall notify MDHHS within 7 days of any changes to the composition of the provider network organizations that negatively affect access to care.<br>42 CFR 438.207(c)(3)<br>Attachment P7.7.1.1 | Example Notice to MDHHS re: Termination of contracts<br>• Ionia County HD, Care Free Clinic, Addiction Solutions – Alma<br><br>Termination checklist<br><br>Credentialing: Provider Suspension/Revocation procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| c. PIHPs shall have procedures to address changes in its network that negatively affect access to care.<br><br>Attachment P7.7.1.1 | Service Provider Procurement policy<br><br>Provider Network Management policy<br><br>Credentialing: Provider Suspension/Revocation procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The 2017 provider network adequacy assessment demonstrates MSHN evaluation of its network. This is completed annually, per the provider network management policy and marked as reviewed and filed by the MSHN Board of Directors. MSHN also has procedures in place to notify MDHHS of any changes to its network as outlined in the termination checklist. Examples of communiques to MDHHS have been provided. The credentialing: suspension/revocation procedure includes language specific to notifying appropriate authorities. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **6. Out-of-Network Responsibility**<br><br>42 CFR 438.206<br>MDHHS Contract Part II A-4.10 | | |
| a. If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network.<br><br>42 CFR 438.206(b)(4)<br>MDHHS Contract Part II A-4.10 | Out of State Placement Policy<br><br>SUD Services - Out of Region Coverage<br><br>Customer Services Handbook<br>• Out-of-Network Providers: Pg. 54 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Out of State Placement policy and SUD Services - Out of Region Coverage policy address MSHNs obligation to cover services for beneficiaries. The Customer Services Handbook addresses Out-of-Network providers for covered services not available within the region. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |
| **7. Requirements Related to Payment**<br>42 CFR 438.206<br>MDHHS Contract Part II A-4.10 | | |
| a. Since there is no cost to the beneficiary for the PIHP's in-network services, there may be no cost to beneficiary for medically-necessary specialty services provided out-of-network.<br>42 CFR 438.206(b)(5)<br>MDHHS Contract Part II A-4.10 | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 18, Section XIV (H)(1-3)<br>FY18 SUD Treatment Contract<br>• Pg. 11, (Section II (B)(5)<br>• Pg. 12, II (B)(6)<br>• Pg. 20, IV (I)<br>Customer Services Handbook<br>• Out-of-Network Providers: Pg. 54 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Contracts include language (see specific references above) related to no cost to beneficiaries for medically necessary services provided out of network. Customer services handbook addresses out-of-network providers if services are not available in region. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **8. Second Opinion**<br><br>42 CFR 438.206<br>MDHHS Contract Part II A-4.9 | | |
| a. If the beneficiary requests, the PIHP must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary.<br><br>42 CFR 438.206(b)(3)<br>MDHHS Contract Part II A-4.9 | FY18 Medicaid Subcontract Delegation Grid<br>• Pg. 3, Section I "Customer Service"<br>• Pg. 17, Section X "Utilization Management"<br><br>FY18 SUD Treatment Contract<br>• Pg. 16/17, Section II (C)(20)<br>• Pg. 19, IV (D) & (G)<br><br>FY18 SUD Provider Manual<br>• Pg. 51<br><br>Customer Services Handbook<br>• Second Opinions: Pgs. 34, 49, & 54 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Contracts include language (see specific references above) related to a beneficiaries right to a second opinion at no cost. This is also part of the SUD provider manual. The customer services handbook addresses second opinions. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **9. Cultural Considerations**<br><br>42 CFR 438.206<br>MDHHS Contract Part II A-4.5 | | |
| a. The PIHP promotes the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.<br><br>42 CFR 438.206(c)(2)<br>MDHHS Contract Part II A-4.5 | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 9, Section X (A)(1)<br><br>FY18 Medicaid Subcontract Delegation Grid<br>• Pg. 11, Section VII "Provider Network"<br><br>FY 18 SUD Treatment Contract<br>• Pg. 19, Section IV (C)<br><br>FY18 SUDSP Provider Manual<br>• Pgs. 19-20<br><br>Cultural Competency Policy<br><br>Customer Service Policy<br><br>Utilization Management (Access system) Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Contracts include language in support of delivery of services in a culturally competent manner. The SUD provider manual also includes language. The following MSHN policies support this requirement: Cultural Competency, Customer Service, and UM Access System. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **10. Accessibility Considerations**<br>The PIHP ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.<br><br>42 CFR 438.206(c)(3)<br>Attachment P4.1.1 | | |
| a. The access system shall maintain the capacity to immediately accommodate individuals who present with: LEP and other linguistic needs, diverse cultural and demographic backgrounds, visual impairments, alternative needs for communication, and mobility challenges.<br><br>42 CFR 438.206(c)(3)<br>Attachment P4.1.1(I)(c) | MSHN FY 2018 Medicaid Subcontracting Agreement<br>• Pg. 9, Section X. A (1)<br>• Pg. 10, XI. B<br><br>FY18 Medicaid Subcontract Delegation Grid<br>• Pg. 2, Section I "Customer Service;<br>• Pg. 11, Section VII "Provider Network"<br><br>FY 18 SUD Treatment Contract<br>• Pg. 19, Section IV (C)<br><br>FY18 SUDSP Provider Manual<br>• Pgs. 19 & 20<br><br>Cultural Competency Policy<br><br>Customer Service Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Provider Network | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Utilization Management (Access system) Policy<br><br>Customer Service – Information Accessibility – Limited English Proficiency Policy | |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Contracts include language in support of provisions for reasonable accommodations and accessible equipment for beneficiaries. The SUD provider manual also includes language. The following MSHN policies support this requirement: Cultural Competency, Customer Service, Information Accessibility, and UM Access System. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Results—Standard X | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 12 | X | 1.0 | = | 12 |
| Not Met | = | 0 | X | .00 | = | 0 |
| Not Applicable | = | 1 | | | | |
| Total Applicable | = | 12 | Total Score | | = | 12 |
