Michigan Department of Health and Human Services

Behavioral Health and Developmental Disabilities Administration

2018–2019 External Quality Review Compliance Monitoring Report *for* Prepaid Inpatient Health Plans

Region 5—Mid-State Health Network

February 2020

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, conducted case file reviews via a scheduled WebEx session, and completed an on-site visit at **Mid-State Health Network** that included reviewing additional documents 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 nine of 17 performance areas:

- Standard I—Quality Assessment and Performance Improvement Program (QAPIP) Plan and Structure
- Standard II—Quality Measurement and Improvement
- Standard III—Practice Guidelines
- Standard IV—Staff Qualifications and Training
- Standard V—Utilization Management
- Standard VIII—Members' Rights and Protections
- Standard XI—Credentialing
- Standard XIII—Coordination of Care
- Standard XVI—Confidentiality of Health Information

For the 2018–2019 review period, MDHHS has elected to conduct a review of nine performance standards. The remaining eight standards were reviewed during the 2017–2018 review period.

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

- **Section 2**—A description of the methodology that HSAG used to conduct the compliance 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 that HSAG used to evaluate **Mid-State Health Network**'s compliance with each requirement contained within the standards.

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—QAPIP Plan and Structure
Standard VII—Grievance Process	Standard II—Quality 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—Members' 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 2018–2019 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 healthcare services furnished by the PIHPs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning 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 WebEx session and on-site review.
- Developing the compliance monitoring review and case file review tools.
- 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 prior authorization denial and credentialing case file reviews.
- Conducting a WebEx with each PIHP to walk through the selected case files.
- Conducting a desk review of all completed review tools and supporting documentation submitted by the PIHP. The desk review, along with the case file 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 and logistics for HSAG's one-day review activities.
- Interview sessions with the PIHP's key administrative and program staff members.
- A closing session during which HSAG reviewed 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.

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*, *Not Met*, or *Not Applicable*. The overall score for each of the nine 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[2-2]

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including PIHP data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof, are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall finding of "noncompliance" for the provision, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

[2-2] 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.

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/monitoring reports.
- Member and provider materials.
- Prior authorization denial records.
- Credentialing, recredentialing, and home and community-based services (HCBS) organizational provider records.
- Letter templates and redacted notices.
- Narrative and/or data reports across a broad range of performance and content areas.
- System demonstrations.

Interviews with PIHP staff members (e.g., PIHP leadership, care manager, quality improvement staff members) provided additional information.

Table 2-3 lists the major data sources used by HSAG in determining the PIHP's performance in complying with requirements and the time period to which the data applied.

Table 2-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk review documentation	October 1, 2018, through April 30, 2019
Information obtained through interviews	October 1, 2018, through the end of each PIHPs' on-site review
File review records	• Prior authorization denials closed between October 1, 2018, through April 30, 2019 • Providers who have completed the credentialing process between October 1, 2018, and April 30, 2019

3. Summary of Results

Table 3-1 presents for each standard the total number of elements as well as the number of elements that received scores of *Met*, *Not Met*, or *Not Applicable (NA)*. Table 3-1 also presents **Mid-State Health Network**'s overall compliance score for each standard, the totals across the nine standards reviewed, and the total compliance score across all standards for the 2018–2019 compliance monitoring review. Refer to *Appendix A—2018–2019 Documentation Request and Evaluation Tool* for a detailed description of the findings.

Table 3-1—Summary of 2018–2019 Compliance Monitoring Review Results

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	7	1	0	88%
Standard II—Quality Measurement and Improvement	8	6	2	0	75%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	12	4	0	75%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	71	11	0	87%

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

Mid-State Health Network achieved full compliance in five of the nine standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of Practice Guidelines, Staff Qualifications and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information. The remaining four standards have identified opportunities for improvement. The areas with the greatest opportunity for improvement were related to QAPIP Plan and Structure, Quality Measurement and Improvement, Utilization Management, and Credentialing, as these areas received performance scores under 90 percent.

Mid-State Health Network demonstrated compliance in 71 of 82 elements, with an overall compliance score of 87 percent, indicating that many program areas had the necessary policies, procedures, and initiatives in place to carry out most required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

4. Performance Improvement Process

Mid-State Health Network is required to submit to MDHHS a CAP for all elements scored *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the PIHP must identify the planned interventions to achieve compliance with the requirement(s); the individual(s) responsible for each intervention; and the timeline, including planned dates of completion for each intervention.

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 requirement, HSAG's findings and recommendations to bring the organization's performance into full compliance with the requirement. Within 30 days after receipt of the final report, the CAP must be submitted to HSAG's secure file transfer protocol (SFTP) site, with an email notification to MDHHS and HSAG indicating that the CAP has been uploaded.

Appendix A. 2018–2019 Documentation Request and Evaluation Tool
Michigan Department of Health and Human Services
Prepaid Inpatient Health Plans (PIHPs)
for Region 5—Mid-State Health Network

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Written Description		
1. The PIHP must have a written description of its quality assessment and performance improvement program (QAPIP) which specifies: a. An adequate organizational structure that allows for clear and appropriate administration and evaluation of the QAPIP. b. The components and activities of the QAPIP, including those as required below: i. The role for recipients of service in the QAPIP; and ii. The mechanisms or procedures to be used for adopting and communicating process and outcome improvement. 42 CFR §438.330(a) MDHHS Contract Part II A-7.9 Attachment P7.9.1(I)(1-4)	**HSAG suggested evidence:** QAPIP description document Organizational chart(s) • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final 1.a: Section 111 page 6 a) Structure; 1.b.i: page 7 c) Governance 1.b.ii: page 10 d) Communication of Process and Outcome 1.b.ii: page 17 e) Performance Measurement	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** Although the PIHP demonstrated numerous QAPIP initiatives that were occurring throughout the PIHP and these initiatives were being tracked in various places, HSAG strongly recommends that the PIHP develop a centralized workplan to document each QAPIP goal and objective; track progress of the QAPIP initiatives; report barriers; etc. so that there is a streamlined process/mechanism to easily evaluate the QAPIP's effectiveness.		
Required Actions: None.		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Governing Body		
2. The QAPIP must be accountable to a Governing Body that is a prepaid inpatient health plan (PIHP) Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include: a. Oversight of QAPIP—There is documentation that the Governing Body has approved the overall QAPIP. b. QAPIP progress reports—The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions. c. Annual QAPIP review—The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP. d. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body. 42 CFR §438.330(a) Attachment P7.9.1(II)(A-D)	**HSAG suggested evidence:** QAPIP description document Evidence of QAPIP approval from Governing Body Written reports/committee minutes of routine monitoring and annual QAPIP review List of Governing Body members/Governing Body meeting charter Evidence of annual report submission to MDHHS • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final -Section Three Evaluation and Priorities page 64-214 2a: Title page approval dates. • 2a: Board Motion FY19 QAPIP and FY18 Annual Effectiveness and Evaluation • 2a: Executive Summary FY19 QAPIP and FY18 Annual Effectiveness and Evaluation • 2.a: 2019-5-07 Board Mtg Minutes-Page 3. Quality Assessment and Performance Improvement Plan. Approved 2.b: The Governing Body receives the following reports: FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final; Compliance Summary Report; External Monitoring Reports HSAG and MDHHS; DMC Summary; Balanced Scorecard.	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• 2018-11-06 Board Meeting Minutes- Page 3-4. Compliance Summary Report, External Monitoring Reports, • 2019-1-08 Board Meeting Minutes – Page 4. Balanced Scorecard • 2019-3-05 Board Meeting Minutes- Page 3. Compliance Summary Report The Operations Council Receives the following Reports: Performance Indicator Summary Report; Behavior Treatment Summary Report; Grievance and Appeals Summary; Critical Incident Summary; Satisfaction Surveys; Balanced Score Card • 2018-10 MSHN Operations Council Consent Agenda • 2018-11 MSHN Operations Council Consent Agenda • 2018-12 MSHN Operations Council Consent Agenda • 2019-03 MSHN Operations Council Consent Agenda • 2019-04 MSHN Operations Council Consent Agenda • 2.c: 2019-5-07 Board Mtg Minutes-Page 3 Quality Assessment and Performance Improvement Plan	
PIHP Narrative: It is required to submit the QAPIP upon request from MDHHS (Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19. 7.9.2 Annual Effectiveness Review. MSHN's QAPIP states on page 7 the following "After review of the Annual Quality Assessment and Performance Improvement Report, through the MSHN CEO and Board of Directors submits the report to the Michigan Department of Health and Human		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Services (MDHHS). MDHHS has never requested, or made it part of our reporting requirements, to submit this report. We have the report available, and posted on our website, and can be provided to MDHHS or any other stakeholder upon request.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** The PIHP's Board of Directors (BOD) approved the QAPIP; however, the approval did not occur until six months after the QAPIP's development. HSAG strongly recommends that the PIHP decrease the amount of time it takes for the QAPIP to be taken to the BOD for review and approval. HSAG further recommends that the approval of the QAPIP occur no later than the first quarter of the year to ensure there is adequate time to implement the goals and objectives that are included as part of the QAPIP.		
Required Actions: None.		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Designated Senior Official		
3. There is a designated senior official responsible for the QAPIP implementation. 42 CFR §438.330(a) Attachment P7.9.1(III)	**HSAG suggested evidence:** QAPIP description document Job description of designated senior official (roles and responsibilities) • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final. Page 7 c) Governance Chief Executive Officer is the designated senior official ensuring implementation of the QAPIP. This is completed under the direction of the Director of Compliance, Customer Service and Quality. • JD Director of Compliance, Customer Service & Quality	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Active Participation		
4. There is active participation of providers and members in the QAPIP processes. 42 CFR §438.330(a) Attachment P7.9.1(IV)	**HSAG suggested evidence:** QAPIP description document Evidence of member and provider input into the QAPIP (member advisory council meeting minutes, provider advisory council meeting minutes, communication documents, etc.) • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final • Minutes MSHN Regional Medical Directors Meeting • QIC Meeting Snapshot 11-15-2018 • QIC Meeting Snapshot 1-24-2019 • RCAC Meeting Snapshot 10-12-2018 • RCAC Meeting Snapshot 12-07-2018 • RCAC Meeting Snapshot 2019-4-12 • 2019-4-MSHN Operations Council Key Decisions and Actions • Board Newsletter February 2019 Page 6	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Data from the Behavior Treatment Committee		
5. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. a. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the members or his/her guardian, may be used with members. b. Data shall include numbers of interventions and length of time the interventions were used per person. 42 CFR §438.330(a) MDHHS Contract Part II A-1.4 Attachment P7.9.1(IX)	**HSAG suggested evidence:** QAPIP description document Behavior treatment review committee meeting minutes Behavior treatment review quarterly reports and data analyses Training documents • Delegation Grid FY19 Page 13 • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 16 c) Behavior Treatment • MSHN Behavior Intervention Description of Project Study 12-17-2018 • MSHN Behavior Treatment Oversight FY19Q1 Summary Report Final • MSHN Behavior Treatment Oversight FY19Q2 Summary Report Final • Quality Behavior Treatment Plans 1.0 (policy) • Quality BTP Review 1.0 (procedure) • Updated Definitions 3/12/2019 • BTPRC Snapshot 3.20.2019 • QIC Meeting Snapshot 2.28.2019	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• QIC Meeting Snapshot 5.23.2019	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Verification of Services		
6. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to members by affiliates (as applicable), providers, and subcontractors. a. The PIHP must submit to the State for approval of its methodology for verification. b. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings. 42 CFR §438.330(a) Attachment P7.9.1(XIII)(1-2)	**HSAG suggested evidence:** QAPIP description document MDHHS approval of verification of services methodology Annual report of verification of services activities • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 10 e) Medicaid Event Verification • Copy of Email sent to MDHHS- MEV FY18 Report • MSHN FY18 MEV Report Cover Letter • MSHN FY2018 MEV Methodology Report (Submitted to the State on 12/26/18)	☒ Met ☐ Not Met ☐ Not Applicable

