Michigan Department of Health and Human Services

SFY 2024 External Quality Review Compliance Review Report *for* Prepaid Inpatient Health Plans

Region 5—Mid-State Health Network

December 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

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

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

As MDHHS' EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the contracted PIHPs delivering services to members enrolled in the Behavioral Health Managed Care Program. When conducting the compliance review, HSAG adheres to the guidelines established in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program] Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[1]

Description of the External Quality Review Compliance Review

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. State fiscal year (SFY) 2024 commenced a new cycle of compliance reviews for the Behavioral Health Managed Care Program. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards. Table 1-1 outlines the standards that will be reviewed over the three-year review cycle for **Mid-State Health Network** (**MSHN**).

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Mar 20, 2024.

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

Standard	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		Review of the PIHP's Year One and Year Two Corrective Action Plans (CAPs)
Standard II—Emergency and Poststabilization Services[3]	§438.114	§457.1228		✓	
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[4]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

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

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

[3] MDHHS requested that the review of the Emergency and Poststabilization Services standard be delayed until SFY 2025 due to upcoming changes in PIHP financial liability of emergency services and pending guidance from MDHHS.

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

Summary of Findings

Review of the Standards

Table 1-2 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **MSHN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **MSHN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all five standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	16	5	3	**76%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**
Standard VI—Coverage and Authorization of Services	23	22	15	7	1	**68%**
Total	**94**	**85**	**72**	**13**	**9**	**85%**

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

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

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

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

MSHN achieved an overall compliance score of 85 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Member Rights and Member Information and Coverage and Authorization of Services as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **MSHN** is required to submit a CAP to bring the element into compliance with the applicable standard(s).

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

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

To ensure the CAP is fully implemented, **MSHN** will be required to submit one progress report on the status of each action plan. A progress report template, instructions, and timeline for completing and submitting the progress report will be provided after the approval of **MSHN**'s CAP.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the PIHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with MDHHS, performed compliance reviews of the PIHPs contracted with MDHHS to deliver services to Michigan's Behavioral Health Managed Care Program members.

MDHHS requires its PIHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews for the Michigan PIHPs consist of 13 program areas referred to as standards, with the current three-year cycle of compliance reviews spanning from SFY 2024 through SFY 2026. MDHHS requested that HSAG conduct a review of the first half of the standards (with the exception of Standard II) in Year One (SFY 2024) and a review of the remaining half of the standards in Year Two (SFY 2025). The SFY 2026 (Year Three) compliance review will consist of a review of the standards and elements that required a CAP during the SFY 2024 (Year One) and SFY 2025 (Year Two) compliance review activities. Table 2-1 outlines the standards that will be reviewed over the three-year review cycle.

Table 2-1—Compliance Review Standards

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		Review of the PIHP's Year One and Year Two CAPs
Standard II—Emergency and Poststabilization Services[3]	§438.114	§457.1228		✓	
Standard III—Availability of Services	§438.206	§457.1230(a)	✓		
Standard IV—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard V—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VI—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard VIII—Confidentiality	§438.224	§457.1233(e)		✓	

Standards	Associated Federal Citation[1,2]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard IX—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard X—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XI—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XII—Health Information Systems[4]	§438.242	§457.1233(d)		✓	
Standard XIII—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

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

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

[3] MDHHS requested that the review of the Emergency and Poststabilization Services standard be delayed until SFY 2025 due to upcoming changes in PIHP financial liability of emergency services and pending guidance from MDHHS.

[4] This standard includes a comprehensive assessment of the PIHP's IS capabilities

This report presents the results of the SFY 2024 review period. MDHHS and the individual PIHPs use the information and findings from the compliance reviews to:

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

Review of Standards

Technical Methods of Data Collection and Analysis

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

HSAG's review consisted of the following activities for each of the PIHPs:

Pre-Site Review Activities:

- Collaborated with MDHHS to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the PIHP a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review documentation tracker.
- Scheduled the site review with the PIHP.
- Hosted a pre-site review preparation session with all PIHPs.
- Generated a list of 10 sample records for service and payment denial case file reviews.
- Conducted a desk review of supporting documentation that the PIHP submitted to HSAG.
- Followed up with the PIHP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the one-day site review interview session and provided the agenda to the PIHP to facilitate preparation for HSAG's review.

Site Review Activities:

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

Post-Site Review Activities:

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

Data Aggregation and Analysis:

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

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

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

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

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

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

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

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for service and payment denials.

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

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

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	Prior to April 30, 2024
Information obtained from a review of a sample of service and payment denial files	Denials that occurred between October 1, 2023, and March 31, 2024
Information obtained through interviews	August 26, 2024
Documentation submitted after the site review	Prior to April 30, 2024