| Total Score ÷ Total Applicable | | | | | = | 100% |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| Findings were derived from the Michigan Mission-Based Performance Indicator System—Access Domain, Indicators 1 through 4b. MDHHS provided data directly to HSAG for April 1, 2017 – December 31, 2017. The PIHP's performance was evaluated and scored based on data across the reported quarters. | | |
| **1. Access Standards**<br>MDHHS Contract Part II A-4.1<br>Attachment P7.7.1.1 | | |
| a. The PIHP shall ensure timely access to supports and services in accordance with the Access Standards in Attachment P4.1.1 and the following timeliness standards, and report its performance on the standards in accordance with Attachment P7.7.1.1 of the contract.<br>MDHHS Contract Part II A-4.1 | MSHN MMBPIS Performance Indicator Policy<br>MSHN Performance Indicator Detail Data Collection Instructions<br>FY18 QAPIP (Pg. 19)<br>PI Summary Report FY18Q1<br>Performance Indicator Description of Project Study<br>PIHP Standardized Elements<br>MSHN PIHP aggregated standardized template | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. MSHN MMBPIS Performance Indicator Policy, MSHN Performance Indicator Detail Data Collection Instructions and the Performance Indicator Description of Project Study demonstrate the requirements for the PI's. The QAPIP, the Performance Indicator Description of Project Study and the PI Summary Report FY18Q1 demonstrates how MSHN monitors compliance with standards for the last fiscal year, including trending data and requiring necessary plans of correction. The PI Summary Report is also reviewed on a quarterly schedule with the Regional Quality Improvement Council. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **2. Access Standards—Preadmission Screening**<br>The percent of all Medicaid beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**<br>MDHHS Contract Part II A-4.1<br>Attachment P7.7.1.1 | | |
| a. Children | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Adult | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. The PI Summary Report FY18Q1 demonstrates full compliance with indicator 1 for the last fiscal year. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **3. Access Standards—Face-to-Face Assessment**<br>The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service. **Standard = 95% in 14 days**<br><br>MDHHS Contract Part II A-4.1<br>Attachment P7.7.1.1 | | |
| a. Children | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Adult | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Developmentally Disabled—Children | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Developmentally Disabled—Adult | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| e. Substance Abuse | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. The PI Summary Report FY18Q1 demonstrates full compliance with indicator 2 for the last fiscal year. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **4. Access Standards—Ongoing Services**<br>The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.<br>**Standard = 95% in 14 days**<br>MDHHS Contract Part II A-4.1<br>Attachment P7.7.1.1 | | |
| a. Mentally Ill—Children | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Mentally Ill—Adult | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Developmentally Disabled—Children | PI Summary Report FY18Q1 | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| d. Developmentally Disabled—Adult | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| e. Substance Abuse | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. The PI Summary Report FY18Q1 demonstrates substantial compliance with indicator 3 for the last fiscal year. | | |
| **HSAG Findings** | | |
| The PIHP's aggregated rates over the three reporting quarters for timely ongoing service within 14 days of an assessment for children and adults with a mental illness, adults with a developmental disability, and beneficiaries with a SUD met the minimum performance standard of 95 percent. However, the aggregated rate for children with a developmental disability fell below the MDHHS benchmark.<br><br>**Required Actions:** The PIHP must ensure that children with a developmental disability receive timely, ongoing service within 14 days of an assessment at least 95 percent of the time. | | |
| **5. Access Standards—Follow-up Care After Discharge/Inpatient**<br>The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. **Standard = 95% in seven days**<br><br>MDHHS Contract Part II A-4.1<br>Attachment P7.7.1.1 | | |
| a. Children | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Adults | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. The PI Summary Report FY18Q1 demonstrates full compliance with indicator 4a for the last fiscal year. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **6. Access Standards— Follow-up After Discharge/Detox**<br>The percent of discharges from a detoxification unit who are seen for follow-up care within seven days. **Standard = 95% in seven days**<br>MDHHS Contract Part II A-4.1<br>Attachment P7.7.1.1 | | |
| a. Substance Abuse | PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. The PI Summary Report FY18Q1 demonstrates full compliance with indicator 4b for the last fiscal year. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **7. Providers Required to Meet Access Standards**<br><br>42 CFR 438.206<br>MDHHS Contract Part I-38.0<br>MDHHS Contract Part II A-4.1, 7.11<br>Attachment P7.7.1.1 | MSHN MMBPIS Performance Indicator Policy<br><br>FY18 QAPIP (Pg. 19)<br><br>FY18 SUD Treatment Contract (Attachment C: Performance Indicators, Pg. 38)<br><br>Performance Indicator Description of Project Study<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid: Section IV. Information Systems Management and Section VIII. Quality Management | |
| a. The PIHP requires its providers to meet Medicaid accessibility standards.<br><br>42 CFR 438.206(c)(1)(i)<br>MDHHS Contract Part II A-4.1<br>MDHHS Contract Part I-38.0(16)<br>Attachment P7.7.1.1 | MSHN MMBPIS Performance Indicator Policy<br><br>MSHN PIHP PI Review Tool<br><br>FY18 QAPIP (Pg. 19) | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The PIHP shall establish ongoing internal monitoring and auditing to assure that the standards are enforced, to identify other high-risk compliance areas, and to identify where improvements must be made.<br><br>42 CFR 438.206(c)(1)(iv)<br>MDHHS Contract Part II A-7.11 | MSHN MMBPIS Performance Indicator Policy<br><br>MSHN PIHP PI Review Tool<br><br>MSHN QIC PI POC Template<br><br>FY18 QAPIP (Pg. 19)<br><br>PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XII—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| c. There are procedures for prompt response to identified problems and development of corrective actions.