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• Quality- Medicaid Event Verification Procedure • Quality – Medicaid Event Verification Policy • Example: Shiawassee – DMC MEV Summary Report 3.7.2019 • Example: Shiawassee – DMC MEV POC	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Quality and Appropriateness of Care		
7. The PIHP's QAPIP must include mechanisms to assess the quality and appropriateness of care furnished to: a. Members with special health care needs, as defined by the State in the quality strategy under §438.340. b. Members with long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(4-5)	**HSAG suggested evidence:** QAPIP description document Policies and procedures Documentation validating that approved services are being received by members Examples of audit findings (utilization management and care management) • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Section 5 Page 14 • MSHN Service Philosophy Policy Page 2, Page 4	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: This requirement for LTSS was added in the FY19 contract amendment #2 that was issued on March 6, 2019 with a date to be signed by the PIHPs by March 29, 2019. MSHN will be adding this language into our QAPIP during the review of our QAPIP for FY20. However, MSHN does have a service delivery policy that includes the mechanisms to assess the quality and appropriateness of care as well as a section in the QAPIP (page 14) that is focused on oversight of vulnerable people.		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Annual Effectiveness Review		
8. The PIHP shall annually conduct an effectiveness review of its QAPIP. a. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for members as a result of PIHP quality assessment and improvement activities and interventions carried out by the PIHP. b. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. c. Information on the effectiveness of the PIHP's QAPIP must be provided annually to network providers and to members upon request. d. Information on the effectiveness of the PIHP's QAPIP must be provided to the MDHHS upon request. 42 CFR §438.330(e) MDHHS Contract Part II A-7.9.2	**HSAG suggested evidence:** QAPIP annual evaluation • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Section Two Annual Reports pages 25 – 81 Section Four Performance Measurement Attachments Pages 81-214 The QAPIP is available on the MSHN Website at the link below. https://midstatehealthnetwork.org/stakeholders-resources/quality-compliance/quality-assessment-and-performance-improvement-plan	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: Although the PIHP's QAPIP is available on the website and the QAPIP was discussed at various committees, there was no evidence to support a formalized process was in place to ensure all contracted providers were receiving information on the effectiveness of the QAPIP annually.		

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Required Actions: The PIHP must annually conduct an effectiveness review of its QAPIP. The PIHP must also have a process to provide the information on the effectiveness of the QAPIP annually to network providers and to members upon request.		

Results—Standard I						
Met	=	7	X	1.0	=	7
Not Met	=	1	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	8	Total Score		=	7
Total Score ÷ Total Applicable					=	88%

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Performance Measures		
1. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. a. The PIHP must utilize standardized performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established in contract. b. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects. 42 CFR §438.330(c) Attachment P7.9.1(V)(A-B)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Performance indicator monitoring reports (State-required) Other performance indicator monitoring reports (PIHP-established) Data analyses • Quality MMBPIS Performance Indicator 3.0 (Policy) • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 17-21 Pages 67-68 • Final FY19Q1 PI Summary Report • MSHN Priority Measures 201905 • Penetration Rate Jan2019 • Minutes MSHN UMC CLC Jan2019 • FY18 MSHN ACR CMHSP Only • SFY 2018 Behavioral Health PIHP MLR Template final	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Minimum Performance Levels		
2. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur. 42 CFR §438.330(c) Attachment P7.9.1(VI)	**HSAG suggested evidence:** Committee meeting minutes Data analyses • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 20 • QIC Meeting Snapshot 4-25-2019 • MSHN Performance Indicator Detail Data Collection Instructions FY2019 Final • Final FY19Q1 PI Summary Report • Montcalm QIC PI POC FY19Q1-3c	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** HSAG recommends that the PIHP require, when appropriate, a formal root cause analysis (RCA) from substance use disorder (SUD) providers who continue to not meet performance indicator standards. Additionally, HSAG recommends that the PIHP enhance its meeting minutes to document a thorough analysis of performance indicator rates and outliers.		
Required Actions: None.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Performance Improvement Projects		
3. The PIHP's QAPIP includes affiliation-wide performance improvement projects (PIPs) that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. a. PIPs must address clinical and non-clinical aspects of care. i. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care. ii. Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services. 42 CFR §438.330(d) Attachment P7.9.1(VII)(A)	**HSAG suggested evidence:** Policies and procedures QAPIP description document PIP work plans • Quality Performance Improvement 1.0 (policy) • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 21 • Final Revised Draft MI2017-18 MSHN PIP Summary Report • FY19 PIP Recovery Implementation Plan Final	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
4. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's members; member demographic characteristics and health risks; and the interest of members in the aspect of service to be addressed. a. PIPs may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDHHS with consultation from the Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system. b. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department. c. The PIHP must engage in at least two projects during the waiver renewal period. 42 CFR §438.330(d) Attachment P7.9.1(VII)(B-E)	**HSAG suggested evidence:** Policies and procedures QAPIP description document PIP work plans • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 21 • Quality Performance Improvement 1.0 (policy) • MDHHS PIP Approved Topics for 2018 • Final Revised Draft MI2017-18 MSHN PIP Summary Report • FY19 PIP Recovery Implementation Plan Final	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Sentinel Events		
5. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm. a. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event. Attachment P7.9.1(VIII)(A)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Timeliness reports System documentation Examples of root cause analyses • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final Page 13 • Quality Critical Incident Policy (Page 1. 7 and 8th bullet.) • DMC Critical Incident Template • DMC Critical Incident Report Newaygo (Example) • NCMH 2019 MSHN CAP approved 7-3-2019 (Example) • NCMH Critical Incident Report (Example)	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: MSHN had not received any reportable sentinel events during the time period of October 1, 2018 and April 30, 2019.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** While the quality program description specified that the PIHP ensures Community Mental Health Services Programs (CMHSPs) and SUD providers review and monitor sentinel events within required time frames, it did not stipulate the required time frames. However, after the on-site review, a critical incident review tool was submitted that confirmed the PIHP monitored time frames as required by this element. HSAG recommends that the PIHP include time frame requirements in its policy. Additionally, HSAG recommends that the PIHP review its monitoring tools used for CMHSPs and SUD providers to ensure consistency of oversight between organizations for the same delegated functions.		
Required Actions: None.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
6. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse. Attachment P7.9.1(VIII)(B)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Organizational charts with credentials Examples of clinical reviews of events • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final page 13 c) Event Monitoring and Reporting	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: No reported sentinel events during the time frame of this review.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** While the quality program description specified that staff members with appropriate credentials are responsible for monitoring sentinel events, the PIHP reported that no sentinel events occurred during the time frame of review; therefore, HSAG reviewers were unable to verify implementation of this requirement. As no events were reported during the six-month review period, HSAG recommends that the PIHP conduct a thorough review of critical incidents reported by the CMHSPs and SUD providers to verify whether sentinel events are being underreported. Additionally, HSAG recommends that the PIHP review its monitoring tools used for CMHSPs and SUD providers to ensure consistency of oversight between organizations for the same delegated functions.		
Required Actions: None.		
Critical Incident Reporting Systems		
7. The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.	**HSAG suggested evidence:** Policies and procedures QAPIP description document Quarterly analyses reports Committee meeting minutes	☐ Met ☒ Not Met ☐ Not Applicable

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
42 CFR §438.330(b)(5)(ii) Attachment P7.9.1(VIII)(E)	• FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final page 13, 37, 38, 66. • Delegation Grid FY19 page 13 • Quality Critical Incidents (policy) • FY19 MSHN CI Submission Report 2.25.2019 • Visualizations by Board and Incident Type 2-19 • QIC Meeting Snapshot 2.28.2019	

PIHP Narrative:

HSAG Findings: While the PIHP demonstrated that it collected data on critical incidents, documentation to support that a qualitative and quantitative analysis occurred was minimal. While the PIHP presented data on the counts of critical incidents per CMHSP and category, and compared incidents per 1,000 members served per CMHSP, no documentation of a meaningful discussion of an analysis of the data was provided. Further, while critical incidents reports were presented at the Quality Improvement (QI) Council, minutes implied that the data were reviewed and no suggestions for additional reports were noted. Minutes did not demonstrate that a trend analysis occurred. After the on-site review, meeting minutes for the QI Council dated August 22, 2019, were provided and did suggest that a more meaningful discussion had occurred pertaining to the data; however, this meeting occurred four months after the review period and documentation of the trend analysis was still minimal and should be further enhanced. During the on-site review, PIHP staff members explained that the review of critical incidents was previously delegated to one CMHSP, and that the PIHP now retains this responsibility as of April 2019.

Recommendations: As the PIHP makes enhancements to its quarterly review of critical incidents, sentinel events, and risk events, HSAG recommends that the PIHP consider:

- Quantitative and qualitative analyses.
- Review of the details of and commonalities between events.
- Member-specific, provider-specific, and systemic trends.
- Incorporation of events related to SUD providers and members receiving SUD services.
- A review of data per event type per 1,000 members in order to conduct a comparative analysis between CMHSPs and providers.