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The PIHP has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network (MSHN) details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
2. The PIHP complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 Contract Schedule A–1(L)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms **Evidence as Submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24 • 2024 CMHSP Delegated Managed Care Tool • MSHN_FY_2024_MEDICAID_SUBCONTRACTING_AGREEMENT, Delegation Grid, Pgs. 34 to 55 • FY24_SUD_Treatment_Contract • FY24 MSHN Training Grid	☒ Met ☐ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
	• 2023 CMHSP Delegated Managed Care Tool, Section #2, ENROLLEE RIGHTS AND PROTECTIONS, Pgs. 4-5 • PNM_Provider_Network_Managemet_Policy • 2024 MSHN ABD-Grievance-Appeal Review Tool	
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Specific Rights		
3. The PIHP complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the PIHP: • R5_CR_Standard I_Member Rights Checklist_D1 • CS_Enrollee_Rights_Policy_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs. 57-58 • 2023 CMHSP Delegated Managed Care Tool, Section #2, ENROLLEE RIGHTS AND PROTECTIONS, Pgs. 4-5	
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP included language in its member handbook and policies to support how it ensures the member right to be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210, HSAG strongly recommends that the PIHP expand upon this member right in the PIHP's member handbook, as well as in any applicable policies, procedures, or provider contracts. Implementation of HSAG's recommendations will be reviewed during the next compliance review cycle, and the PIHP may receive a *Not Met* score if HSAG's recommendations are not adequately addressed.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Information Requirements		
4. The PIHP provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. "Readily accessible" means electronic information and services that comply with modern accessibility standards such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and the World Wide Web Consortium's (W3C's) Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. 42 CFR §438.10(c)(1) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(a)(iii) Contract Schedule A–1(M)(2)(a)(i) Contract Schedule A–1(M)(2)(b)(i) Contract Schedule A–1(B)(4)(e)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Proof of website accessibility **Evidence as Submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24 • CS_Customer_Consumer_Service_FY24 • CS_Information_Accessiblity_LEP_FY24 • FY24 MSHN Guide to Services.LifeWays, pg. 10 • 2024 MSHN ABD-Grievance-Appeal Review Tool • MSHN Regional Grade Level Technical Advisory Guidelines • CustomerServiceCommitteeMeetingSnapshot 22_07_18 • Print Directory Example (midstate_directory_result_2024_06_28.xlsx) - Example of the download produced from the website on 6.28.24 • IT-Website_procedure • MSHN_website_access_audit • MSHN_website_accessiblity_score	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process. MSHN is updating its website and accessibility will be reviewed once the website is finalized and deployed.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
5. The PIHP uses the definitions for managed care terminology developed by MDHHS including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(a)(vii)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • CS_Customer_Handbook_FY24 • FY24 MSHN Guide to Services.LifeWays, Behavioral Health & Substance Use Disorder Glossary, pgs. 86-95 • MSHN Guide to Services Handbook Approval Letter 12.08.2023	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the PIHP's member handbook included definitions for managed care terminology developed by MDHHS, HSAG recommends that the PIHP request from MDHHS the definitions for the managed care terminology currently not included in the MDHHS-developed model member handbook template.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
6. The PIHP uses MDHHS-developed model member handbooks and member notices. 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(i)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, and grievance and appeal letter templates **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY 24 • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Customer_Handbook_FY24 • FY24 MSHN Guide to Services.LifeWays • MSHN Guide to Services Handbook Approval Letter 12.08.2023 • MSHN SUD Adverse Benefit Determination • MSHN SUD Notice of Receipt of Appeal • MSHN SUD Notice of Appeal Denial • MSHN SUD Notice of Receipt of Grievance • MSHN SUD Notice of Grievance Resolution	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: The PIHP's member handbook did not include all of the items in the MDHHS-developed model member handbook, *Template #6: Language Assistance and Accommodations* of the *PIHP Customer Service Standards*; specifically, the PIHP's member handbook did not include information about Computer Assisted Realtime Translation (CART). The PIHP's member handbook also did not include all of the information in *Template #8: Person-Centered Planning*; specifically, the PIHP's member handbook did not inform members to contact the PIHP's customer service unit to file a grievance if they do not believe they have received appropriate information regarding psychiatric advance directives from the PIHP. Further, *Template #11: Service Array* of the MDHHS template listed a service as Methadone and LAAM Treatment; however, the PIHP's member handbook listed this service as Medication Assisted Treatment (MAT) (such as Methadone and Suboxone). Lastly, the PIHP's member handbook also did not include all of the information in *Template #13: Taglines*; specifically, the PIHP's member handbook did not contain the sentence, "You have the right to		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost," as included in the MDHHS template. After further review and discussion among HSAG reviewers following the site review, it was determined to score this element as *Not Met* to ensure that the PIHP's member handbook fully aligns to the MDHHS-developed model member handbook as required.		
Required Actions: The PIHP must use MDHHS-developed model member handbooks and member notices and ensure that the PIHP's member handbook and member notices include all MDHHS-developed template language.		
Language and Format		
7. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the PIHP's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3)	**HSAG Required Evidence:** • Policies and procedures • Provider directory in prevalent languages • Member handbook in prevalent languages • Definition of "conspicuously visible font" • Mechanisms to ensure taglines are included as part of all critical member materials • All template notices required to include taglines **Evidence as Submitted by the PIHP:** • CS_Information_Accessiblity_LEP_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs. 6,7, 10 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • FY24 MSHN Guide to Services LIFEWAYS_es • MSHN_FY_2024_MEDICAID_SUBCONTRACTING_AGREEMENT • 2024 MSHN ABD-Grievance-Appeal Review Tool • MSHN_Advance_Directive_Brochure.06.24-ES • GIHN ABD_Spanish • MSHN SUD Adverse Benefit Determination • MSHN SUD Notice of Receipt of Appeal • MSHN SUD Notice of Appeal Denial	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)	• MSHN SUD Notice of Receipt of Grievance • MSHN SUD Notice of Grievance Resolution	
PIHP Description of Process: Mid-State Health Network (MSHN) maintains an annual process to have the MSHN Guide to Services translated into Spanish. In 2018, regional Customer Service staff through the MSHN Customer Service Committee (CSC) determined that the need is infrequent for LEP formatted appeal and grievance notices and denial and termination notices. The CSC decided that providers should work with their contracted LEP translation service to translate Notices and extend the effective date to accommodate the additional timeframe for the translation of the notice. This process has effectively been utilized to make written materials critical to obtaining services available to individuals engaged in services. Mid-State Health Network defines "conspicuously visible font" as a font greater than the minimum font size of 12pt, is not a large font, and is more pronounced than the adjacent font.		
HSAG Findings: Although the PIHP's electronic provider directory included a link for the taglines on the PIHP's website, the PIHP's paper provider directory did not include taglines with information about how to request auxiliary aids and services nor the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number of the PIHP's member/customer services unit when printed from the PIHP's website. Additionally, many of the PIHP's CMHSPs had their own provider directories on their websites, and when printed, these did not contain taglines explaining the availability of written translation or oral interpretation to understand the information provided, nor information on how to request auxiliary aids and services, nor the toll-free and TTY/TDD telephone number of the PIHP's or CMHSPs' member/customer services unit. **Recommendations:** During the site review, PIHP staff members explained their process for annually assessing the prevalent languages of its members; however, the PIHP's policies and procedural documents did not include this specific process, nor the frequency of the PIHP's assessment. As such, HSAG recommends that the PIHP list its procedures for identifying prevalent languages in its service regions to ensure that its written materials critical to obtaining services include taglines in a conspicuously visible font for any languages spoken by more than 5 percent of the population. Additionally, HSAG recommends that the PIHP continue to routinely assess the languages of its region. Further, although the PIHP did not identify a "prevalent non-English language," defined by MDHHS as any language spoken as the primary language by more than 5 percent of the population in the PIHP's region, HSAG strongly recommends that the PIHP include taglines in larger than 12 point font (i.e., conspicuously visible) in its written materials that are critical to obtaining services to ensure that non-English speaking members are informed of the availability of language assistance services in their prevalent language, and ensure effective communication for individuals with disabilities. Lastly, to enhance the PIHP's monitoring of delegated functions to contracted CMHSPs, HSAG strongly recommends that the PIHP include an evaluation of the CMHSPs' written member materials in its *CMHSP Delegated Managed Care Tool* to ensure all of the CMHSPs' written materials that are critical to obtaining services contain appropriate taglines as several of the CMHSPs' paper provider directories did not contain taglines.		
Required Actions: The PIHP, and its delegated CMHSPs, must ensure that written materials that are critical to obtaining services include at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, include taglines explaining the availability of		