<br><br>42 CFR 438.206(c)(1)(vi)<br>MDHHS Contract Part II A-7.11 | MSHN MMBPIS Performance Indicator Policy<br><br>MSHN QIC PI POC Template<br><br>FY18 QAPIP (Pg. 19)<br><br>PI Summary Report FY18Q1 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN oversees the Performance Indicator aggregation, validation and reporting for the region. The provider network contracts with the PIHP, the PIHP MMBPIS Performance Indicator Policy and the MSHN QAPIP all require provider compliance with reporting performance indicators.<br><br>The PI Summary Report FY18Q1 demonstrates how MSHN reviews compliance with standards for the last fiscal year, including trending data and requiring necessary plans of correction. The PI Summary Report is also reviewed on a quarterly schedule with the Regional Quality Improvement Council. For any provider that is below the state established standard, then a plan of correction is required utilizing the standards plan of correction template.<br><br>MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. The MSHN PIHP PI Review Tool is used to review a sample of files for compliance with standards during the site reviews. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Results—Standard XII | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 18 | X | 1.0 | = | 18 |
| Not Met | = | 1 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | |
| Total Applicable | = | 19 | Total Score | | = | 18 |
| Total Score ÷ Total Applicable | | | | | = | 95% |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. Appeals**<br><br>42 CFR 438.402<br>Attachment P6.3.1.1 | | |
| a. The PIHP has an appeal system in place for Enrollee's that complies with Subpart F of Part 438.<br><br>Attachment P6.3.1.1(III) | MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pg. 19<br><br>FY18 SUDSP Provider Manual: Pgs. 5, 11, & 14<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal<br><br>Example: CMH for Central Michigan Handbook, pgs. 33-36 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN has an established process in place that is compliant with the MDHHS contract attachment P.6.3.1.1. MSHN utilizes the Consumer Handbook to provide information to enrollee's on their rights for appeals, grievances and Medicaid Fair Hearings. MSHN provides information to the provider network through the referenced policies/procedures and includes the requirement for providers to comply with the State standards as part of their contract with | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| MSHN. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |
| **2. Information to Subcontractors and Providers**<br>The PIHP provides information about the appeal system to all providers and subcontractors at the time they enter into a contract. The information includes:<br><br>42 CFR 438.414<br>42 CFR 438.10<br>MDHHS Contract Part II A-7.0(4) | | |
| a. The right to file appeals.<br><br>42 CFR 438.10(g)(2)(xi)(A) | Example: CMH for Central Michigan Handbook, pgs. 33-34<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 14 & 19<br><br>FY18 SUDSP Provider Manual: Pgs. 5 & 11 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. The requirement and timeframes for filing an appeal.<br><br>42 CFR 438.10(g)(2)(xi)(B) | Example: CMH for Central Michigan Handbook, pgs. 33-34<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 14 & 19<br><br>FY18 SUDSP Provider Manual: Pgs. 5 & 11 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. The availability of assistance in the filing process.<br><br>42 CFR 438.10(g)(2)(xi)(C) | Example: CMH for Central Michigan Handbook, pgs. 33-34<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 14 & 19<br><br>FY18 SUDSP Provider Manual: Pgs. 5 & 11 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| d. The right to request a State fair hearing after the PIHP has made a determination on an enrollee's appeal which is adverse to the enrollee.<br>42 CFR 438.10(g)(2)(xi)(D) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| e. The fact that, when requested by the enrollee, benefits that the PIHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing.<br>42 CFR 438.10(g)(2)(xi)(E) | Example: CMH for Central Michigan Handbook, pgs. 34, 36<br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| f. The fact that, the enrollee may be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.<br>42 CFR 438.10(g)(2)(xi)(E) | Example: CMH for Central Michigan Handbook, pg. 36<br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| The provider contracts with MSHN includes information on following the appeal process outlined by MSHN and the MDHHS standards. MSHN also has an Appeals and Grievance Policy, as well as the Consumer Handbook, that outlines information about appeals, the timeframes for filing appeals, assistance with filing, Medicaid Fair Hearings and continuation of benefits during an appeal. MSHN utilizes a standardized adverse benefit determination document that also includes information on timeframes, fair hearings, assistance, etc. MSHN delegates this function to the provider network through the delegation grid and the Appeals and Grievance Policy. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **3. Appeal Process**<br><br>42 CFR 438.402<br>42 CFR 438.406<br>Attachment P6.3.1.1 | | |
| a. The Enrollee has 60 calendar days from the date of the notice of Adverse Benefit Determination to request an Appeal.<br><br>42 CFR 438.402(c)(2)(ii)<br>Attachment P6.3.1.1(VI)(A)(1) | FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 19<br><br>FY18 SUDSP Provider Manual: Pg. 5<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The Enrollee may request an Appeal either orally or in writing.<br><br>42 CFR 438.402(c)(3)(ii)<br>Attachment P6.3.1.1(VI)(A)(2) | FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 19<br><br>FY18 SUDSP Provider Manual: Pg. 5 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | |
| c. Unless the Enrollee requests an expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal.<br><br>42 CFR 438.402(c)(3)(ii)<br>Attachment P6.3.1.1(VI)(A)(2) | FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 19<br><br>FY18 SUDSP Provider Manual: Pg. 5<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 33-34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| d. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).<br><br>42 CFR 438.406(b)(3)<br>Attachment P6.3.1.1(VI)(A)(2) | FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>FY18 SUDSP Treatment Contract: Pgs. 19 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | FY18 SUDSP Provider Manual: Pg. 5<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 33<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | |
| e. The Appeal System must provide Enrollees: | | |