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
• Conducting an in-depth review of CMHSPs and providers who consistently report minimal or no critical incidents, sentinel events, and risk events. • Ensuring reporting requirements are standardized between CMHSPs and providers to allow the PIHP to more easily aggregate the data. • Including staff members with varying credentials in its analysis of critical incidents and sentinel events. • Ensuring meeting minutes demonstrate that a meaningful analysis occurred at least every quarter, including a review of trends; review of RCAs and corrective actions; making recommendations for improvement when trends are identified; determining educational needs for staff members and providers; and monitoring compliance of delegated functions related to critical incidents, sentinel events, and risk events.		
Required Actions: The PIHP must analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.		
Assessment of Member Experiences with Services		
8. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered. a. The assessments must address the issues of the quality, availability, and accessibility of care. b. As a result of the assessments, the organization: i. Takes specific action on individual cases as appropriate; ii. Identifies and investigates sources of dissatisfaction; iii. Outlines systemic action steps to follow-up on the findings; and iv. Informs practitioners, providers, recipients of service and the governing body of assessment results. c. The organization evaluates the effects of the above activities.	**HSAG suggested evidence:** Policies and procedures QAPIP description document Examples of member experience surveys, focus groups, etc. Examples of quantitative and qualitative assessments and subsequent actions Committee meeting minutes • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final page 11, page 66, • Quality Consumer Satisfaction Surveys 1.0 (policy) • Delegation Grid FY19 page 13 • MSHN QIC Meeting Minutes 9-27-2018 • QIC Meeting Snapshot 11-15-2018	☐ Met ☒ Not Met ☐ Not Applicable

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
d. The organization insures the incorporation of members receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods. 42 CFR §438.330(c) Attachment P7.9.1(X)(A-D)	• RCAC Meeting Snapshot 10-12-2018 • RCAC Meeting Snapshot 12-07-2018 • RCAC Meeting Snapshot 2019-4-12 • Final SUD Satisfaction Survey • NCI Survey Adult in Person Survey 2011-2017 • FY18 Provider Satisfaction Survey no comments • Satisfaction Survey Action Plan • RSA Persons in Recovery Version #2 • RSA -R Provider Version • RSA-R Administrator Version • RSA-R Persons in Recovery • FY19 Recovery Implementation Plan Persons in Recovery Final 6.25.2019 • FY19 PIP Recovery Implementation Plan Final Survey results can be found on the MSHN Website Satisfaction Surveys	
PIHP Narrative: The SUD Satisfaction survey is conducted annually with those individuals receiving services. The NCI is conducted by Michigan Developmental Disabilities Institute (MIDDI) and reported out by MIDDI in coordination with MDHHS. This data is not separated by PIHP. The sample is meant to be adequate for all PIHPs to generalize the results. The Recovery Self-Assessment has three versions (Administrators, Providers and Persons in Recovery). The persons in recovery version was implemented in May of 2019 and will be completed annually.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
While not directly related to this standard, MSHN also completes an annual provider survey for the SUD provider network. MSHN uses the results of these surveys to complete an action plan for quality improvement efforts. The improvements that result from the action plan not only address the concerns of the providers, but also lead to changes to improve services for those we serve, such as reduction in duplication of paperwork, better informed/trained staff, efficiencies in processes, etc.		
HSAG Findings: The SUD member satisfaction survey presented a year-to-year comparison of results from 2015 to 2018. The summary of findings implied that the results will be presented at various committees. While meeting minutes confirmed that survey findings were presented, it was unclear as to what specific action steps were taken based on each year's findings, or the PIHP's evaluation process to determine the effectiveness of those actions. After the on-site review, a SUD monitoring tool was submitted that included a scoring element verifying the provider maintained a member satisfaction process that demonstrates progress towards continual improvement; however, this tool was blank and did not confirm that specific actions were taken based on the results of a satisfaction survey or that an evaluation of previously implemented actions occurred. Additionally, the PIHP did not demonstrate having a mechanism to assess member experience with services specific to members receiving long-term services and supports (LTSS) or home and community-based services (HCBS). Lastly, while survey results were presented at various committees that included members and providers and are available on the PIHP's website, documentation did not support that the PIHP had implemented a mechanism to inform providers and members of the availability of those results. The PIHP elected to conduct the Recovery Self-Assessment (RSA) survey in 2019, which was initiated in May 2019. **Recommendations:** HSAG recommends that the PIHP develop an annual assessment of member experience report. The PIHP could consider including in this report: • All activities to assess member experience with services such as member satisfaction surveys, focus groups, member interviews, feedback from the consumer advisory council, member grievances, etc. • National surveys and how the PIHP compares to national benchmarks. • An identified area (or areas) of focus across all activities to target actions steps and interventions to improve satisfaction. • An evaluation of the previous year's action steps and interventions to determine if they led to improved satisfaction. • Challenges or barriers in achieving member satisfaction goals. • Year-to-year comparison of activity results. An area (or areas) of focus could be directed toward a year-to-year decrease in member satisfaction in a particular area.		

Standard II—Quality Measurement and Improvement		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
• Should the PIHP achieve and sustain its member satisfaction goals over a period of time, revise the mechanisms for assessing member experience, such as identifying new member satisfaction surveys or developing new satisfaction questions; revise sampling methodology; and initiate new activities to assess satisfaction. • Findings specific to members receiving LTSS or HCBS. • National Core Indicators (NCI) survey results. While these results are not specific to PIHPs, the PIHP could use the results to identify and investigate areas of dissatisfaction and implement interventions for improvement.		
Required Actions: The PIHP must conduct periodic quantitative and qualitative assessments of member experiences with services. The assessments must be representative of the persons served and the services and supports offered, and meet all requirements of this element.		

Results—Standard II						
Met	=	6	X	1.0	=	6
Not Met	=	2	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	8	**Total Score**		=	6
Total Score ÷ Total Applicable					=	75%

Standard III—Practice Guidelines		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Practice Guidelines		
1. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served. 42 CFR §438.236(b)(1-2) Attachment P7.9.1(XI)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Quality_Evidence_Based_Practices FY19 QAPIP and FY18 Annual Effectiveness: Page 17 CLC_Charter_2018: Pages 1-2 Regional Medical Directors Committee Charter: Pages 1-2	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Adoption of Practice Guidelines		
2. The PIHP adopts practice guidelines that meet the following requirements: a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. b. Consider the needs of the PIHP's members. c. Are adopted in consultation with contracting health care professionals. d. Are reviewed and updated periodically, as appropriate. 42 CFR §438.236(b)(3-4)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Committee meeting minutes Document of consultation with network providers List of clinical practice guidelines with review and approval dates Quality_Evidence_Based_Practices FY19 QAPIP and FY18 Annual Effectiveness: Page 17 CLC_Charter_2018: Page 1-2	☒ Met ☐ Not Met ☐ Not Applicable

Standard III—Practice Guidelines		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	Regional Medical Directors Committee Charter: Pages 1-2 Region_5_Medical_Directors_Meeting__10.19.18 MSHN Clinical Practice Guidelines List	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Dissemination of Guidelines		
3. The PIHP disseminates the guidelines to all affected providers and, upon request, to members and potential members. 42 CFR §438.236(c)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Evidence of dissemination of guidelines to network providers and members	☒ Met ☐ Not Met ☐ Not Applicable
	Quality_Evidence_Based_Practices MSHN Clinical Practice Guidelines List	
PIHP Narrative: All policies and procedures are available to the general public as well as internal and external stakeholders on the MSHN website: https://midstatehealthnetwork.org/provider-network-resources/provider-requirements/policies-procedures/policies		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** HSAG recommends that the PIHP add detailed information to its written documentation about its process for disseminating the practice guidelines to its providers through its Constant Contact provider bulletin process. HSAG further recommends that the PIHP document its process for disseminating the guidelines to its members and potential members upon request.		
Required Actions: None.		

Standard III—Practice Guidelines		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Application of Guidelines		
4. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236(d)	**HSAG suggested evidence:** Policies and procedures QAPIP description document Staffing training materials Examples of member education materials	☒ Met ☐ Not Met ☐ Not Applicable
	MSHN FY19 LifeWays Handbook: Pages 57-69 MSHN_Access_Policy: Page 6 FY19 QAPIP and FY18 Annual Effectiveness: Page 15	
PIHP Narrative: The document "MSHN FY19 LifeWays Handbook" is an example of the regional member handbook. Pages 57-69 describes coverage of services and authorization decision-making based on eligibility and medical necessity.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Results—Standard III						
Met	=	4	X	1.0	=	4
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	4	Total Score		=	4
Total Score ÷ Total Applicable					=	100%

Standard IV—Staff Qualifications and Training		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Employed and Contracted Staff Qualifications		
1. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. a. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. Attachment P7.9.1(XII)	**HSAG suggested evidence:** Policies and procedures QAPIP description document • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final – pg. 12, section IV.a • PNM Provider Network Mgmt (Policy) pg. 2-3	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Staff Qualifications		
2. The PIHP must also ensure, regardless of funding mechanism (e.g., voucher): a. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following: i. Educational background ii. Relevant work experience iii. Cultural competence iv. Certification, registration, and licensure as required by law	**HSAG suggested evidence:** Human resources policies and procedures Cultural competency training Examples of job descriptions • FY19 MSHN Training Grid Final– entire document • Training Requirements Glossary – entire document • 2019 CMHSP Staff Training Tool – pg. 1-9 • CMHSP Credentialing Monitoring – pg. 2, number 10-11 • 2019 SUD – Staff Training Tool - pg. 1-7	☒ Met ☐ Not Met ☐ Not Applicable

Standard IV—Staff Qualifications and Training		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Attachment P7.9.1(XII)(1)(a-d)	• SUD Credentialing Monitoring pg. 1 number 1, 10, 11 • HR Personnel Manual 4.0 – pg. 7 • Quality Assurance Performance Improvement Manager – pg. 1, pg., 2 • Treatment Specialist – Job Descrip. 2019 • 2019 Staff Credentialing Tool – entire document • FY19 QAPIP and FY18 Annual Effectiveness and Evaluation with Attachments Final – pg. 14, section V.b.	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Staff Training		
3. The PIHP must also ensure, regardless of funding mechanism (e.g., voucher): a. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures. b. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities. Attachment P7.9.1(XII)(2-3)	**HSAG suggested evidence:** New hire training plan Examples of ongoing education and training • FY19 MSHN Training Grid Final – entire document • Training Requirements Glossary – entire document • 2019 CMHSP Staff Training Tool– pg. 1-9 • 2019 SUD – Staff Training Tool - pg. 1-7 • HR Performance Evaluation Procedure 1.0 – Pg. 2 • HR Employee Orientation Checklist Form 1.0 – pg. 2	☒ Met ☐ Not Met ☐ Not Applicable

Standard IV—Staff Qualifications and Training		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• RELIAS Training Screenshot – entire document • CMHSP Credentialing Monitoring – pg. 2, number 13 • Medicaid Subcontract Agreement – pg. 9, item X. • Performance Review Template – pg. 3	
PIHP Narrative: Training grid outlines minimum regional requirements per role/responsibility based on regulatory requirements. CMHSPs/ Subcontract Providers may institute additional requirements based on needs identified.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Results—Standard IV						
Met	=	3	X	1.0	=	3
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	3	Total Score		=	3
Total Score ÷ Total Applicable					=	100%