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Requirement	**Supporting Documentation**	**Score**
written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, as well as the toll-free and TTY/TDD telephone number of the PIHP's or CMHSPs' member/customer services unit.		
8. The PIHP makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that MDHHS identifies as prevalent. c. *In mental health settings, video remote interpreting (VRI) is to be used only in emergency situations, extenuating circumstances, or during a state or national emergency as a temporary solution until they can secure a qualified interpreter and in accordance with R 393.5055 VRI standards, usage, limitations, educational, legal, medical, and mental health standards.* 42 CFR §438.10(d)(4) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(i) Michigan Administrative Code R 393.5055	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services **Evidence as Submitted by the PIHP:** • CS_Information_Accessiblity_LEP_FY24 • CS_Enrollee_Rights_Policy_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs. 6,7, 10 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • LifeWays_Global_Interpreting_Services_Agreement • CEI_7C Lingo Contract • CEI_Voices for Health Inc. - Contract • MSHN LanguageLine User Guide.6.24	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
9. The PIHP notifies 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 these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(i)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the PIHP:** • CS_Information_Accessiblity_LEP_FY24 • FY24 MSHN Guide to Services.LifeWays, pg., 10 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
10. The PIHP provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. *Written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis, and conditions that do not meet the 6.9 grade reading level criteria).* c. Use a font size no smaller than 12 point. d. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Examples of member notices (in Microsoft Word), such as an ABD notice, grievance resolution letter, appeal resolution letter, etc. • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Mechanism to assess prevalent languages in the PIHP's region	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
e. The PIHP shall also identify additional languages that are prevalent among the PIHP's membership. *For purposes of this requirement, "prevalent non-English language" is defined as any language spoken as the primary language by more than five percent (5%) of the population in the PIHP's region.* f. *Material must not contain false, confusing, and/or misleading information.* "Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. 42 CFR §438.10(d)(6) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(e) Contract Schedule A–1(M)(2)(a)(i)-(ii) Contract Schedule A–1(M)(2)(a)(iv) Contract Schedule A–1(M)(2)(b)(i)	**Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_FY24 • CS_Information_Accessiblity_LEP_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs., 10, 90 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • MSHN Regional Grade Level Technical Advisory Guidelines • CustomerServiceCommitteeMeetingSnapshot 22_07_18 • MSHN SUD Adverse Benefit Determination • MSHN SUD Notice of Receipt of Appeal • MSHN SUD Notice of Appeal Denial • MSHN SUD Notice of Receipt of Grievance • MSHN SUD Notice of Grievance Resolution • MSHN Regional Grade Level Technical Advisory Guidelines • Determining Local Language Needs Technical Guidelines	
PIHP Description of Process: N/A		
HSAG Findings: Many of the PIHP's written materials for potential members and members did not contain text with the minimum 12-point font size in all areas of the document, such as the PIHP's member handbook, paper provider directory, and member notices. Following the site review, the PIHP acknowledged in the *Post Site Review Documentation Tracker* that not all written member materials contained text with the minimum 12-point font size, and that the PIHP was currently investigating the discrepancy. **Recommendations:** HSAG strongly recommends that the PIHP include an evaluation of the CMHSPs' written member materials in its *CMHSP Delegated Managed Care Tool* to ensure that the CMHSPs' member materials use a font size no smaller than 12 point and do not contain false, confusing, and/or misleading information.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: The PIHP, and any delegated CMHSP, must ensure that all written materials for potential members and members use a font size no smaller than 12 point.		
Information for Members		
11. The PIHP makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(3)	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Three examples of written notices to members of provider termination (include a copy of the notice of termination, with the date of notice) • Tracking or reporting mechanism that demonstrates timeliness **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_FY24 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.9 • CCJLH Closure Notification Letter • CCJLH Termination Notice - Eff. 12.29.23 • CCJLH Termination Checklist - Eff. 12.26.23 • CCSGC Closure Notification Letter • CCSGC Contract Cancellation Notification - Eff. 2.29.24 • CCSGC Termination Checklist - Eff. 2.29.24 • FCS SUD Admissions Detail.No current consumers • FCS Termination Checklist - Eff. 1.31.24 • FCS Termination Research	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: The PIHP was unable to demonstrate that the PIHP, or any delegated entity sending notifications on its behalf, made a good faith effort to give timely written notice to members of the termination of contracted providers as required. The PIHP provided two examples of written notices sent		