| i. With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal.<br><br>42 CFR 438.402(c)(1)(ii)<br>Attachment P6.3.1.1(III) | FY18 Medicaid Subcontract Exhibit A Delegation Grid – Section I: Customer Service<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| ii. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.<br><br>Attachment P6.3.1.1(III) | Example: CMH for Central Michigan Handbook pg. 51<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes the Consumer Handbook to provide information regarding consumer rights involving appeals. MSHN has also developed standardized Notices for Notice of Receipt of Appeal, Notice of Appeal Denial and Notice of Appeal Approval that are used region wide. MSHN's policy/procedure for appeals and grievances is in compliance with the MDHHS contract requirements. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| None of the cases reviewed on-site were compliant with the requirement that an oral request for appeal must be followed by a written, signed request for appeal.<br>**Required Actions:** Following the acceptance of an oral request for appeal, the PIHP must obtain a written, signed request for non-expedited appeals. | | |
| **4. Medicaid Services Continuation or Reinstatement**<br>42 CFR 438.420<br>42 CFR 438.424<br>Attachment P6.3.1.1 | | |
| a. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: | | |
| i. The Enrollee files the request for Appeal timely (within 60 calendar days).<br>42 CFR 438.420(b)(1)<br>Attachment P6.3.1.1(V)(A)(1) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| ii. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination).<br>42 CFR 438.420(b)(5)<br>Attachment P6.3.1.1(V)(A)(2) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iii. The period covered by the original authorization has not expired.<br>42 CFR 438.420(b)(4)<br>Attachment P6.3.1.1(V)(A)(3) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs: | | |
| i. The Enrollee withdraws the Appeal or request for State Fair Hearing.<br>42 CFR 438.420(c)(1)<br>Attachment P6.3.1.1(V)(B)(1) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| ii. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal.<br>42 CFR 438.420(c)(2)<br>Attachment P6.3.1.1(V)(B)(2) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iii. A State Fair Hearing office issues a decision adverse to the Enrollee.<br>42 CFR 438.420(c)(3)<br>Attachment P6.3.1.1(V)(B)(3) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements.<br>42 CFR 438.420(d)<br>Attachment P6.3.1.1(V)(C) | Example: CMH for Central Michigan Handbook, pg. 36<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.<br>Attachment P6.3.1.1(V)(D) | Example: CMH for Central Michigan Handbook, pg. 36<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| e. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.<br>42 CFR 438.424(b)<br>Attachment P6.3.1.1(V)(E) | Example: CMH for Central Michigan Handbook, pg. 36 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| f. If the PIHP, or the MDHHS fair hearing administrative law judge 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 Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.<br>42 CFR 438.424(a)<br>Attachment P6.3.1.1(V)(F) | Example: CMH for Central Michigan Handbook, pg. 36 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes the Consumer Handbook to provide information regarding consumer rights involving appeals. MSHN has also developed standardized Notices for Notice of Receipt of Appeal, Notice of Appeal Denial and Notice of Appeal Approval that are used region wide. MSHN's policy/procedure for appeals and grievances is in compliance with the MDHHS contract requirements. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **5. PIHP Responsibilities When Enrollee Requests an Appeal**<br>42 CFR 438.406<br>Attachment P6.3.1.1 | | |
| a. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. 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.<br>42 CFR 438.406(a)<br>Attachment P6.3.1.1(VI)(B)(1) | Example: CMH for Central Michigan Handbook, pgs. 33-34 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Acknowledge receipt of each appeal.<br>42 CFR 438.406(b)(1)<br>Attachment P6.3.1.1(VI)(B)(2) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Receipt of Appeal | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Maintain a record of appeals for review by the State as part of its quality strategy.<br>Attachment P6.3.1.1(VI)(B)(3) | MSHN CS_Reporting Medicaid Appeals.Grievances.RR Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes the Consumer Handbook to provide information regarding consumer rights involving appeals. MSHN's policy/procedure for appeals and grievances is in compliance with the MDHHS contract requirements and the Consumer Services Policy includes additional information on providing assistance to the consumer as needed, including the use of interpreter services etc. MSHN also have developed a standard template for use region wide for the notice of receipt of appeal. MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **6. Individuals Making Decisions**<br>Ensure that the individual(s) who make the decisions on Appeals:<br>42 CFR 438.406<br>Attachment P6.3.1.1 | | |
| a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual.<br>42 CFR 438.406(b)(2)(i)<br>Attachment P6.3.1.1(VI)(B)(4)(a) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>2017-2018 Appeal Review Template | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.<br>42 CFR 438.406(b)(2)(ii)(A, C)<br>Attachment P6.3.1.1(VI)(B)(4)(b) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>FY18 Medicaid Subcontract Exhibit A Delegation Grid – VII. Provider Network (Pg. 13)<br><br>MSHN FY18 QAPIP (Pg. 13 -14)<br><br>Utilization Management Policy<br><br>2017-2018 Appeal Review Template | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.<br>42 CFR 438.406(b)(2)(iii)<br>Attachment P6.3.1.1(VI)(B)(4)(c) | Example: CMH for Central Michigan Handbook, pg. 34 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates this responsibility to the Provider Network and provides oversight and monitoring as part of the Delegated Managed Care site reviews. As part of the site review. MSHN reviews a sample of appeals to ensure that standards are met. MSHN's QAPIP also identifies the requirement for decision makers to have the appropriate level of expertise. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **7. Right to Examine Records**<br>42 CFR 438.406<br>Attachment P6.3.1.1 | | |
| a. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing.<br>42 CFR 438.406(b)(4)<br>Attachment P6.3.1.1(VI)(B)(5) | Example: CMH for Central Michigan Handbook, pg. 34<br>MSHN CS-Medicaid Appeals_Grievances Policy<br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| i. Inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals.<br>42 CFR 438.406(b)(4)<br>Attachment P6.3.1.1(VI)(B)(5) | Example: CMH for Central Michigan Handbook, pg. 34<br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. | Example: CMH for Central Michigan Handbook, pg. 34<br>MSHN CS-Medicaid Appeals_Grievances Policy<br>MSHN Form Templates: | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| 42 CFR 438.406(b)(5)<br>Attachment P6.3.1.1(VI)(B)(6) | • MSHN FY18 Adverse Benefit Determination | |