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Utilization Management Program		
1. Written Plan—Written utilization program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services. Attachment P7.9.1(XIV)(A)	**HSAG suggested evidence:** Policies and procedures Utilization management program description document • MSHN_UM_Plan_FY19: Pages 5-6, Section A. 2-3 • MSHN_Access_Policy: Pages 3-5 • FY19 QAPIP and FY18 Annual Effectiveness: Page 15	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
2. Scope—The program has mechanisms to identify and correct under-utilization as well as over-utilization. 42 CFR §438.330(b)(3) Attachment P7.9.1(XIV)(B)	**HSAG suggested evidence:** Policies and procedures Mechanisms to identify and correct under- and over-utilization Utilization management program description document Examples of under- and over-utilization reports • MSHN_UM_Plan_FY19, Pages 12-15, Section B.5 and C • MSHN_Utilization_Management_Policy: Page 1 • LOCUS Exception Report Guidance_Jan2019: Page 5 • LOCUSreport_CEI CMH_2019-04-04	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• Underuse_Report_CMH for Central Michigan • LOCUS Service Grid Rev. 2019-01-16 • CEI_LOCUS Quarterly Review Response_04_04_2019	
PIHP Narrative: MSHN has developed common benefit grids for populations served based on assessed level of need and recommended minimum and maximum amounts of services. Please see "LOCUS Service Grid Rev. 2019-01-16" as an example of the recommended utilization benefit grid for adult mental health consumers based on assessed level of care. The recommended minimum and maximum service thresholds are not meant in any way to be an arbitrary limit on services; they are meant to provide regional guidance only around average service utilization. On a quarterly basis, each CMH is provided with an exception report of cases falling over or under the recommended thresholds which they review to ensure individuals are being served appropriately according to individual need and medical necessity (please see "LOCUSreport_CEI CMH_2019-04-04"). Each CMH submits a response to MSHN outlining the findings of their reviews and any suggested corrective action to address over or under-utilization patterns (please see "CEI_LOCUS Quarterly Review Response_04_04_2019"). Please note: there have not been instances of under-utilization during FY19. A sample under-utilization report from FY18 was included here as an example.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
3. Procedures—Prospective (preauthorization), concurrent and retrospective procedures are established and include: a. Review decisions are supervised by qualified medical professionals. b. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate. c. The reasons for decisions are clearly documented and available to the member.	**HSAG suggested evidence:** Policies and procedures Utilization management program description document Organizational charts Member and provider materials (e.g., handbooks, manuals) Examples of analyses of member and provider satisfaction results, and other measures related to the utilization management Delegation oversight monitoring reports	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
d. There are well-publicized and readily-available appeals mechanisms for both providers and members. e. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures. f. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate. 42 CFR §438.210(b)(2)(ii) Attachment P7.9.1(XIV)(C)(1-4, 6-7)	• 3.a-d MSHN_Utilization_Management_Policy: Page 2 • MSHN_UM_Plan_FY19: Pages 4-16, Section III-Prospective, Concurrent & Retrospective Utilization Management Review • 3.f SHW_Delegated Managed Care Tool-Final: Pages 15-17 • MSHN_Delegation_Grid_FY19: Pages 1-3, 15 • 3.d CS Medicaid Beneficiary Appeals Grievances Policy • 3.d MSHN FY19 LifeWays Handbook: Pages 37-39 • 3.d Provider_Network_Provider_Appeals_Procedure • 3.e Quality Consumer Satisfaction Survey • 3.e FY18 Provider Satisfaction Survey • 3.e FINAL-SUD Satisfaction Survey Summary FY18 • 3.e Satisfaction Survey Action Plan	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Consistent Application		
4. The PIHP has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i)	**HSAG suggested evidence:** Policies and procedures Utilization management program description document Staff training materials Examples of inter-rater reliability audit results Examples of utilization management audit results • MSHN_UM_PLAN_FY19: Page 8 • SHW_Delegated Managed Care Tool-Final: Page 16 • Inter-Rater Reliability Review Process • Inter-Rater Reliability Form • Inter-Rater Reliability Analysis Tracking Document FY19 Quarter 1	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: *This is a delegated function; MSHN_UM_PLAN_FY19 is evidence of the regional PIHP guidance. Additional supporting documents are evidence of monitoring and oversight activities conducted by the PIHP of the CMHSP system*		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Authorization of LTSS		
5. The PIHP authorizes LTSS based on member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) Attachment P4.4.1.1	**HSAG suggested evidence:** Policies and procedures Utilization management program description document Examples of utilization management and/or care management audit results Case file review results • MSHN_Utilization_Management_Policy: Page 3 • MSHN_UM_PLAN_FY19: Page 7 • MSHN_Access_Policy: Page 6 • SHW_Chart Review Summary- Final: Page 12 • SHW_Delegated Managed Care Tool-Final: Page 25, 27	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Decision Makers		
6. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions. 42 CFR §438.210(b)(3) Attachment P7.9.1(IV)(C)(1)	**HSAG suggested evidence:** Policies and procedures Utilization management program description document Case file review results • MSHN_Utilization_Management_Policy: Page 1 • MSHN_Access_Policy: Page 2	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• SHW_Chart Review Summary- Final: Page 16 • SHW_Delegated Managed Care Tool-Final: Page 16	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Notice of Adverse Benefit Determination—Format		
7. The notice of Adverse Benefit Determination (ABD) must meet the following requirements: a. Member notice must be in writing and must meet the requirements of 42 CFR 438.10 (i.e., "…manner and format that may be easily understood and is readily accessible by such member and potential member," meets the needs of those with limited English proficiency and or limited reading proficiency). 42 CFR §210(c) 42 CFR §438.404(a) Attachment P6.3.1.1(IV)(A)(1)	**HSAG suggested evidence:** Policies and procedures Utilization management program description document ABD templates (including non-English languages if available) Case file review results • MSHN-FY19_Adverse_Benefit_Determination • CS_Customer_Consumer_Service_Policy • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy • SHW_Delegated Managed Care Tool-Final: Page 18	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. Please refer to Element 8 findings related to denial decision language.		
Required Actions: None.		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Notice of Adverse Benefit Determination—Content		
8. The notice of ABDs must meet the following requirements: a. Notification that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures; b. Description of ABD; c. The reason(s) for the ABD, and policy/authority relied upon in making the determination; d. Notification of the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the member's ABD (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits); e. Notification of the member's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter; f. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal; g. Notification of the member's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the member may be required to pay the costs of the continued	**HSAG suggested evidence:** Policies and procedures ABD templates Case file review results • MSHN-FY19_Adverse_Benefit_Determination • CS_Customer_Consumer_Service_Policy • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy	☐ Met ☒ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
services (only required when providing "Advance Notice of ABD"; h. Description of the procedures that the member is required to follow in order to exercise any of these rights; and i. An explanation that the member may represent him/herself or use legal counsel, a relative, a friend or other spokesman. 42 CFR §210(c) 42 CFR §438.404(b)(1-6) Attachment P6.3.1.1(IV)(A)(2-10)		
PIHP Narrative:		
HSAG Findings: Per the findings from the case file review, the descriptions of the adverse benefit determinations (ABDs) were not always clearly documented to ensure member understanding. The policy/authority relied upon in making the determinations was also not always specified. Additionally, there was at least one case example where it was not clear if the services were being terminated or reduced and an additional case where a member did not receive an ABD at all. Case #10 included an ABD, but the ABD was missing most of the required components. **Recommendations:** HSAG strongly recommends that the PIHP standardize the process for managing the ABDs across all CMHSPs, which includes ensuring that a standardized template is used by all CMHSPs. HSAG also recommends that the PIHP implement a quality auditing process of the ABDs to ensure that the ABDs being sent to members contain all required language and are easily understood. The PIHP should specifically review the language that is developed outside of the template language.		
Required Actions: The PIHP must ensure the notice of ABDs include all requirements listed under sub-elements *a–i*.		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Timing of Notice—Adequate Notice of Adverse Benefit Determination		
9. For a denial of payment for services requested (not currently provided), notice must be provided to the member at the time of the action affecting the claim. 42 CFR §438.404(c)(2) Attachment P6.3.1.1(IV)(B)(1)(a)	**HSAG suggested evidence:** Policies and procedures ABD template for denial of payment for services requested • MSHN-FY19_Adverse_Benefit_Determination • MSHN Notice of Authorization Denial • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy: Page 2 • SHW_Delegated Managed Care Tool-Final: Page 18	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** HSAG strongly recommends that the PIHP document a clear process for operationalizing the requirements for sending a notice of ABD to members when a denial of payment has been made.		
Required Actions: None.		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
10. For a Service Authorization decision that denies or limits services, notice must be provided to the member within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. 42 CFR §438.210(d)(1-2) Attachment P6.3.1.1(IV)(B)(1)(b)	**HSAG suggested evidence:** Policies and procedures ABD templates Timeliness reports Case file review results • SHW_Chart Review Summary- Final: Page 16 • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy: Page 2 • MSHN-FY19_Adverse_Benefit_Determination • MSHN_Delegation_Grid_FY19: Page 15 • FINAL-SummaryReportDenialGrievanceAppeals_FY19_Q1: page 9	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: Per the case file review findings, two authorization decisions were made outside of the required time frames.		
Required Actions: The PIHP must have a process to ensure that, for service authorization decisions that deny or limit services, notice is provided to members within 14 days following receipt of the requests for service for standard authorization decisions, or within 72 hours after receipt of requests for expedited authorization decisions.		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
11. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an ABD), on the date that the timeframes expire. 42 CFR §438.404(c)(5) Attachment P6.3.1.1(IV)(B)(1)(c)	**HSAG suggested evidence:** Policies and procedures ABD templates for untimely decisions Examples of ABD for untimely authorization decisions Timeliness reports Case file review results • SHW_Chart Review Summary- Final: Page 16 • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy: Page 2 • SHW_Delegated Managed Care Tool-Final: Page 16, 18	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: The PIHP's CS Medicaid Beneficiary Appeals Grievance policy stipulated that failure to make standard and expedited service authorization decisions and provide notice timely constitutes an ABD. However, during the on-site review, PIHP staff members explained that this process is not occurring as additional requests for services (after initial authorization of services) are not going through a formal request process. PIHP staff members indicated that, instead, needed services are authorized as a result of conversations that occur between the member and the provider. Additionally, the PIHP's Chart Review Tool included a section labeled *Service Authorization and Utilization Management*, which stated that the CMHSP provides Medicaid members with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and the CMHSP provides Medicaid members with written service authorization decisions no later than three days following receipt of a request for expedited service authorization, if warranted by the member's health or functioning, unless the PIHP has authorized an extension. The time frame should be 72 hours. Comments noted by the PIHP within this tool also indicated there was evidence that written authorizations were sent to the member's family within 15 days of the meeting. The case under review was scored a 100 percent, even though the standard time frame is 14 days. There was no mention of the process that should occur when a prior authorization decision is not made within the standard or expedited time frame. After the on-site review, the PIHP provided a Notice of Benefit Determination, which explained that the CMHSP's ability to resolve the member's standard appeal had been delayed more than 14 days. It was not clear if this notice was pertaining to an initial authorization request decision		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
or a decision on an appeal. It also was not clear if this letter was meant to be an ABD or notice of extension, as the letter also mentioned that the member's case manager was working with a provider to get an appointment scheduled and that services would remain authorized. **Recommendations:** HSAG strongly recommends that the PIHP ensure all requests for services are formally managed as a prior authorization request.		
Required Actions: The PIHP must have a process to ensure that, for service authorization decisions not reached within 14 days for standard request or 72 hours for an expedited request, the authorization needs to be handled as a denial and the member must receive notice of ABD on the date that the time frame expires.		
12. The PIHP may be able to extend the standard Service Authorization timeframe in certain circumstances. If so, the PIHP must: a. Provide the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a Grievance if he or she disagrees with that decision; and b. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) Attachment P6.3.1.1(IV)(B)(1)(c)	**HSAG suggested evidence:** Policies and procedures Member notice of extension template Examples of member notice of extension letters Timeliness reports for extensions • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy: Page 1, item 6 • SHW_Delegated Managed Care Tool-Final: Page 16-17	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: The PIHP provided its CS Medicaid Beneficiary Appeals Grievance Policy, which indicated that each CMHSP and SUD provider must have a local procedure in place that is in compliance with the MDHHS Grievance and Appeal Technical Requirement and 42 CFR §438 Subpart F—Grievance and Appeal System. The PIHP also included its CMHSP Delegated Managed Care Tool, which included a section on utilization management that specifically required written notice to members within 14 calendar days for a standard request or three days following receipt of a request for expedited authorization, unless the PIHP has authorized an extension. The tool referenced federal Content of Notice requirements but did not reference Timing of		