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Requirement	**Supporting Documentation**	**Score**
to members by the PIHP; however, neither example notice was provided to members 30 calendar days prior to the effective date of the terminations, nor within 15 calendar days of receipt of the termination notice. Following the site review, the PIHP provided additional examples related to termination of contracted providers. In one example, the PIHP provided a letter from a CMHSP to a provider informing them that the CMHSP made the decision to terminate their contract; however, no evidence that members were given written notice of the provider termination was included in this example. **Recommendations:** During the site review, PIHP staff members discussed their oversight and monitoring process for its CMHSPs related to written notices to members regarding the termination of contracted providers, and explained that this process includes reviewing the date the CMHSP received notification of the termination of a contracted provider and the effective date of the termination; however, the PIHP's *CMHSP Delegated Managed Care Tool* only listed a policy or description of written notice of termination as evidence of implementation of this requirement. As such, HSAG strongly recommends the PIHP update its audit tool to require evidence of when the CMHSP was notified of the provider termination (e.g., notice sent to CMHSP from provider informing them of the termination), and the effective date of the termination, to confirm that written notices are being sent by the later of 30 calendar days prior to the effective date of the termination, or within 15 calendars of receipt or issuance of the termination notice. HSAG further recommends the PIHP develop a tracking or reporting mechanism to track timeliness related to this requirement.		
Required Actions: The PIHP, or a delegated CMHSP, must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice.		
12. The PIHP makes available upon request any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(4)(b)	**HSAG Required Evidence:** • Policies and procedures • List of physician incentive plans • Example of physician incentive plan provided to a member upon request • If the PIHP does not have physician incentive plans, please state so under the PIHP Description of Process **Evidence as Submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg., 62	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process: Mid-State Health Network (MSHN) does not use any type of physician or other financial incentive plans to limit the services available to members. MSHN assures that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Medicaid enrollee.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: This element is *Not Applicable*, as PIHP staff members stated during the site review that the PIHP currently does not have any physician incentive plans in place.		
Required Actions: None.		
13. *The PIHP provides information to members about the managed care and care coordination responsibilities of the PIHP, including*: a. *Information on the structure and operation of the managed care organization (MCO) or the PIHP*. Contract Schedule A–1(M)(2)(b)(ii)(4)(a)	**HSAG Required Evidence:** • Policies and procedures • One example of the PIHP providing information to members about managed care and care coordination responsibilities **Evidence as Submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs., 2, 14-15, 45, 61-63 • GM_Pop_Health__Integrated_Care_Rev.June_2022	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Member Handbook		
14. The member handbook is provided to the member *upon first request of services and annually thereafter, or sooner if substantial revisions have been made*. The member handbook is considered provided if the PIHP: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the PIHP's website and advises the member in paper or electronic form that the information is	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as member welcome packet • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website) • Tracking mechanism for mailings of the member handbook or welcome notice (include the date the PIHP received notice of the member's first request of services, and the mailing date of the member handbook/member enrollment materials)	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207 Contract Schedule A–1(B)(3)(f) Contract Schedule A–1(B)(3)(h) Contract Schedule A–1(B)(4)(b)	**Evidence as Submitted by the PIHP:** • CS_Customer_Handbook_FY24 • MSHN_FY_2024_MEDICAID_SUBCONTRACTING_AGREEMENT, pg. 36 • 2023 CMHSP Delegated Managed Care Tool, pg. 3, item 1.7(i) • CS_Customer_Consumer_Service_FY24 • MVA_Admission Checklist • SHW Consumer Orientation Policy	
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
15. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 Contract Schedule A–1(B)(4)	**HSAG Required Evidence:** • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on the PIHP's website • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the PIHP:** • R5_CR_Standard I_Member Rights Checklist_D1 • CS_Enrollee_Rights_Policy_FY24 • FY24 MSHN Guide to Services.LifeWays	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• MSHN Guide to Services Handbook Approval Letter 12.08.2023 • Member handbook on MSHN Website: https://www.midstatehealthnetwork.org/consumers-resources/customer-services/handbook	
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP's member handbook did not contain a version number; however, HSAG confirmed with MDHHS that the revision date was sufficient to demonstrate historical versions of the PIHP's member handbook. Additionally, Element 30 of the Member Handbook Checklist indicated a *Y*, as the PIHP demonstrated inclusion of the MDHHS-model member handbook templates; however, please refer to the findings in Element 6 related to missing components of the MDHHS-model member handbook templates.		
Required Actions: None.		
16. The PIHP gives each member notice of any change to the member handbook that MDHHS defines as significant in the information specified in the member handbook at least 30 days before the intended effective date of the change. a. "*Significant" is defined as any change that affects a member's Medicaid benefits, including but not limited to: PIHP contract information, authorization for services, covered benefits, and copays.* 42 CFR §438.10(g)(4) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(c)	**HSAG Required Evidence:** • Policies and procedures • Workflow for member handbook changes • One example of a change to the member handbook and notice sent to members • Tracking mechanism for timely member notifications of significant changes **Evidence as Submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg. 36 • CS_Customer_Handbook_FY24 • 2023 CMHSP Delegated Managed Care Tool, 1.8 • FY24 Handbook Process Timeline	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Mid-State Health Network (MSHN) has not provided any notice of significant changes to members during the look-back period. If/when MDHHS contractual requirement updates are made, MSHN will provide written notice of any significant change in the information at		