| i. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for the appeal.<br>42 CFR 438.406(b)(5)<br>Attachment P6.3.1.1(VI)(B)(6) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate.<br>42 CFR 438.406(b)(6)<br>Attachment P6.3.1.1(VI)(B)(7) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.<br>Attachment P6.3.1.1(VI)(B)(7) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates this function to the Provider Network through the delegation grid and the Customer Service Medicaid Enrollee Appeals and Grievances Policy. Information is also within the Consumer Handbook and the Adverse Benefit Determination Form. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **8. Standard Appeal Resolution**<br><br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 30 calendar days from the day the PIHP receives the Appeal.<br><br>42 CFR 438.408(b)(2)<br>Attachment P6.3.1.1(VI)(C)(1) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates this function to the Provider Network through contract obligations and Customer Service Policies. Information is also contained in the Handbook and the MSHN Adverse Benefit Determination Form, Notice of Appeal Approval Form and the Notice of Appeal Denial Form. | | |
| **HSAG Findings** | | |
| Two of the cases reviewed on-site exceeded 30 calendar days from the date the PIHP received the appeal.<br>**Required Actions:** The PIHP must resolve the appeal and provide notice of resolution to the affected parties as quickly as the enrollee's health condition requires, but not to exceed 30 calendar days from the day the PIHP receives the appeal. | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **9. Expedited Appeal Resolution**<br><br>42 CFR 438.408<br>42 CFR 438.410<br>Attachment P6.3.1.1 | | |
| a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.<br><br>42 CFR 438.410(a)<br>Attachment P6.3.1.1(VI)(C)(2)(a) | Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal.<br><br>42 CFR 438.410(b)<br>Attachment P6.3.1.1(VI)(C)(2)(b) | Example: CMH for Central Michigan Handbook, pg. 51 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. If a request for expedited resolution is denied, the PIHP must: | | |
| i. Transfer the appeal to the timeframe for standard resolution.<br><br>42 CFR 438.410(c)(1)<br>Attachment P6.3.1.1(VI)(C)(2)(c)(i) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | • MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | |
| ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial.<br><br>42 CFR 438.408(c)(2)(i)<br>42 CFR 438.410(c)(2)<br>Attachment P6.3.1.1(VI)(C)(2)(c)(ii) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iii. Within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.<br><br>42 CFR 438.408(c)(2)(ii)<br>42 CFR 438.410(c)(2)<br>Attachment P6.3.1.1(VI)(C)(2)(c)(iii) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.<br><br>42 CFR 438.408(c)(2)(iii)<br>42 CFR 438.410(c)(2)<br>Attachment P6.3.1.1(VI)(C)(2)(c)(iv) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | • MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | |
| d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than 72 hours after the PIHP receives the request for expedited resolution of the Appeal.<br><br>42 CFR 438.408(b)(3)<br>Attachment P6.3.1.1(VI)(C)(2)(d) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>Example: CMH for Central Michigan Handbook, pg. 34<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial<br>• MSHN FY18 Notice of Receipt of Appeal | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates this function to the Provider Network through contract obligations and Customer Service Policies. Information is also contained in the Handbook and the MSHN Adverse Benefit Determination Form, Notice of Appeal Approval Form and the Notice of Appeal Denial Form. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **10. Extension of Timeframes**<br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. The PIHP may extend the resolution and notice timeframe by up to 14 calendar days if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest<br>42 CFR 438.408(c)(1)(i-ii)<br>Attachment P6.3.1.1(VI)(C)(3) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Receipt of Appeal | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. If the PIHP extends resolution/notice timeframes, it must complete all of the following: | | |
| i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;<br>42 CFR 438.408(c)(2)(i)<br>Attachment P6.3.1.1(VI)(C)(3)(a)(i) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| ii. Within 2 calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.<br>42 CFR 438.408(c)(2)(ii)<br>Attachment P6.3.1.1(VI)(C)(3)(a)(ii) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.<br>42 CFR 438.408(c)(2)(iii)<br>Attachment P6.3.1.1(VI)(C)(3)(a)(iii) | MSHN CS-Medicaid Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN delegates this function to the Provider Network through contract obligations and Customer Service Policies. Information is also contained in the Handbook and the MSHN Adverse Benefit Determination Form and Notice of Receipt of Appeal. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **11. Appeal Resolution Notice Format**<br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution.<br>42 CFR 438.408(d)(2)(ii)<br>Attachment P6.3.1.1(VI)(C)(4)(a) | Example: CMH for Central Michigan Handbook, Pg. 34<br><br>MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Receipt of Appeal<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. Enrollee notice must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).<br><br>42 CFR438.10<br>42 CFR 438.408(d)(2)(i)<br>Attachment P6.3.1.1(VI)(C)(4)(a) | MSHN CS_Medicaid_Enrollee_Appeals_Grievances Policy<br><br>Customer Service Policy<br><br>Customer Service Accessibility LEP Policy<br><br>MSHN Form Templates:<br>• MSHN FY18 Adverse Benefit Determination<br>• MSHN FY18 Notice of Receipt of Appeal<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes standard templates for notice of receipt of appeal, notice of appeal approval and notice of appeal denial. The notices follow the template requirement identified in contract attachment P6.3.1. MSHN also ensures that information is provided to the enrollees in a format that is easily understood and meets the language needs as evidenced by the Customer Service Policy and the Customer Service Accessibility LEP Policy. | | |
| **HSAG Findings** | | |
| The resolution letters reviewed on-site were written at a level higher than the required fourth-grade reading level. Further, many of the letters were excessively long and were more like clinical progress notes than formal notices of the appeal decision.<br><br>**Required Actions:** Enrollee resolution notices must be provided in a manner and format that is easily understood by enrollees with limited English proficiency and or limited reading proficiency. | | |