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Notice requirements under 42 CFR §438.404(c)(4), so it was not clear if the CMHSP's extension process was being reviewed. Additionally, it appeared that only the CMHSP's Utilization Management Plan was reviewed as part of the audit, which would not include a review of the notices sent to members in the case of a time frame extension. Although the PIHP also provided a Chart Review Summary, there was no documentation to support a review of CMHSP's compliance with extension requirements, including notice to members of the reason for the decision to extend the time frame and the member's right to file a grievance if he or she disagrees with the extension. Additionally, the Chart Review Summary referenced a 15-day time frame, so it was not clear if this is referring to the standard time frame for making an authorization decision, which would be inaccurate, or if this is referring to some other standard being reviewed. After the on-site review, the PIHP provided a Notice of Benefit Determination, which explained that the CMHSP's ability to resolve the member's standard appeal had been delayed more than 14 days. It was not clear if this notice was pertaining to an initial authorization request decision or a decision on an appeal. It also was not clear if this letter was meant to be an ABD or notice of extension, as the letter also mentioned that the member's case manager was working with a provider to get an appointment scheduled and that *CSM* services would remain authorized. Finally, although the PIHP provided a copy of one of the CMHSP's handbooks, which explained that a grievance includes a member's right to dispute an extension of time proposed by the PIHP to make an authorization decision, no additional evidence was provided to show implementation of this process.		
Required Actions: The PIHP must have a documented process for extending service authorization time frames in certain circumstances. The process must include that, if the time frame is extended, the PIHP will provide the member with written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and the PIHP will issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.		
Timing of Notice—Advance Notice of Adverse Benefit Determination		
13. Advance notice of ABD is required for reductions, suspensions or terminations of previously authorized/currently provided Medicaid Services. a. Must be provided to the member at least ten (10) calendar days prior to the proposed effective date. 42 CFR §438.404(c)(1) 42 CFR §431.211 Attachment P6.3.1.1(IV)(B)(2)(a-b)	**HSAG suggested evidence:** Policies and procedures ABD templates Timeliness reports • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy: Page 2 • MSHN-FY19_Adverse_Benefit_Determination: Page 1	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
14. Limited Exceptions: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, if: a. The PIHP has factual information confirming the death of a member; b. The PIHP receives a clear written statement signed by a member that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information; c. The member has been admitted to an institution where he is ineligible under the plan for further services; d. The member's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address; e. The PIHP establishes that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; h. The date of action will occur in less than 10 calendar days.	**HSAG suggested evidence:** Policies and procedures ABD templates • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy: Page 1, item 6 • SHW_Delegated Managed Care Tool-Final: Page 19	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
i. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the member (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action). 42 CFR §438.404(c)(1) 42 CFR §431.213 42 CFR §438.214 Attachment P6.3.1.1(IV)(B)(2)(c)(i-iv)		
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Required Recipients of Notice of Adverse Benefit Determination		
15. Required Recipients of notice of ABD: a. The member must be provided written notice. b. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. c. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person-centered planning process still	**HSAG suggested evidence:** Policies and procedures ABD templates Examples of provider notification Case file review results • MSHN-FY19_Adverse_Benefit_Determination • UM_Utilization_Management_Policy: Page 2 • SHW_Delegated Managed Care Tool-Final: Page 17-18	☒ Met ☐ Not Met ☐ Not Applicable

Standard V—Utilization Management		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
constitutes an adverse benefit determination, and requires a written notice of action. 42 CFR §438.210(c) 42 CFR §438.404(a) Attachment P6.3.1.1(IV)(C)(1-3)		
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Compensation for Utilization Management Activities		
16. The PIHP must assure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) MDHHS Contract Part II A-4.12	**HSAG suggested evidence:** Policies and procedures Staff attestations Staff training materials • MSHN_Utilization_Management_Policy: Page 3 • MSHN_Access_Policy: Page 6	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Results—Standard V						
Met	=	12	X	1.0	=	12
Not Met	=	4	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	16	Total Score		=	12
Total Score ÷ Total Applicable					=	75%

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Member Rights		
1. The PIHP has written policies regarding member rights. 42 CFR §438.100(a)(1)	**HSAG suggested evidence:** Policies and procedures • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP_Policy • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy • CS_Advance_Directives_Policy • CS_SUD_Recipient_Rights_Policy	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations**: While the Customer/Consumer Service policy included a statement that the PIHP is to provide information to members on how to access the various recipient rights processes, it did not specify what the various recipient rights processes were. HSAG strongly recommends that the PIHP specify all member rights, including both member rights defined in federal regulations and Michigan Mental Health Code into one policy.		
Required Actions: None.		
2. The PIHP ensures that its employees and contracted providers observe and protect member rights. 42 CFR §438.100(a)(2)	**HSAG suggested evidence:** Policies and procedures Staff training materials Provider manual, contract, orientation materials • MSHN_Delegation_Grid_FY19 • FY19_MSHN_Training_Grid_FINAL Pages 1,2 • 2019 CMHSP Delegated Managed Care Tool: Pages 4, 37	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• 2019 MSHN Grievance and Appeal Review Tool • PN_Provider_Network_Mgmt_Policy • MSHN FY 2019 MEDICAID SUBCONTRACTING AGREEMENT: Pages 10, 27-28	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
3. In accordance with 42 CFR 438.100, the PIHP shall guarantee members all rights in the Member Rights Checklist. 42 CFR §438.100(b-d)	**HSAG suggested evidence:** Policies and procedures Member materials Member Rights Checklist	☒ Met ☐ Not Met ☐ Not Applicable
	• MI2018-19_PIHP_CM_Standard VIII_Member Rights Checklist • CS_Medicaid_Beneficiary_Appeals_Grievances_Policy • MSHN FY19 LifeWays Handbook • UM_Utilization_Management_Policy • 2019 CMHSP Delegated Managed Care Tool: Page 5	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Information Requirements—Language and Format		
4. Members have the right to receive information in accordance with the following: a. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria). b. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific non-English Language that is spoken as the primary language by more than 5% of the population in the PIHP's Region. 42 CFR §438.10(c)(1) 42 CFR §438.10(d)(1) MDHHS Contract Part II A-6.3.2(A)(1, 3)	**HSAG suggested evidence:** Policies and procedures Reading grade-level evaluation tools Audit reports or results Examples of non-English member materials • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP_Policy • FY18_MSHN_Guide_To_Services-Spanish • 2019 CMHSP Delegated Managed Care Tool: Pages 1-2	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
5. The PIHP must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. a. Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. c. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the PIHP's member/customer service unit. d. Large print means printed in a font size no smaller than 18 point. 42 CFR §438.10(d)(3) MDHHS Contract Part II A-6.3.2(A)(3) MDHHS Contract Part II A-6.3.2(B)(1-2)	**HSAG suggested evidence:** Policies and procedures Examples of non-English member materials Examples of member materials in alternative formats Member handbook Examples of taglines • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP_Policy • FY18_MSHN_Guide_To_Services-Spanish • MSHN FY19 LifeWays Handbook: Pages 6-7, 10	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
6. The PIHP must make those services available free of charge to each member. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. b. Oral interpretation requirements apply to all non-English languages, not just those that MDHHS identifies as prevalent. 42 CFR §438.10(d)(4) MDHHS Contract Part II A-6.3.2(A)(3) MDHHS Contract Part II A-6.3.2(B)(1)	**HSAG suggested evidence:** Policies and procedures Member handbook • MSHN FY19 LifeWays Handbook: Pages 10, 53 • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP_Policy	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
7. The PIHP must notify its members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access those services. d. How to access alternative formats. 42 CFR §438.10(d)(5)(i-iii) MDHHS Contract Part II A-6.3.2(B)(1)	**HSAG suggested evidence:** Policies and procedures Member handbook • MSHN FY19 LifeWays Handbook: Pages 10 • CS_Customer_Consumer_Service_Policy • CS_Information_Accessiblity_LEP_Policy	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
8. The PIHP must provide all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner than takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. d. Include large print taglines and information on how to request aids and services, including the provision of the materials in alternative formats. e. Large print means printed in a font size no smaller than 18 point. 42 CFR §438.10(d)(6)(i-iv)	**HSAG suggested evidence:** Policies and procedures Member handbook Member materials Internal audit results • CS_Customer_Consumer_Service_Policy: Page 2 • MSHN FY19 LifeWays Handbook: Pages 6-7, 10 • CS_Information_Accessiblity_LEP_Policy • 2019 CMHSP Delegated Managed Care Tool: Page 1	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Written Notification of Significant Change		
9. The PIHP must give each member written notice of any significant change in the information specified in 438.10(g) (member handbook) at least 30 days before the intended effective date of the change. 42 CFR §438.10(g)(4)	**HSAG suggested evidence:** Policies and procedures Examples written member notification • CS_Customer_Consumer_Service_Policy: Page 2 • CS_Customer_Handbook_Policy: Page 1 • FY19 MSHN Handbook Insert	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Notice of Termination of Providers		
10. The PIHP will make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. 42 CFR §438.10(f)(1) MDHHS Contract Part II A-6.3(B)(2)(b)	**HSAG suggested evidence:** Policies and procedures Member notification of provider termination template Examples of member notification of provider termination • CS_Customer_Consumer_Service_Policy: Page 2 • 2019 CMHSP Delegated Managed Care Tool: Page 1 • Renewal-Closure Letter • Renewal Contract Termination Notice Acknowledgement	☒ Met ☐ Not Met ☐ Not Applicable

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Advance Directives		
11. In accordance with 42 CFR 422.128 and 42 CFR 438.6, the PIHP shall: a. Maintain written policies and procedures for advance directives. b. Provide adult members with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. c. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. d. Inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services. e. Prohibit conditioning the provision of care based on whether or not the individual has executed an advance directive. 42 CFR §422.128 42 CFR §438.6 42 CFR §438.10(g)(2)(xii) MDHHS Contract Part II A-7.10.5	**HSAG suggested evidence:** Policies and procedures Member information materials related to advance directives Member handbook • CS_Advance_Directives_Policy • 2019 CMHSP Delegated Managed Care Tool: Page 3 • MSHN_Delegation_Grid_FY19: Pages 3-4 • MSHN Advance Directive Brochure_2017 • MSHN FY19 LifeWays Handbook: Page 44	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Managed Care and Care Coordination		
12. The PIHP will provide information to members about managed care and care coordination responsibilities of the PIHP, including: a. The information on the structure and operation of the PIHP. b. Physician incentive plans in use by the PIHP or network providers. 42 CFR §438.10(f)(3) MDHHS Contract Part II A-6.3.2(B)(2)(d)(i-ii)	**HSAG suggested evidence:** Policies and procedures Member materials Member handbook • MSHN FY19 LifeWays Handbook: Pages 13, 58	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard VIII—Member Rights and Protections		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Annual Cost of Services		
13. The PIHP must annually (e.g., at the time of person-centered planning) provide to the member the estimated annual cost to the PIHP of each covered support and service he/she is receiving. MDHHS Contract Part II A-6.3.2(B)(2)(a)(vi)	**HSAG suggested evidence:** Policies and procedures Examples of annual cost notifications • MSHN_Utilization_Management_Policy: Page 3 • MSHN FY19 LifeWays Handbook: Page 58 • 2019 CMHSP Delegated Managed Care Tool: Pages 23, 42 • Estimated Cost of Service Example	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Results—Standard VIII						
Met	=	**13**	**X**	**1.0**	=	**13**
Not Met	=	**0**	**X**	**.00**	=	**0**
Not Applicable	=	**0**				
Total Applicable	=	**13**	**Total Score**		=	**13**
Total Score ÷ Total Applicable					=	**100%**