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Requirement	**Supporting Documentation**	**Score**
least 30 days before the intended effective date of the change. Prior instances of written notice have been done by a Consumer Handbook insert to communicate the significant information changes.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG strongly recommends that the PIHP develop a tracking mechanism to confirm timely member notification when there are changes to the member handbook that MDHHS defines as significant.		
Required Actions: None.		
17. *The PIHP must obtain MDHHS approval, in writing, prior to publishing original and revised editions of the member handbook.* Contract Schedule A–1(B)(4)(g)	**HSAG Required Evidence:** • Policies and procedures • Most recent approval received from MDHHS, in writing, of revisions to the member handbook **Evidence as Submitted by the PIHP:** • CS_Customer_Handbook_FY24 • MSHN Guide to Services Handbook Approval Letter 12.08.2023	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Provider Directory		
18. The PIHP makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory • Copy of provider directory in Word format or PDF (excerpts are acceptable) • Link to the online provider directory	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Contract Schedule A–1(M)(1) Contract Schedule A–1(M)(2)(a)(iii)	• HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the PIHP:** • MSHN Provider Directory Website - https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory • Print Directory Example (midstate_directory_result_2024_06_28.xlsx) - Example of the download produced from the website on 6.28.24 • PNM_Provider_Directory • CS_Customer_Consumer_Service_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs. 15, 31 • R5-MSHN_MI2024_PIHP_CR_Standard I_Provider Directory Checklist_D1	
PIHP Description of Process: CMHSPs are to submit their electronic directory on the 4th Friday of the month. The following week, MSHN exports the directories along with the SUD Network directory into a single CSV file and uploads the entire file into the MSHN website which is machine readable. Any person who visits the MSHN web-based directory can download/print the directory by clicking on the 'Download/Print Directory' link. An excel file will download and can be further customized/formatted for a print version.		
HSAG Findings: Although the PIHP's machine-readable provider directory included information related to accommodations for members with special needs, the PIHP's electronic provider directory on its website, as well as the printed PDF version, only listed "ADA Compliant Accommodations: Yes" or "ADA Compliant Accommodations: No" and did not include the same details as the machine-readable version of the provider directory, such as exam room(s), and equipment. All versions of the PIHP's provider directory should contain all required information. **Recommendations:** HSAG recommends that the PIHP develop definitions for provider types that must be in the PIHP's provider directory (e.g., medical suppliers, ancillary health providers) for clarity about the services that fall under each provider type (e.g., occupational therapy and physical therapy are considered ancillary health providers). Further, as some of the website Uniform Resource Locators (URLs) listed for providers incorrectly routed members back to another webpage on the PIHP's website instead of the provider's website, HSAG strongly recommends the PIHP ensure that all URLs listed in its provider directory function correctly. Lastly, although the PIHP's provider directory contained most required information, many of the CMHSPs' provider directories on their websites did not consistently contain required information such as languages, whether the provider's office is accepting new members, accommodation information for members with special needs, or URLs; or were not sorted by county. As such, HSAG strongly		

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Requirement	**Supporting Documentation**	**Score**
recommends that the PIHP confirm that all its CMHSPs' provider directories, if maintained separately, include all requirements under 42 CFR §438.10 and ensure that its oversight process for monitoring its CMHSPs includes a robust process for evaluating any separately maintained provider directories. Implementation of HSAG's recommendations related to the CMHSPs' provider directories will be reviewed during the next compliance review cycle, and the PIHP will automatically receive a *Not Met* score if HSAG's recommendations are not adequately addressed.		
Required Actions: The PIHP must ensure that its provider directory, and any delegated CMHSPs' provider directories, include all of the required information from the Provider Directory Checklist.		
19. Information included in a paper provider directory must be updated *at least monthly*. 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating paper provider directories • Three consecutive provider directory update examples **Evidence as Submitted by the PIHP:** • PNM_Provider_Directory • PN_-_Provider_Directory_Procedure • Provider Directory Upload (Internal Procedure) – Standard I • Screenshot – Provider Directory Uploads – Standard I • REMI – Affiliate Submission Screenshot Provider Directory – Standard I • Provider Directory Screenshot_28_6_2024 – Standard I • Approved Services List Provider Directory – Standard I	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The file PN_-_Provider_Directory_Procedure outlines the steps/workflow that CMHs take to produce and upload an updated directory into REMI. The file Provider Directory Upload (Internal Procedure) outlines the steps/workflow that MSHN takes to produce and upload an updated directory on the MSHN website. The file titled Screenshot – Provider Directory Uploads provides evidence that MSHN has been following this process since April 2018 with date stamps reflecting dates of the Website upload. The file titled REMI – Affiliate Submission Screenshot Provider Directory provides evidence of CMHs Directory Submission to MSHN with date stamps. While the electronic directory must be updated quarterly, MSHN's procedure includes monthly submission and refresh to ensure changes are captured within 30 days. To ensure consistency of 'services' provided by each provider, the region has developed an approved list to ensure the filtering feature is standardized. The file titled Approved Services List Provider Directory outlines the list of services which includes Independent Facilitation and Fiscal Intermediaries as noted on the directory checklist.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
20. Information included in the PIHP's electronic provider directory is updated no later than 30 calendar days after the PIHP receives updated provider information. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples **Evidence as Submitted by the PIHP:** • PNM_Provider_Directory • PN_-_Provider_Directory_Procedure • MSHN_FY_2024_MEDICAID_SUBCONTRACTING_AGREEMENT, pg 35 • Provider Directory Upload (Internal procedure) – Standard I • Screenshot – Provider Directory Uploads – Standard I • REMI – Affiliate Submission Screenshot Provider Directory – Standard I • Approved Services List Provider Directory – Standard I	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The file PN_-_Provider_Directory_Procedure outlines the steps/workflow that CMHs take to produce and upload an updated directory into REMI. The file Provider Directory Upload (Internal Procedure) outlines the steps/workflow that MSHN takes to produce and upload an updated directory on the MSHN website. The file titled Screenshot – Provider Directory Uploads provides evidence that MSHN has been following this process since April 2018 with date stamps reflecting dates of the Website upload. The file titled REMI – Affiliate Submission Screenshot – Provider Directory provides evidence of CMHs Directory Submission to MSHN with date stamps. While the electronic directory must be updated quarterly, MSHN's procedure includes monthly submission and refresh to ensure changes are captured within 30 days. To ensure consistency of 'services' provided by each provider, the region has developed an approved list to ensure the filtering feature is standardized. The file titled Approved Services List Provider Directory outlines the list of services which includes Independent Facilitation and Fiscal Intermediaries as noted on the directory checklist.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