| Standard XIV—Appeals | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **12. Appeal Resolution Notice Content**<br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. The notice of resolution must include the results of the resolution and the date it was completed.<br>42 CFR 438.408(e)(1)<br>Attachment P6.3.1.1(VI)(C)(5)(a) | MSHN Form Templates:<br>• MSHN FY18 Notice of Appeal Approval<br>• MSHN FY18 Notice of Appeal Denial | ☐ Met<br>☒ Not Met<br>☐ Not Applicable |
| b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's: | | |
| i. Right to request a state fair hearing, and how to do so.<br>42 CFR 438.408(e)(2)(i)<br>Attachment P6.3.1.1(VI)(C)(5)(b)(i) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request.<br>42 CFR 438.408(e)(2)(ii)<br>Attachment P6.3.1.1(VI)(C)(5)(b)(ii) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination.<br>42 CFR 438.408(e)(2)(iii)<br>Attachment P6.3.1.1(VI)(C)(5)(b)(iii) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XIV—Appeals | | |
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| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes standard templates for notice of receipt of appeal, notice of appeal approval and notice of appeal denial. The notices follow the template requirement identified in contract attachment P6.3.1. The notice of appeal denial contains information about requesting a Medicaid fair hearing and how to continue benefits while doing so. The Consumer Handbook also contains information about Medicaid fair hearings and continuation of benefits. | | |
| **HSAG Findings** | | |
| Only two of the records reviewed on-site included all the required content in the appeal resolution letters, most did not include the date of resolution.<br>**Required Actions:** The PIHP must ensure that appeal resolution letters include the results of the resolution and the date it was completed. | | |
| **13. State Fair Hearing**<br>42 CFR 438.408<br>Attachment P6.3.1.1 | | |
| a. Enrollees are given 120 calendar days from the date of the applicable notice of resolution to file a request for a State Fair Hearing.<br>42 CFR 438.408(f)(2)<br>Attachment P6.3.1.1(VIII)(D) | Example: CMH for Central Michigan Handbook, pgs. 35-36<br><br>MSHN Form Templates:<br>• MSHN FY18 Notice of Appeal Denial | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN utilizes standard templates for notice of receipt of appeal, notice of appeal approval and notice of appeal denial. The notices follow the template requirement identified in contract attachment P6.3.1. The notice of appeal denial contains information about requesting a Medicaid fair hearing. The Consumer Handbook also contains information about Medicaid fair hearings and the timeframes.<br><br>MSHN's Customer Service and Rights Specialist is the Medicaid Fair Hearings Officer for all hearings involving MSHN and the Substance Use Provider Agencies. Medicaid Fair Hearings involving the CMHSP's are a delegated function and handled by the CMHSP's. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Results—Standard XIV | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 50 | X | 1.0 | = | 50 |
| Not Met | = | 4 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | |
| Total Applicable | = | 54 | Total Score | | = | 50 |
| Total Score ÷ Total Applicable | | | | | = | 93% |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. Disclosure of Ownership, Controlling Interest and Management Statement and Attestation of Criminal Convictions, Sanctions, Exclusions, Debarment or Termination**<br>The PIHP ensures that its providers and contractors submit full disclosures identified in 42 CFR Part 455 Subpart B. Disclosures include:<br>42 CFR 455.104<br>42 CFR 455.106<br>MDHHS Contract Part I-34.0–34.1 | | |
| a. Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location, and P.O. Box location.<br>42 CFR 455.104(b)(1)(i) | Disclosure, Ownership and Controlling Interest Statement<br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Date of birth and Social Security number of each person with an ownership or control interest in the disclosing entity.<br>42 CFR 455.104(b)(1)(ii) | Disclosure, Ownership and Controlling Interest Statement<br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent or more interest.<br><br>42 CFR 455.104(b)(1)(iii) | Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling.<br><br>42 CFR 455.104(b)(2) | MSHN FY2018 Medicaid Subcontracting Agreement<br>• Pg. 31, Section XXVI 1.c.<br><br>FY 18 SUD Treatment Contract<br>• Pgs. 16, 23, & 24<br><br>Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| e. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.<br><br>42 CFR 455.104(b)(3) | Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| f. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.<br><br>42 CFR 455.104(b)(3) | Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| g. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.<br><br>42 CFR 455.106(a)(1-2) | MSHN FY2018 Medicaid Subcontracting Agreement<br>• Pg. 31, Section XXVI 1.d.<br><br>FY 18 SUD Treatment Contract<br>• Pgs. 16, 23, & 24<br><br>Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| A policy *Disclosure of Ownership, Control, and Criminal Convictions* and procedure *Disclosure of Ownership, Control, and Criminal Convictions* outlines the requirements of the disclosures. The *MSHN Ownership, Control, and Criminal Conviction Disclosure* statement (form) includes required information and sites 42 CFR 455 for reference. Contracts include language regarding disclosure requirements. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **2. Time of Disclosure**<br>Disclosure from any provider or disclosing entity is due at any of the following times:<br>42 CFR 455.104<br>MDHHS Contract Part I-34.2 | | |
| a. Upon the provider or disclosing entity submitting the provider application.<br>42 CFR 455.104(c)(1)(i) | MSHN FY2018 Medicaid Subcontracting Agreement<br>• Pg. 31, Section XXVI 1.c.<br><br>FY 18 SUD Treatment Contract<br>• Pg. 16<br><br>Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure<br><br>Application for Organizational Providers, Checklist Pg. 6. | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. Upon the provider or disclosing entity executing the provider agreement.<br>42 CFR 455.104(c)(1)(ii) | MSHN FY2018 Medicaid Subcontracting Agreement<br>• Pg. 31, Section XXVI 1.c.<br><br>FY 18 SUD Treatment Contract<br>• Pg. 16<br><br>Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414.<br>42 CFR 455.104(c)(1)(iii) | MSHN FY2018 Medicaid Subcontracting Agreement<br>• Pg. 31, Section XXVI 1.c.<br><br>FY 18 SUD Treatment Contract<br>• Pg. 16<br><br>Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | Disclosure of Ownership, Control, and Criminal Convictions Procedure | |
| d. Within 35 days of any change in ownership of a disclosing entity.<br>42 CFR 455.104(c)(1)(iv) | MSHN FY2018 Medicaid Subcontracting Agreement<br>• Pg. 31, Section XXVI 1.c.<br><br>FY 18 SUD Treatment Contract<br>• Pgs. 16 & 23<br><br>Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| A policy *Disclosure of Ownership, Control, and Criminal Convictions* and procedure *Disclosure of Ownership, Control, and Criminal Convictions* outlines the requirements of the disclosures. The *MSHN Ownership, Control, and Criminal Conviction Disclosure* statement (form) includes required information and sites 42 CFR 455 for reference. Contracts include language regarding disclosure requirements. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **3. Monitoring Provider Networks**<br>MDHHS Contract Part I-34.1 | | |
| a. The PIHP must search the OIG exclusions database monthly to capture exclusions since the last search and at any time providers submit new disclosure information.<br>MDHHS Contract Part I-34.1 | Credentialing Background Checks and PSV Procedure<br>Screen shot verify comply monthly e-mail Feb - April<br>Verify comply user manual<br>The Right Door_MSHN CMHSP Delegate Functions Final, Pg. 12 Standard 4.13<br>Catholic Charities of West MI SUD Delegated Functions, Pg 33 Standard 10.15 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

**PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement**

Credentialing Background Checks and PSV Procedure requires a process to ensure that the OIG exclusions database is searched monthly for its entire network to capture exclusions since the last search and at any time providers submit new disclosure information. Since this is delegated to the provider network, contracts include language specific to monthly OIG searches. The delegated functions audit tool includes a standard for monitoring provider networks. An example is included in the final report for the delegated functions audit for The Right Door and Catholic Charities of West MI.

Also provided is a screen shot of Verify Comply e-mail for the month of Feb – April. This demonstrates MSHNs monthly monitoring of its provider network. MSHN purchased the Verify Comply subscription in 2015. The Verify Comply user manual provides more information on the services. Our account is setup to search the OIG, SAM, and Michigan Sanctioned provider list.

**HSAG Findings**

HSAG determined that the PIHP was compliant with this element.

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **4. Reporting Criminal Convictions Involved**<br>The PIHP is required to promptly notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS if:<br><br>42 CFR 1001.1001<br>42 CFR 455.106<br>MDHHS Contract Part I-34.2 | | |
| a. Any disclosures made by providers with regard to the ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.<br><br>MDHHS Contract Part I-34.2(a) | Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure<br><br>Credentialing Background Checks and PSV Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. Any staff member, director, or manager of the PIHP, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting or other arrangement with PIHP has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1)(2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.<br><br>MDHHS Contract Part I-34.2(b) | Disclosure, Ownership and Controlling Interest Statement<br><br>Disclosure of Ownership, Control, and Criminal Convictions Policy<br><br>Disclosure of Ownership, Control, and Criminal Convictions Procedure<br><br>Credentialing Background Checks and PSV Procedure | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XV—Disclosure of Ownership, Control, and Criminal Convictions | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| A policy *Disclosure of Ownership, Control, and Criminal Convictions* and procedure *Disclosure of Ownership, Control, and Criminal Convictions* outlines the requirements of the disclosures. Credentialing Background Checks and PSV Procedure outlines notification requirements. Contracts include language regarding disclosure requirements. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Results—Standard XV | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 14 | X | 1.0 | = | 14 |
| Not Met | = | 0 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | |
| Total Applicable | = | 14 | Total Score | | = | 14 |
| Total Score ÷ Total Applicable | | | | | = | 100% |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **1. Management Information Systems (MIS)**<br><br>42 CFR 438.242<br>MDHHS Contract Part II A-7.7 | | |
| a. The PIHP shall ensure that Management Information Systems and practices have the capacity that the obligations of its contract are fulfilled by the entity and/or its subcontractors.<br><br>42 CFR 438.242<br>MDHHS Contract Part II A-7.7 | 1a1_Information_Management_Policy<br><br>1a2_Record_Retention_Policy<br><br>1a3_Breach_Notification_Policy<br><br>1a4_Compliance_Required_Reporting_Policy<br><br>1a5_MSHN_FY2018_Delegation_Grid<br><br>1a6_InformationTechnologyCouncil_Charter2017<br><br>1a7_InformationTechnologyCouncil_Snapshot2017Sep20<br><br>1a8_MSHN_CMHSP_DelegatedFunctionsAudit 14-1 thru 14-9 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN has a management information system to support the retained functions and delegated functions to meet the contractual requirements for the region. The policies, charter, delegation grid, system guides and reporting standards provide evidence to carry out these obligations. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with this element. | | |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **2. Uniform Data and Information**<br>42 CFR 438.242<br>MDHHS Contract Part II A-7.7.1 | | |
| a. To measure the PIHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfactions, and to provide sufficient information to track expenditures and calculate future capitation rates, the PIHP must provide MDHHS with uniform data and information specified by MDHHS.<br>MDHHS Contract Part II A-7.7.1 | MSHN_EncounterComparisonReporting_FY2015-2017<br>FY2017 MSHN MUNC Templates 02-28-2018<br>FY2017 FINAL MSHN FSRBUNDLE 02-28-18<br>MDHHS approval letter<br>FC Dashboard FY2017<br>2017 Risk Management Strategy Mid State Health Network | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The PIHP must certify that the data they submit are accurate, complete and truthful: | | |
| i. An annual certification from and signed by the Chief Executive Officer or the Chief Financial Officer, or a designee who reports directly to either must be submitted annually.<br>MDHHS Contract Part II A-7.7.1 | MSHN_EncounterComparisonReporting_FY2015-2017<br>FY2017 FINAL MSHN FSRBUNDLE 02-28-18<br>MDHHS approval letter | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| ii. The certification must attest to the accuracy, completeness, and truthfulness of the information in each of the sets of data.<br><br>MDHHS Contract Part II A-7.7.1 | MSHN_EncounterComparisonReporting_FY2015-2017<br><br>FY2017 FINAL MSHN FSRBUNDLE 02-28-18<br><br>MDHHS approval letter | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

**PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement**

Fiscal information is gathered through the Medicaid Utilization Net Cost report and the Financial Status Report (FSR). Both reports provide different formats for regional expenditure tracking. MSHN's general ledger system also tracks internal administrative expenses as well as those related to the Substance Use Disorder provider network.

The PIHP Chief Financial Officer (CFO) reviews all financial reports prior to submission to MDHHS. This process includes review of source data used to complete reports and an assessment of reasonable for the numbers submitted. The Financial Status report, the Utilization Net Cost reports, and all other fiscal reports are submitted by MSHN's Deputy Director to ensure MDHHS timeliness standard are met. Many of the reports submitted also require the CFO's signature.

MSHN reviews and confirms accuracy of encounter and cost reports to meet the requirements of the contract.

**HSAG Findings**

HSAG determined that the PIHP was compliant with these elements.