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Credentialing		
1. The PIHP shall have written credentialing policies and procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. a. Credentialing shall take place every two years. b. The PIHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. c. The PIHP also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the PIHP's standards. 42 CFR §438.214(a-b) MDHHS Contract Part II A-7.1	**HSAG suggested evidence:** Policies and procedures • PNM_Credentialing_Recredentialing_3.0 – pg. 1 • Provider_Network – Credentialing_Monitoring_Procedure – entire document • 2019 CMHSP Staff Credentialing & Recredentialing Tool – entire document • 2019 SUD – Staff Credentialing Tool – entire document • SUD Credentialing Monitoring – entire document • CMHSP Credentialing Monitoring – entire document • SDS Out of State Placement – pg. 1	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Provider Network policies and procedures are due for annual review at the committee level in September. To improve understanding of requirements, we have already begun the process of revising credentialing and recredentialing policies and procedures by developing a single policy and a single procedure to include requirements for initial, recredentialing, temporary, provisional, suspension, primary source verification guidelines, monitoring, and notification. In addition, the criminal background check procedure is being separated into its own procedure. We believe this will help providers to better understand the requirements and responsibilities.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** While PIHP staff members explained that out-of-state providers are required to complete the PIHP's credentialing process and that verification of the out-of-state licensure would be completed, HSAG recommends that the PIHP add this clarifying language to its credentialing policies. Additionally, while sanction provisions were included in the CMHSP and SUD provider contracts, HSAG recommends that the PIHP add provisions for sanctioning providers who are out of compliance with the PIHP's standards in its credentialing policies.		
Required Actions: None.		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Provider Discrimination		
2. The PIHP must ensure the credentialing and re-credentialing processes do not discriminate against: a. A health care professional solely on the basis of license, registration, or certification. b. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment. 42 CFR §438.214(c) Attachment P7.1.1(B)(2)(a)(i-ii)	**HSAG suggested evidence:** Policies and procedures Provider manual Provider contract templates Audits of credentialing decisions • PNM_Credentialing_Recredentialing_3.0 – pg. 2 • Medicaid Subcontracting Agreement - Pg. 10-11 • SUD Contract - pg. 15 • 2019 CMHSP Staff Credentialing & Recredentialing Tool – pg.1 • 2019 SUD – Staff Credentialing Tool – pg. 2	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Retain Rights for Provider Selection		
3. If the PIHP delegates to another entity any of the responsibilities of credentialing/recredentialing or selection of providers, it must: a. Retain the right to approve, suspend, or terminate providers from participation in Medicaid funded services a provider selected by that entity	**HSAG suggested evidence:** Policies and procedures Delegation agreement or subcontract template Examples of delegation agreements or subcontracts Delegation oversight documentation (meeting minutes, reports, audit tools, etc.)	☐ Met ☒ Not Met ☐ Not Applicable

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
b. Meet all requirements associated with the delegation of PIHP functions. c. Be responsible for oversight regarding delegated credentialing or re-credentialing decisions. Attachment P7.1.1(B)(3)	• PNM_Credentialing_Recredentialing_3.0 – pg. 2 • Delegation Grid – FY19 – pg.11 • SUD Credentialing Monitoring – pg. 2 • CMHSP Credentialing Monitoring – entire document • 2019 CMHSP Staff Credentialing & Recredentialing Tool – entire document • 2019 SUD – Staff Credentialing Tool - entire document • Medicaid Subcontracting Agreement (Pg. 10-11) • SUD Contract – pg. 13 & 20 • Provider_Network – Credentialing_Monitoring_Procedure – pg. 2	
PIHP Narrative: *2019 CMHSP Staff Credentialing & Recredentialing Tool* and the *2019 SUD – Staff Credentialing Tool* are used when selecting a sample of providers credentialing/recredentialing records to verify the process meets requirements and there is evidence of primary source verification. *SUD Credentialing monitoring* and *CMHSP Credentialing Monitoring* represent the overall monitoring of the Credentialing processes, including review of policies and procedures.		
HSAG Findings: While the PIHP demonstrated that it completed credentialing file reviews as part of its oversight and monitoring of credentialing functions being performed by the CMHSPs and SUD providers, the credentialing file review tool did not include a review of all credentialing components required by the PIHP's contract with MDHHS. Additionally, while the PIHP's credentialing monitoring standard verified CMHSPs had an appeal process for adverse credentialing decisions, this was not verified on the credentialing monitoring standard for SUD providers performing credentialing functions. Further, the SUD provider manual and contract submitted as evidence of compliance for this element did not include provisions requiring SUD providers performing credentialing functions to have an appeal process for adverse credentialing decisions. Documentation and discussion with PIHP staff members did not confirm that SUD providers had an appeal process or who was responsible for managing the appeal process. **Recommendations:** The credentialing monitoring standard for the CMHSPs and SUD providers included a requirement related to provider written notice of adverse credentialing functions. The credentialing file review tool for CMHSPs also included a section where the PIHP reviewed denied applications and		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
notices; however, this was not included on the SUD provider tool. HSAG recommends that the PIHP's oversight process for credentialing functions be consistent across all organizations performing credentialing functions.		
Required Actions: The PIHP must be responsible for oversight regarding delegated credentialing or recredentialing decisions and meet all requirements associated with the delegation of PIHP functions.		
Notification of Adverse Credentialing Decision		
4. An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP. 42 CFR §438.12(a)(1) MDHHS Contract Part I-37.0(2) Attachment P 7.1.1(H)	**HSAG suggested evidence:** Policies and procedures Provider credentialing denial letter template Examples of provider credentialing denial notices Case file review results • Provider Network Credentialing Suspension Revocation Procedure – pg. 1 • 2019 CMHSP Delegated Managed Care Tool – pg. 3 • 2019 SUD DMC Monitoring Tool – pg. 2 • SUD Credentialing Monitoring – pg. 2 • CMHSP Credentialing Monitoring – pg. 2 • Denied credentialing applications – entire document • Denied Application (3.7.2018)	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Denied credentialing applications (excel file) represents the organizations that were denied participation in the MSHN SUD network as a result of organizational credentialing. If a LIP were to be denied credentialing, they would be listed on this document as well. To date, MSHN has not denied credentialing to a LIP (employed or contracted). The appeal process is can be found in the SUD Provider Manual and the SUD Contract as indicated below.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. Refer to Element 3 for additional findings.		
Required Actions: None.		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Appeal of Adverse Credentialing Decision		
5. Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended or terminated for any reason other than lack of need. Attachment P7.1.1(I)	**HSAG suggested evidence:** Policies and procedures Provider manual Provider credentialing denial letter template Examples of provider credentialing denial notices • Providers Network Provider Appeals Form Fillable – entire document • SUD Provider Manual FY19 – pg. 6 • CMHSP Credentialing Monitoring – pg. 3 • SUD Contract – pg. 27	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: To date, MSHN has not had an appeal as a result of an adverse credentialing decision. The appeal process is can be found in the SUD Provider Manual and the SUD Contract as indicated below		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. Refer to Element 3 for additional findings.		
Required Actions: None.		
Case File Review—Initial Credentialing		
6. The PIHP complies with all initial (including provisional) credentialing requirements according to the Initial Credentialing Audit Tool. Attachment P7.1.1(C-D)	**HSAG suggested evidence:** Case file review results	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative: This was covered in the case file reviews that occurred on 7-26-2019. MSHN monitors compliance during the Delegated Managed Care Reviews. If Additional evidence is needed, MSHN may be able to provide upon request.		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**

HSAG Findings: The initial credentialing file review identified the following opportunities for improvement:

- For five cases, at least one attestation and disclosure question was not located in the file. For two of these cases, no questions were located. For one of these cases, while questions related to having license suspension, felony conviction, privileges removed, and disciplinary actions were located in the file, it only asked for a three-year history and not all history. For one case, while an application with disclosure and attestation questions was located in the file, it was dated several months after the credentialing process.
- For two cases, the Michigan Department of Licensing and Regulatory Affairs (LARA) verification did not occur timely. For one of these cases, it occurred several months prior to the credentialing process and for another case it occurred several months after the credentialing process.
- For one case, an evaluation of the provider's work history for the prior five years was not located.
- For one case, a provider disclosed being board certified; however primary source verification (PSV) was not located. Additionally, while the American Medical Association (AMA) profile was included in the file, it was dated several months after the credentialing process was initiated. The profile did not specify that the provider was board certified.
- For one case, PSV of graduation from an accredited school was not located in the file.
- For four cases, the National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query was either not located in the file or dated after the provider was credentialed and outside the time period of review. Or, in lieu of the NPDB/HIPDB query, all of the following were either not located in the file or did not occur timely:
  - Minimum five-year history of professional liability claims resulting in a judgment or settlement.
  - Disciplinary status with regulatory board or agency.
  - Medicare/Medicaid sanctions.
- For four cases, verification that the provider was approved by a credentialing committee or designee was not located in the file.
- For one case, a provider that was included on the initial universe file as beginning the initial credentialing process in October 2018, appeared to have been hired in 2005. Based on the documentation received in the file, it was unclear if the provider was included on the universe file in error or had not been formally credentialed. Further, PSV was documented at different times; for example, the provider's application was dated 2005, the LARA profile was verified in January 2014 and June 2019, the Drug Enforcement Administration (DEA) registration was verified in 2017, and the AMA profile was verified in July 2019. The discrepancies in the dates suggest that the provider had not gone through the complete formal credentialing process at a given period of time.
- The PIHP's credentialing policies did not identify a timeliness requirement for which it must complete the credentialing process; therefore, compliance with timeliness standards could not be completed.