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Requirement	**Supporting Documentation**	**Score**
Recommendations: To further enhance the PIHP's monitoring of delegated functions to contracted CMHSPs, HSAG strongly recommends that the PIHP include information in its *CMHSP Delegated Managed Care Tool* to evaluate its CMHSPs processes for updating their provider directories and ensure the CMHSPs are updating their electronic provider directories no later than 30 calendar days after the CMHSP receives updated provider information (e.g., requesting an example of an update to the provider directory the CMHSP received, and evidence it was reflected in their electronic provider directory within 30 calendar days of receipt). The PIHP should also validate that it updated the PIHP's provider directory within 30 calendar days after the CMHSPs received updated provider information (i.e., the PIHP's provider directory should be updated within 30 calendar days of the CMHSP receiving updated provider information as opposed to within calendar days of the CMHSP notifying the PIHP of updates to the provider directory). Implementation of HSAG's recommendations related to the CMHSPs' provider directories will be reviewed during the next compliance review cycle, and the PIHP may receive a *Not Met* score if HSAG's recommendations are not adequately addressed.		
Required Actions: None.		
21. The PIHP's provider directory is made available on the PIHP's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • If the provider directory is a delegated function, confirmation of delegated entities' machine-readable provider directories • Link to the machine-readable provider directory on website **Evidence as Submitted by the PIHP:** • Provider Directory Screenshot_28-6-2024 – Standard I	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Please refer to narrative above (#18). To verify it is optimized for mobile use, please visit https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory on your phone or refer to the file titled Provider Directory – phone screenshot. You will notice that a user can click on the phone number, email address, or provider website, as well as utilize the filter function from their mobile device.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
Formulary		
22. The PIHP makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §457.1207	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the PIHP:** • Not applicable	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process:		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		
23. The PIHP's formulary drug list is made available on the PIHP's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(3) 42 CFR §457.1207	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the PIHP:** • Not applicable	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process:		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Electronic Materials and Communications		
24. Member information required in 42 CFR §438.10 may not be provided electronically unless the PIHP meets all of the following: a. The format is readily accessible. b. The information is placed in a location on the PIHP's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and the PIHP provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(a)(iii) Contract Schedule A–1(M)(2)(a)(v)	**HSAG Required Evidence:** • Policies and procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to website **Evidence as Submitted by the PIHP:** • CS_Information_Accessiblity_LEP_FY24 • CS_Customer_Handbook_FY24 • CS_Customer_Consumer_Service_FY24, B	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Mid-State Health Network Handbooks: https://www.midstatehealthnetwork.org/consumers-resources/customer-services/handbook. MSHN does not have any materials that are provided only electronically.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** For any member information provided electronically, HSAG strongly recommends that the PIHP develop a reporting or tracking mechanism for the PIHP and CMHSPs to ensure that members who request the information in 42 CFR §438.10 in paper format are provided with the requested information within five business days of the request. Additionally, as the PIHP's provider directory was available on its website electronically and in a machine-readable format that could be printed, therefore the PIHP received a *Met* score for this element. However, while there was an option on the PIHP's website to right-click and print the provider directory as a PDF document, this only printed the first page of providers, and did not print the full list of providers. The member would have to individually print each page. As such, HSAG strongly recommends the PIHP enhance its website to		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
include the option to print its entire provider directory in a single PDF document. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed		
Required Actions: None.		

Standard I—Member Rights and Member Information						
Met	=	16	X	1	=	16
Not Met	=	5	X	0	=	0
Not Applicable	=	3				
Total Applicable	=	21	**Total Score**		=	16
Total Score ÷ Total Applicable					=	76%

Standard I—Member Rights Checklist		
Reference	**Required Components**	
A member enrolled with the PIHP has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220	1. Receive information in accordance with 42 CFR §438.10. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(a) • 2023 CMHSP Delegated Managed Care Tool, All section 1: INFORMATION (CUSTOMER SERVICES) section	Y ☒ N ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(b) • 2023 CMHSP Delegated Managed Care Tool, item 2.4	Y ☒ N ☐
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(c) • 2023 CMHSP Delegated Managed Care Tool, item 2.5	Y ☒ N ☐
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220	4. Participate in decisions regarding his or her healthcare, including the right to refuse treatment. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(d) • 2023 CMHSP Delegated Managed Care Tool, item 2.7	Y ☒ N ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(e) • 2023 CMHSP Delegated Managed Care Tool, item 2.9	Y ☒ N ☐

Standard I—Member Rights Checklist		
Reference	**Required Components**	
42 CFR §438.100(b)(2)(vi) 42 CFR §457.1220 45 CFR Part 160 25 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(f) • MSHN Privacy Rule – Page 3	Y ☒ N ☐
42 CFR §438.100(b)(3) 42 CFR §438.206 through §438.210 42 CFR §457.1220	7. Be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 2(g) • 2023 CMHSP Delegated Managed Care Tool, item 1.3	Y ☒ N ☐
42 CFR §438.100(c) 42 CFR §457.1220	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PIHP and its network providers or MDHHS treat the member. **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 3(a) • 2023 CMHSP Delegated Managed Care Tool, item 2.9	Y ☒ N ☐
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557	9. The PIHP shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 [regarding education programs and activities], Titles II and III of the Americans with Disabilities Act [ADA], and Section 1557 of the Patient Protection and Affordable Care Act [ACA]). **Evidence as submitted by the PIHP:** • CS_Enrollee_Rights_Policy_FY24, Section 4(a)	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(1)	1. Benefits provided by the PIHP. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, Pgs. 61-73	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(2)	2. How and where to access any benefits provided by MDHHS. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, Pgs. 64-78	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(2)	3. How transportation is provided. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, Pgs. 67, 70, 75, 82, 97	Y ☒ N ☐
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207	4. In the case of a counseling or referral service that the PIHP does not cover because of moral or religious objections, the PIHP informs members that the service is not covered by the PIHP. **Evidence as submitted by the PIHP:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207	5. The PIHP informs members how they can obtain information from MDHHS about how to access the services not provided by the PIHP because of moral or religious objections. **Evidence as submitted by the PIHP:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(c)	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 61-63	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(d)	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 61-62	Y ☒ N ☐
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(e)	8. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg. 34	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207	9. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg. 34	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207	10. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg. 34	Y ☒ N ☐
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207	11. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg. 34	Y ☒ N ☐
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	12. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 46, 60	Y ☒ N ☐
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(e)	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the PIHP cannot require members to obtain a referral before choosing a family planning provider.	Y ☐ N ☐ NA ☒