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **3. Information System Management**<br>The PIHP must have an information management system that supports the core administrative activities of the region including:<br>Attachment P13.0.B | | |
| a. The ability to detect and correct errors in data receipt, transmissions and analyses.<br>Attachment P13.0.B-2.3(g) | 3a1_EncounterValidations201702<br>3a2_4950_InstitutionalEncounter_ResponseFile<br>3a3_4950_ProfessionalEncounter_ResponseFile<br>3a4_5476_EncounterAcknowledgment<br>3a5_5876_BHTEDSAcknowledgment<br>3a6_MSHN_ReconciliationAnalysis2017 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. This includes screening for completeness, logic, and consistency; and identifying and tracking fraud and abuse.<br>Attachment P13.0.B-2.3(g) | 3a1_EncounterValidations201702<br>3b1_BHTEDS_ERROR_ DESCRIPTION_FY2018<br>MSHN_EncounterComparisonReporting_FY2015-2017<br>3b2_MSHN_EncounterMonitoringFormFY2017<br>3b_Medicaid Event Verification Policy | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| | 3b_Medicaid Event Verification Procedure<br><br>3b_Medicaid Event Verification FY2017 Report | |
| c. The ability (within limits of law) to safely and securely send and receive data to and from other systems which includes, but is not limited to, the State of Michigan, health plans and providers systems including physical health and non-healthcare support systems of care.<br><br>Attachment P13.0.B-2.3(h) | 3c1_SOM_SecureFileTransferProtocol_Guide<br><br>3c2_MSHN_eMail_Office365_ContentEncryption<br><br>3c3_MDHHS_5010A1_HIPAA837P_EncounterCompanion Guide<br><br>3c4_MSHN_ACRS_FileCreationProcess<br><br>3c5_MSHN_ADTMessageProcessing<br><br>3c6_MSHN_ADT_MessageProcessingToZTS | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| Encounter validation is performed with a specific set of rules that match MDHHS reporting requirements. MSHN provides response files that support the reporting requirements. Reconciliation files are utilized for cross-matching all records transmitted and confirmed through the submission process. MSHN performs Medicaid Event Verification (MEV) for all providers to evaluate potential and risk for fraud and abuse. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **4. Enrollee Encounter Data**<br>42 CFR 438.242<br>MDHHS Contract Part II A-7.7.2<br>Attachment P7.7.1.1 | | |
| a. In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, the PIHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PIHP.<br>42 CFR 438.242(c)(2)<br>MDHHS Contract Part II A-7.7.2 | MSHN_EncounterComparisonReporting_FY2015-2017<br>3EEDa1_MSHN_CMHSP_EncounterSubmissionTimeliness FY2018<br>3EEDa2_MSHN_EncounterSubmissionGuide_201707<br>3a6_MSHN_ReconciliationAnalysis2017<br>3EEDa3_MDHHS_Milliman_EncounterReview | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| b. The PIHP collects and maintains sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees:<br>42 CFR 438.242(c)(1)<br>Attachment P7.7.1.1 | | |
| i. The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, social security number and name of the consumer, and the provider name and identification number, place of service, and amount paid.<br>Attachment P7.7.1.1 | 3EEDb1_MDHHS_BHRegistry_Requirements pages 14-15<br>3EEDb2_CareNet_270_271_Guide<br>3c3_MDHHS_5010A1_HIPAA837P_EncounterCompanion Guide | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN subscribes to the HIPAA 837 transaction set standard and validates all encounter transactions with that standard using EDIFACS translator. MSHN utilizes the encounter demographic data to build client registry file and to check for matches. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |
| **5. Oversight of CMHSPs**<br>MDHHS Contract Part II A-7.7 | | |
| a. 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:<br>MDHHS Contract Part II A-7.7(2) | | |
| i. 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.<br>MDHHS Contract Part II A-7.7(2) | 4a1_MSHN_CEI_QI_BHTEDS_EncounterReporting_ ContractFY2018 | ☐ Met<br>☐ Not Met<br>☒ Not Applicable |
| ii. The contract between the PIHP and the CMHSP for PIHP health plan information technology functions shall be separate from other EHR functions performed as a CMHSP.<br>MDHHS Contract Part II A-7.7(2) | 4a1_MSHN_CEI_QI_BHTEDS_EncounterReporting_ ContractFY2018 | ☐ Met<br>☐ Not Met<br>☒ Not Applicable |

| Standard XVII—Management Information Systems | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the PIHP** | **Score** |
| b. The PIHP shall analyze claims and encounter data to create information about region wide and CMHSP specific service utilization.<br>MDHHS Contract Part II A-7.7(3) | FY2017 MSHN MUNC Templates 02-28-2018<br><br>4b1_MSHN_EncounterComparisonFY2017 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| c. The PIHP shall provide regular reports to each CMHSP as to how the CMHSP's individual utilization compares to the PIHP's region as a whole.<br>MDHHS Contract Part II A-7.7(3) | 4b1_MSHN_EncounterComparisonFY2017<br><br>4c1_MSHN_PenetrationRatesFY2015-2017 | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| d. The PIHP shall utilize this information to inform risk management strategies and other health plan functions.<br>MDHHS Contract Part II A-7.7(3) | MDHHS approval letter<br><br>2017 Risk Management Strategy Mid State Health Network | ☒ Met<br>☐ Not Met<br>☐ Not Applicable |
| **PIHP Narrative: Provide a Description of the Process/Describe How the Documents Submitted Demonstrate Compliance With the Requirement** | | |
| MSHN provides oversight to the CMHSPs in its region. The contractual arrangement with CEI to provide information management services for QI, BH-TEDS and Encounter reporting is defined with a clear separation of duty. Utilization is evaluated consistently using the Utilization Net Cost Report and Encounter Comparison Report. Review and oversight is completed regarding changes in utilization and shifts in funding sources, along with volume of encounters submitted monthly, quarterly and annually. A risk management plan is developed with risk strategies based on relevant information.<br><br>5b: This requirement is met through the Utilization Net Cost reports. CMHSP information is completed individually and then aggregated for a final Regional submission to MDHHS.<br><br>5c: This information is compiled in the Finance Council dashboard for several codes identified based on high cost or high unit HCPCS and/or CPT codes.<br><br>5d: The Risk Management plan is submitted to MDHHS in December each year. The plan and the MDHHS approval is submitted as proof for this requirement. | | |
| **HSAG Findings** | | |
| HSAG determined that the PIHP was compliant with these elements. | | |

| Results—Standard XVII | | | | | | |
|---|---|---|---|---|---|---|
| Met | = | 14 | X | 1.0 | = | 14 |
| Not Met | = | 0 | X | .00 | = | 0 |
| Not Applicable | = | 0 | | | | |
| Total Applicable | = | 14 | Total Score | | = | 14 |
| Total Score ÷ Total Applicable | | | | | = | 100% |