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Recommendations: When the PIHP identifies timeliness requirements for credentialing, HSAG recommends that the time frame standard be calculated from the date of receipt of a complete application from a provider to the date the notice is sent to a provider informing him or her of the credentialing decision. The PIHP should also consider implementing a standardized time frame in which verification of credentialing requirements is acceptable; for example, verification of licensure, board certification, and sanctions, etc., must be dated within a certain time frame prior to the date of the credentialing decision. Additionally, HSAG strongly recommends that the PIHP develop a process to ensure that providers going through the credentialing process are reviewed and approved by an individual or committee with the same or similar credentials of that provider, especially for providers whose files are considered adverse. HSAG further recommends that the PIHP strengthen processes to ensure that it maintains an initial and recredentialing file for each credentialed provider that includes (1) the initial credentialing and all subsequent recredentialing applications, (2) information gained through PSV, and (3) any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards. HSAG also recommends that the PIHP include an attestation and disclosure question related to the inability to perform the essential functions of the position. Lastly, HSAG recommends that the five-year history of professional liability claims resulting in a judgment or settlement be verified by NPDB/HIPDB or directly by the insurance carrier.		
Required Actions: The PIHP must comply with (and ensure that delegates performing credentialing functions comply with) all initial credentialing requirements as outlined in its contract with MDHHS.		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Case File Review—Recredentialing		
7. The PIHP complies with all initial (including provisional) credentialing requirements according to the Re-Credentialing Audit Tool. Attachment P7.1.1(E)	**HSAG suggested evidence:** Case file review results	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative: This was covered in the case file reviews that occurred on 7-26-2019. MSHN monitors compliance during the Delegated Managed Care Reviews. If Additional evidence is needed, MSHN may be able to provide upon request.		
HSAG Findings: The recredentialing file review identified the following opportunities for improvement: • For two cases, one or more attestation and disclosure questions were not located in the file. • For two cases, LARA verification was either not found in the file or was not completed timely. For one case, LARA verification occurred in 2016 and indicated the license expired in 2017. A second LARA verification occurred in March 2019, which was four months after the provider was credentialed. • For one case, the provider disclosed being board certified; however, PSV was not located in the file. • For two cases, PSV of documentation of graduation from an accredited school was not located in the file. One of these cases included a diploma only and the second case included transcripts that were issued to the student, suggesting that PSV was not completed during the initial credentialing process. • For four cases, the NPDB/HIPDB query was either not located in the file or dated after the provider was credentialed. Or in lieu of the NPDB/HIPDB query, all of the following were either not located in the file or did not occur timely: – Minimum five-year history of professional liability claims resulting in a judgment or settlement. – Disciplinary status with regulatory board or agency. – Medicare/Medicaid sanctions. • For three cases, Medicare and Medicaid sanction searches were either not located in the file, were dated after the provider completed the credentialing process, or an Office of the Inspector General (OIG) sanction search was completed but included the names of other individuals and not the provider being credentialed. • For five cases, documentation of a review and consideration of member grievances and appeal information during the recredentialing process were not located in the files.		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
• For three cases, documentation of a review and consideration of PIHP quality issues during the recredentialing process were either not located in the file or did not occur timely. For two cases, while a performance evaluation was included in the file, one was dated in 2015 and the other was dated after the provider was recredentialed. • For five cases, verification that the provider was approved by a credentialing committee or designee was not located in the file. For one case, a supervisor signature was located; however, it was unclear if this individual had the authority to approve or deny a provider's credentials. • For one case, the prior credentialing date was not provided; therefore, compliance with the two-year recredentialing cycle could not be determined. • The PIHP's credentialing policies did not identify a timeliness requirement for which it must complete the credentialing process; therefore, compliance with timeliness standards could not be completed. **Recommendations:** When the PIHP identifies timeliness requirements for credentialing, HSAG recommends that the time frame standard be calculated from the date of receipt of a complete application from a provider to the date the notice is sent to a provider informing him or her of the credentialing decision. The PIHP should also consider implementing a standardized time frame in which verification of credentialing requirements is acceptable; for example, verification of licensure, board certification, and sanctions, etc., must be dated within a certain time frame prior to the date of the credentialing decision. Additionally, HSAG strongly recommends that the PIHP develop a process to ensure that providers going through the credentialing process are reviewed and approved by an individual or committee with the same or similar credentials of that provider, especially for providers whose files are considered adverse. HSAG further recommends that the PIHP strengthen processes to ensure that it maintains an initial and recredentialing file for each credentialed provider that includes (1) the initial credentialing and all subsequent recredentialing applications, (2) information gained through PSV, and (3) any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards. HSAG also recommends that the PIHP include an attestation and disclosure question related to the inability to perform the essential functions of the position. Lastly, HSAG recommends that the five-year history of professional liability claims resulting in a judgement or settlement be verified by NPDB/HIPDB or directly by the insurance carrier.		
Required Actions: The PIHP must comply with (and ensure delegates performing credentialing functions comply with) all initial credentialing requirements as outlined in its contract with MDHHS.		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Case File Review—Organizational Credentialing		
8. The PIHP complies with all initial (including provisional) credentialing requirements according to the Organizational Credentialing Audit Tool. Attachment P7.1.1(F)	**HSAG suggested evidence:** Case file review results	☐ Met ☒ Not Met ☐ Not Applicable
PIHP Narrative: This was covered in the case file reviews that occurred on 7-26-2019. MSHN monitors compliance during the Delegated Managed Care Reviews. If Additional evidence is needed, MSHN may be able to provide upon request.		
HSAG Findings: The HCBS organization credentialing file review identified the following opportunities for improvement: • For one case, while a license was located in the file, it was not the provider that was being credentialed. Documentation suggested that the license for the provider had yet to be received. • For one case, while a license was located in the file, LARA verification was not located in the file to ensure the provider is in good standing with the State regulatory body. • For four cases, documentation that the provider was approved by a credentialing committee or designee was not located in the file. • The PIHP's credentialing policies did not identify a timeliness requirement for which it must complete the credentialing process; therefore, compliance with timeliness standards could not be completed. **Recommendations:** When the PIHP identifies timeliness requirements for credentialing, HSAG recommends that the time frame standard be calculated from the date of receipt of a complete application from a provider to the date the notice is sent to a provider informing him or her of the credentialing decision. The PIHP should also consider implementing a standardized time frame in which verification of credentialing requirements is acceptable; for example, verification of licensure, board certification, and sanctions, etc., must be dated within a certain time frame prior to the date of the credentialing decision. Additionally, HSAG recommends that the PIHP develop a process to ensure that providers going through the credentialing process are reviewed and approved by a committee or individual with the appropriate expertise, especially for providers whose files have adverse findings (clinical, compliance, environmental, etc.). HSAG further recommends that the PIHP strengthen processes to ensure that it maintains an initial and recredentialing file for each credentialed provider that includes (1) the initial credentialing and all subsequent recredentialing applications, (2) information gained through PSV, and (3) any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards. In addition to documenting		

Standard XI—Credentialing		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
verification of sources on a standard credentialing form, HSAG recommends that the PIHP ensure screen shots of verifications are also saved in each credentialing file.		
Required Actions: The PIHP must comply with (and ensure delegates performing credentialing functions comply with) all organizational credentialing requirements as outlined in its contract with MDHHS.		
HCBS Final Rule		
9. The PIHP will not enter into new contracts with new providers of services covered by the Federal HCBS Rule (42 CFR Parts 430, 431, 435, 436, 440, 441 and 447) unless the provider has obtained provisional approval status through completion of the HCBS New Provider Survey, demonstrating that the provider does not require heightened scrutiny. Provisional approval allows a new provider or an existing provider with a new setting or service to provide services to HCBS participants for 90 days. HCBS Final Rule 2017 MDHHS Contract Part I-18.1.13	**HSAG suggested evidence:** Policies and procedures Case file review results • Service Delivery System Procedure: Provisional Approval to Provide Residential and Non-Residential Home and Community Based Services (HCBS) • NEW_HCBS_NON-RES.PROVISIONAL_SURVEY3.2018 • HCBS provider standards checklist.3.2018docx • HCBS Residential Provisional Approval survey 3.2018	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** HSAG recommends that the PIHP develop a formal policy and/or work plan to ensure all providers are in compliance with the Home & Community Based Services Final Regulation (https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html) by the date required by CMS, for both pre-existing and new providers.		
Required Actions: None.		

Results—Standard XI						
Met	=	5	X	1.0	=	5
Not Met	=	4	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	9	Total Score		=	5
Total Score ÷ Total Applicable					=	56%

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Care and Coordination of Services		
1. The PIHP must ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally responsible for coordinating the services accessed by the member. a. The member must be provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) MDHHS Contract Part II A-6.3.2(B)(2)(d)(iii)	**HSAG suggested evidence:** Policies and procedures Examples of member notification of designated person or entity (member ID card, new member materials, member handbook, service plan, etc.) MSHN FY19 LifeWays Handbook: Page 41 MSHN_Access_Policy: Page 1	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** While PIHP staff members explained that the person who is formally responsible for coordinating services for a member is the primary case holder identified during the pre-planning process, HSAG recommends that the PIHP add this clarifying language to its care coordination policies.		
Required Actions: None.		
2. The PIHP coordinates the services the PIHP furnishes to members: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital or institutional stays. b. With the services the member receives from any other managed care organization or entity. c. With the services the member receives in fee-for-service (FFS) Medicaid.	**HSAG suggested evidence:** Policies and procedures Examples of service plans Examples of integrated care plans MSHN_Delegation_Grid_FY19: Page 13 MSHN_Population_Health_Integrated_Care_Policy: Page 1 MSHN_Care_Coordination_Planning_Procedure: Integrated Care Plan Example 1: Page 1	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
d. With the services the member receives from community and social supports. 42 CFR §438.208(b)(2)(i-iv) MDHHS Contract Part II A-7.2 – 7.4	MSHN_Service_Philosophy_Policy: Pages 1, 4 SHW_Delegated Managed Care Tool-Final: Pages 29-30	
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** While discussion with PIHP staff members during the on-site review confirmed care coordination expectations that meet the requirements of this element, HSAG recommends that the PHIP add clarifying language to its care coordination policies; specifically, care coordination with Medicaid fee-for-service (FFS) programs when applicable.		
Required Actions: None.		
3. The PIHP makes a best effort to conduct an initial health screening of each member's needs, within 90 days of the effective date of enrollment for all new members. a. Including subsequent attempts if the initial attempt to contact the member is unsuccessful. 42 CFR §438.208(b)(3)	**HSAG suggested evidence:** Policies and procedures Timeliness tracking mechanisms ACCESS.SCREENING.TOOL: Pages 4-5 MSHN_Access_Policy: Page 5	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: The PIHP delegates screening activities to its CMHSP participants; basic health information is collected as a standard part of all initial screenings at the time an individual makes a request for service. Expectations related to inclusion of health information in screening is contained in the MSHN Access Policy (pg.5). The ACCESS.SCREENING.TOOL document is an example of an initial screening used at the CMH level and the type of health information that is included. All individuals who contact the access system participate in the initial screening, therefore health screening occurs 100% of the time and subsequent attempts to contact the member are not needed.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element. **Recommendations:** While PIHP staff members explained that an assessment occurs at intake and an initial assessment is completed within 14 days of initial contact with a member, HSAG recommends that the PIHP add language to its care coordination policies to further clarify how it meets compliance		

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
with the element. HSAG recommends that the PIHP also clarify the time frame begins when a member presents for services as opposed to the date of enrollment for new members as the PIHP is not an enrollment Medicaid model.		
Required Actions: None.		
4. The PIHP shares with MDHHS or other MCOs or PIHPs serving the members the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4) MDHHS Contract Part II A-7.4	**HSAG suggested evidence:** Policies and procedures Examples of service plans Examples of integrated care plans MSHN_Population_Health_Integrated_Care_Policy: Page 1 MSHN_Care_Coordination_Planning_Procedure MSHN_Service_Philosophy_Policy: Page 1 Integrated Care Plan Example 1: Page 1	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Assessment		
5. The PIHP implements mechanisms to comprehensively assess each Medicaid member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of MDHHS or the PIHP as appropriate.	**HSAG suggested evidence:** Policies and procedures Examples of assessments MSHN_UM_Plan_FY19: Pages 5-7 MSHN_Region 5_HSW_PDN_Annual_CW_3.25.19_LLF 16500 Nursing Assessment	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
42 CFR §438.208(c)(2) Attachment P4.4.1.1		
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Treatment/Service Plans		
6. The PIHP produces a treatment or service plan for members who require LTSS and for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: a. Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member; b. Developed by a person trained in person-centered planning using a person-centered process and plan; c. Approved by the PIHP in a timely manner, if this approval is required by the PIHP; d. In accordance with any applicable State quality assurance and utilization review standards; and e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member. 42 CFR §438.208(c)(3) Attachment P4.4.1.1	**HSAG suggested evidence:** Policies and procedures Examples of service plans Timeliness tracking mechanisms Staff training plans 18626 IPOS MSHN_Person-Family_Centered_Plan_of_Service FY19_MSHN_Training_Grid_FINAL MSHN_Delegation_Grid_FY19 6.a-e SHW Delegated Managed Care Tool_Final: Pages 22-29 6.e WL PDN 2018 6.e WL QTR 1	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Document "WL PDN 2018" is provided as evidence of the annual reassessment of need (6.e.); Document "WL QTR 1" is provided as evidence of formal service plan review and revision (6.e.)		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Direct Access to Specialists		
7. Members with special health care needs have direct access to a specialist, as appropriate for the individual's health care condition (for example, through a standing referral or an approved number of visits). 42 CFR §438.208(c)(4) MDHHS Contract Part II A-5.5	**HSAG suggested evidence:** Policies and procedures Examples of service plans MSHN_Access_Policy: Page 1 18626 IPOS	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Integrated Physical and Mental Health Care		
8. The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid members. a. These efforts will focus on members that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports. MDHHS Contract Part II A-7.4	**HSAG suggested evidence:** Policies and procedures Examples of integrated care plans MSHN_Population_Health_Integrated_Care_Policy MSHN_Care_Coordination_Planning_Procedure Integrated Care Plan Example 1	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
9. The PIHP will implement practices to encourage all members eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. a. The physical health assessment will be coordinated through the member's MHP. b. As authorized by the member, the PIHP will include the results of any physical health care findings that relate to the	**HSAG suggested evidence:** Policies and procedures Examples of integrated care plans Examples of care management records MSHN_Service_Philosophy_Policy: Page 1 MSHN_Population_Health__Integrated_Care_Policy MSHN_Delegation_Grid_FY19 SHW_Chart Review Summary-Final: Page 21 Integrated Care Plan Example 1	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
delivery of specialty mental health services and supports in the person-centered plan. c. The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on members who have not visited a primary care physician, even after encouragement, for more than 12 months. d. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it. MDHHS Contract Part II A-7.4		
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
Implementation of Joint Care Management Processes		
10. The PIHP and MHP develop joint care plans for members with appropriate severity/risk that have been identified as receiving services from both entities. a. The PIHP demonstrates to MDHHS the existence of these joint care plans on a quarterly basis. MDHHS Contract Part II A-8.4.2.1	**HSAG suggested evidence:** Policies and procedures Examples of integrated care plans Examples of care management records MSHN_Population_Health_Integrated_Care_Policy MSHN_Care_Coordination_Planning_Procedure Integrated Care Plan Example 1	☒ Met ☐ Not Met ☐ Not Applicable

Standard XIII—Coordination of Care		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: 10.a- On a quarterly basis MDHHS randomly selects beneficiaries from the available care plans in CareConnect360 for review in order to confirm existence of joint care plans between all managed care plan combinations (ie: MSHN and each of the 8 Medicaid Health Plans that provide coverage in the 21 county MSHN region).		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
11. The MHPs and PIHPs will work jointly to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS. MDHHS Contract Part II A-8.4.2.1	**HSAG suggested evidence:** Policies and procedures Examples of integrated care plans Examples of care management records MSHN_Population_Health_Integrated_Care_Policy COPD_Protocol_FINAL Diabetes_Protocol_FINAL Integrated Care Plan Example 2 Blue Cross_MSHN Agenda 1-30-2019 MSHN ICDP Performance Measure Detail Instructions	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative:		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Results—Standard XIII						
Met	=	11	X	1.0	=	11
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	11	Total Score		=	11
Total Score ÷ Total Applicable					=	100%

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Confidentiality		
1. The PIHP shall maintain the confidentiality, security and integrity of member information that is used in connection with the performance of its contract with MDHHS to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2. MDHHS Contract Part I-17.0	**HSAG suggested evidence:** Policies and procedures • Confidentiality and Notice of Privacy Policy • Breach Notice Policy • Breach Notice Procedure • Information Management Policy • Consent to Share Information Policy • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: MSHN has several policies related to the requirements of HIPAA, the Mental Health Code, Public Health Code and our contract with MDHHS. MSHN also includes the requirements for the disclosure and safeguarding of protected health information as well as reporting required disclosures and breaches. MSHN has a Privacy Notice as well as a breach reporting template that is available for the provider network to utilize.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Uses and Disclosures		
2. The PIHP complies with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 with respect to all Protected Health Information and substances use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions. 42 CFR §438.224 MDHHS Contract Part I-18.1.7	**HSAG suggested evidence:** Policies and procedures Release of information forms • Confidentiality and Notice of Privacy Policy • Breach Notice Policy • Breach Notice Procedure • Information Management Policy • Consent to Share Information Policy • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MDHHS Standard Consent to Share BH Information Form • Client Consent Form Example	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: MSHN has several policies related to the requirements of HIPAA, the Mental Health Code, Public Health Code and our contract with MDHHS. Per our contract with MDHHS, MSHN utilizes and accepts the MDHHS standard consent to share behavioral health information document and MSHN has a policy (consent to share information) that includes the use of the MDHHS form by MSHN and the provider network. MSHN's Electronic Information Management System also allows for the creation of a consent within the system. An example of the use of the standard form is included in the evidence (Client Consent Form Example).		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Discovery of a Breach		
3. The covered entity, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the covered entity to have been, accessed, acquired, used, or disclosed as a result of such breach. a. A breach shall be treated as discovered by a covered entity as of the first day on which such breach is known to the covered entity, or, by exercising reasonable diligence would have been known to the covered entity. b. A covered entity shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the covered entity (determined in accordance with the federal common law of agency). 45 CFR §164.404(a)(1-2)	**HSAG suggested evidence:** Policies and procedures Member breach notification templates Examples of member breach notification letters • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: MSHN has policies, procedures and a breach notification template that includes the requirements for breach notification as defined by 45 CFR 164.404. MSHN also has identified these requirements within our provider contracts and the business associate's agreements. During the time frame identified by HSAG for this review (10-01-18 – 04-30-19) there were no reported breaches within our provider network. However, there was one incident that involved a CMHSP that inadvertently disclosed a small number of client names (24) while presenting some documentation at a Fair Hearing Officers meeting. This meeting involved the Fair Hearings Judge and the Fair Hearings Officers for the CMHSPs within Michigan. This group is an ongoing group that has met for years to review best practices, concerns, new requirements, etc. The document that was shared was an excel spreadsheet that identified client last names on tabs at the bottom of the document. The information in the document only contained a numerical number as to where the individual fell on the Full Life Level of Care scale. The intent of the presentation was to provide training on how to utilize the Full Life Level of Care scale. No other protected health information was involved other than the client last name. The incident was discovered during the presentation and all members of the group were asked to destroy the document. Based on the Breach Notification Rule, it was determined that the risk of the PHI being used, retained, or		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
otherwise compromised is low. The information released only contained a last name with no other PHI included. The information was released to a group of individuals who are employed by CMHSPs and a federal Judge. All individuals who had temporary access to this information are under the same contractual obligations with MDHHS to uphold all federal and state requirements regarding security and confidentiality of PHI. So based on the following facts, it was determined that this incident was not a required reportable breach: 1. All individuals whom the information was released to are governed by the HIPAA Privacy and Security Rules 2. All individuals are bound under their CMHSP and PIHP contracts with MDHHS and the requirements for use of PHI 3. All individuals stated they would destroy the information and would not disclose it further, therefore mitigating the risk 4. The disclosure only included a last name with no other PHI or identifiable information Despite it being determined that this was a low risk event and therefore not required to provide breach notifications, it was the decision of the agency to still send out letters to the clients involved notifying them of the incident as the agency felt the clients had the right to this information. The letters (a sample letter is provided) included the following: 1. Brief description of the incident 2. Date of the incident (same as the discovery date) 3. Description of what information was released 4. Action taken to mitigate any risks of redisclosure 5. Contact information for any questions or concerns The letter intentionally did not include any information regarding credit checks or fraud protection as it had already been determined that there was low, to no, risk of redisclosure or improper use based on the individuals whom the information was released to. Therefore, there were no steps the clients needed to take to protect themselves in this situation. The letters were also delivered via first class mail to known current addresses for the clients.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Timeliness of Notification		
4. Except as provided in 45 CFR 164.412 (law enforcement delay,) the covered entity provides notification to individuals affected by a breach without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach. 45 CFR §164.404(b)	**HSAG suggested evidence:** Policies and procedures Timeliness tracking mechanism Member breach notification templates Examples of member breach notification letters • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Content of Notification		
5. The notification includes, to the extent possible: a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b. A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach. d. A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address. 45 CFR §164.404(c)(1)(A-E)	**HSAG suggested evidence:** Policies and procedures Member breach notification templates Examples of member breach notification letters • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Plain Language		
6. The notification is written in plain language. 45 CFR §164.404(c)(2)	**HSAG suggested evidence:** Policies and procedures Member breach notification templates Examples of member breach notification letters Reading grade-level evaluation • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Written Notification		
7. Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available. a. If the covered entity knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of subpart E), written notification by first-class mail to either the next of kin or personal representative of the individual. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1)(i-ii)	**HSAG suggested evidence:** Policies and procedures Examples of member breach notification letters • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
Substitute Notice		
8. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under paragraph (d)(1)(i) of this section, a. A substitute form of notice reasonably calculated to reach the individual shall be provided. b. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under paragraph (d)(1)(ii). 45 CFR §164.404(d)(2)	**HSAG suggested evidence:** Policies and procedures Examples of member breach substitute notices • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
9. In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means. 45 CFR §164.404(d)(2)(i)	**HSAG suggested evidence:** Policies and procedures Examples of member breach substitute notices or documentation • Breach Notice Policy • Breach Notice Procedure	☒ Met ☐ Not Met ☐ Not Applicable

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
	• FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		
10. In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall: a. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the Web site of the covered entity involved, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. b. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured protected health information may be included in the breach. 45 CFR §164.404(d)(2)(i)(A-B)	**HSAG suggested evidence:** Policies and procedures Examples of member breach substitute notices (website screenshot, news script, etc.) • Breach Notice Policy • Breach Notice Procedure • FY19 SUD Treatment Contract (pgs. 24, 26 and 38 – 42) • MSHN FY 2019 Medicaid Subcontracting Agreement (pgs. 29 – 30 and 69 – 76) • MSHN Privacy Notice – Revised January 2019 • MSHN Breach Notification Template • PHI Disclosure Letter -CEI CMHSP	☒ Met ☐ Not Met ☐ Not Applicable

Standard XVI—Confidentiality of Health Information		
Requirement	**Evidence as Submitted by the PIHP**	**Score**
PIHP Narrative: Please refer to narrative provided under #3 above.		
HSAG Findings: HSAG determined that the PIHP was compliant with this element.		
Required Actions: None.		

Results—Standard XVI						
Met	=	10	X	1.0	=	10
Not Met	=	0	X	.00	=	0
Not Applicable	=	0				
Total Applicable	=	10	Total Score		=	10
Total Score ÷ Total Applicable					=	100%