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
	Evidence as submitted by the PIHP: • FY24 MSHN Guide to Services.LifeWays, pg. 75	
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207	14. Cost sharing. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 63, 78	Y ☒ N ☐
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(b)	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. a. *Member rights and protections as specified in the contract as they relate to grievances and appeals.* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 56-59 • CS_Enrollee_Rights_Policy_FY24	Y ☒ N ☐
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207	16. The process of selecting and changing the member's primary care provider. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 73	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 Contract Schedule A–1(L)(3-4)	17. The right to file grievances and appeals. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pg. 39	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 Contract Schedule A–1(L)(2)(b-c)	18. The requirements and time frames for filing a grievance or appeal. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 39-40	Y ☒ N ☐
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 Contract Schedule A–1(L)(2)(d)	19. The availability of assistance in the filing process for grievances and appeals. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 39-40	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 Contract Schedule A–1(L)(2)(a)(iii)	20. The right to request a State fair hearing (SFH) (or a State external review for the Children's Health Insurance Program [CHIP]) after the PIHP has made a determination on a member's appeal that is adverse to the member.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide to Services.LifeWays, pg. 42	
42 CFR §438.10(g)(2)(xi)(E) Contract Schedule A–1(L)(5)(h)	21. The fact that, when requested by the member, benefits that the PIHP seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the time frames specified for filing, and that the member may, consistent with MDHHS policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide to Services.LifeWays, pg. 41	
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) Contract Schedule A–1(Q)(5)	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j).	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide to Services.LifeWays, Pg. 48 • CS_Advance_Directives_FY24	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(i)	23. How to access auxiliary aids and services, including additional information in alternative formats or languages.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide to Services.LifeWays, Pg. 10	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(4)	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide to Services.LifeWays, pgs. 16-30, Behavioral Health Provider Directory • FY24 MSHN Guide to Services.LifeWays, pg. 34-35, Emergency and After-Hours Access to Services	

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207	25. Information on how to report suspected fraud or abuse. **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, Pgs. 12-13	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(a)	26. *The date of publication/revision and version number.* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, front, and back cover	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(h)	27. *Produce supplemental materials to the member handbook, as needed, to ensure compliance with the contractual requirements (e.g., inserts/stickers).* **Evidence as submitted by the PIHP:** • CS_Customer_Handbook_FY24	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(i)	28. *Use MDHHS' description for each Medicaid covered service.* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 63-72	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(j)	29. *Include the following contact information for Medicaid health plans (MHPs) or Medicaid fee-for-service (FFS) programs:* a. *Plan/program name* b. *Locations* c. *Telephone numbers* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide to Services.LifeWays, pgs. 76-77	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(i)	30. *Include the following topics in the Customer Services Handbook (topics requiring use of MDHHS template language, which can be found at: https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/customer-services)*: a. *Template #1: Confidentiality and Family Access to Information* b. *Template #2: Coordination of Care* c. *Template #3: Emergency and After-Hours Access to Services*	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
	d. *Template #4: Glossary or Definition of Terms* e. *Template #5: Grievance and Appeals Processes* f. *Template #6: Language Assistance and Accommodations* g. *Template #7: Payment for Services* h. *Template #8: Person-Centered Planning* i. *Template #9: Recipient Rights* j. *Template #10: Recovery and Resiliency* k. *Template #11: Service Array* l. *Template #12: Service Authorization* m. *Template #13: Tag Lines* n. *Template #14: Fraud, Waste and Abuse*	
	Evidence as submitted by the PIHP: • CS_Customer_Handbook_FY24: o Template #1: Confidentiality and Family Access to Information, pg. 60 o Template #2: Coordination of Care, pg. 45 o Template #3: Emergency and After-Hours Access to Services, pgs. 34-35 o Template #4: Glossary or Definition of Terms, pgs. 86-94 o Template #5: Grievance and Appeals Processes, pgs. 39-42 o Template #6: Language Assistance and Accommodations, pg. 10 o Template #7: Payment for Services, pg. 63 o Template #8: Person-Centered Planning, pg. 46 o Template #9: Recipient Rights, pg. 57 o Template #10: Recovery and Resiliency, pg. 51 o Template #11: Service Array, pgs. 64-78 o Template #12: Service Authorization, pgs. 61-62 o Template #13: Tag Lines, pgs. 6-7 o Template #14: Fraud, Waste and Abuse, pgs. 12-13	

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(4)	31. *Affiliate the names, addresses, and phone numbers of the following personnel:* a. *Executive director* b. *Medical director* c. *Recipient rights officer* d. *Customer services* e. *Emergency (911) and after-hours contact numbers* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide To Services.LifeWays, pgs. 16-30, Behavioral Health Provider Directory	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(5)	32. *Community resource list (and advocacy organizations).* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide To Services.LifeWays, pgs. 97-101	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(6)	33. *Index.* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide To Services.LifeWays, pg. 95	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(7)	34. *Right to information about PIHP operations (e.g., organizational chart, annual report).* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide To Services.LifeWays, pgs. 2, 14-15 • CS_Customer_Handbook_FY24	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(8)	35. *Services not covered under contract.* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide To Services.LifeWays, pg. 78	Y ☒ N ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(9)	36. *Welcome to the PIHP.* **Evidence as submitted by the PIHP:** • FY24 MSHN Guide To Services.LifeWays, pgs. 14-15	Y ☒ N ☐

Standard I—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(ii)(10)	37. *What are customer services and what they can do for the individual; hours of operation and process for obtaining customer assistance after hours?*	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide To Services.LifeWays, pgs. 36-38	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(1)(b)	38. *Member rights and protections as specified in the contract as they relate to grievances and appeals.*	Y ☒ N ☐
	Evidence as submitted by the PIHP: • FY24 MSHN Guide To Services.LifeWays, pgs. 39-42	

Standard I—Provider Directory Checklist		
Reference	**Required Components**	
The PIHP makes available in paper form, upon request, and electronic form the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(i) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	1. The provider's name as well as any group affiliation. **Evidence as submitted by the PIHP:** • See Column "A" & "B" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(ii) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	2. Street address(es). **Evidence as submitted by the PIHP:** • See Column "D" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(iii) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	3. Telephone number(s). **Evidence as submitted by the PIHP:** • See Column "I" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(iv) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	4. Website Uniform Resource Locator (URL), as appropriate. **Evidence as submitted by the PIHP:** • See Column "L" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(v) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	5. Specialty *and services provided*, as appropriate. **Evidence as submitted by the PIHP:** • See Column "S" "T" & "X" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(vi)	6. Whether the provider will accept new members. **Evidence as submitted by the PIHP:** • See Column "O" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(vii-viii) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. **Evidence as submitted by the PIHP:** • See Column "P" & "Q" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐

Standard I—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(f)(ix) Contract Schedule A–1(M)(2)(b)(ii)(1)(a)	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to, wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. **Evidence as submitted by the PIHP:** • See Column "R" & "AB" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☐ N ☒
42 CFR §438.10(h)(2) 42 CFR §457.1207 Contract Schedule A–1(M)(1)(a)	9. The provider directory components are included for the following provider types: a. Physicians, including specialists b. Hospitals c. Pharmacies (*not applicable for the PIHPs*) d. Behavioral health providers e. Long-term services and supports (LTSS) providers f. *Medical suppliers* g. *Ancillary health providers* h. *Independent facilitators* i. *Fiscal intermediaries*, as appropriate **Evidence as submitted by the PIHP:** • See Column "A - AB" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐
Contract Schedule A–1(M)(1)(e)	10. *Provider directory is organized by county.* **Evidence as submitted by the PIHP:** • See Column "H" of MSHN Provider Directory Spreadsheet & MSHN on-line provider directory	Y ☒ N ☐

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		

1. The PIHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.
 	
42 CFR §438.206(b)(1)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(1)
Contract Schedule A–1(E)(9)(a)
	HSAG Required Evidence:
	• Policies and procedures
	• Analysis of provider network linguistic capabilities
	• Analysis of provider network capabilities to serve members with special health care needs
	• Provider materials, such as the provider manual
	• One example of each type of provider contract (ancillary, hospital, and individual/group)
	
	Evidence as Submitted by the PIHP:
	• TRD_2024 Delegated Managed Care – Audit 3734- Final
	  ○ Standard 4.1 Page 10
	• Arbor Circle_2023 Delegated Functions – Final
	  ○ Standards 1.1-1.4 pages 1-2
	  ○ Standards 2.1-2.10 pages 2-4
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 6 (IX)(A)
	  ○ Pg. 7 (X)(A)
	  ○ Pg. 7 (XI)(B)
	  ○ Pg. 19 (XX)(D)
	  ○ Pg. 35 (Information Requirements & Notices)
	  ○ Pg. 43, 44 (VI. Provider Network)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (2)
	  ○ Pg. 19 (C)
	  ○ Pg. 29 (4)(6)
		☒ Met
		☐ Not Met
		☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	○ Pg. 32 (3)	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
2. The MCO provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) 42 CFR §457.1230(a) Contract F.4.01	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the MCO:** • Not applicable	☐ Met ☐ Not Met ☒ NA
MCO Description of Process: N/A		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		
3. The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) 42 CFR §457.1230(a) Contract E.1.23	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the MCO:** • Not applicable	☐ Met ☐ Not Met ☒ NA
MCO Description of Process: N/A		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**

4. The PIHP provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.
 	
*Note: Second opinion rights under Michigan Mental Health Code 330.1705, 330.1409, 330.1498e, or 330.1498h are a separate requirement than the federal requirement noted under this element.
 	
42 CFR §438.206(b)(3)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(12)
	HSAG Required Evidence:
	• Policies and procedures
	• Member materials, such as the member handbook
	• Second opinion tracking/analysis
	• Coverage/authorization guidelines
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 34 (I. Customer Service)
	  ○ Pg 50 (IX. Utilization Management)
	• FY24 MSHN Guide To Services.LifeWays, pgs. 41, 57, 62
	• TBHS 2023 Delegated Managed Care – 5.2 Pg. 15
	• TBHS_2023 Chart Review – Crisis Residential- Audit 3679-5.5 page 9-10.
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**

5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the PIHP adequately and timely covers these services out of network for the member, for as long as the PIHP provider network is unable to provide them.
 	
42 CFR §438.206(b)(4)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(4)(a)
	HSAG Required Evidence:
	• Policies and procedures
	• Member materials, such as the member handbook
	• Network adequacy monitoring mechanisms
	• Three examples of executed single case agreements (SCAs) (if the execution of SCAs is also a delegated function, one case example must pertain to an SCA executed by the PIHP, and two case examples must pertain to an SCA executed by two different delegates)
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 36 (Information Requirements & Notices)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 19 (D)
	  ○ Pg. 33 (6)
	• FY24 MSHN Guide to Services.LifeWays, pg. 62
	• TBHS 2023 Delegated Managed Care-Standard III, 1.7 pg. 3, 4.3, 4.4 pg. 11
	• Bear River Single Case Agreement
	• Ascension Single Case Agreement
	• Sunrise Centre Single Case Agreement
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
6. The PIHP requires out-of-network providers to coordinate with the PIHP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network, *including a prohibition on balance billing in compliance with 42 CFR 438.106, 42 CFR 438.116, and the Medicaid Provider Manual*. a. *The PIHP must comply with all related Medicaid policies regarding authorization and reimbursement for out-of-network providers*. b. *The PIHP must pay out-of-network Medicaid providers' claims at established Medicaid fees in effect on the date of service*. c. *If Michigan Medicaid has not established a specific rate for the covered service, the PIHP must follow Medicaid policy to determine the correct payment amount*. 42 CFR §438.206(b)(5) 42 CFR §457.1230(a) Contract Schedule A–1(E)(4)(c-d)	**HSAG Required Evidence:** • Policies and procedures • Claims processing guidelines for out-of-network providers • Member materials, such as the member handbook • Provider materials, such as materials on the PIHP's website • Three examples of executed SCAs (if the execution of SCAs is also a delegated function, one case example must pertain to an SCA executed by the PIHP, and two case examples must pertain to an SCA executed by two different delegates) **Evidence as Submitted by the PIHP:** • FY24 SUD Provider Manual ○ Pg. 52 • Service Delivery System SUD Out of Region Coverage • Bear River Single Case Agreement (Pg. 2-3) • Ascension Single Case Agreement (Pg. 2) • Sunrise Centre Single Case Agreement (pg 2-3) • FY24 MSHN Guide to Services.LifeWays, pg. 62 • TBHS 2023 Delegated Managed Care – Standard III, 4.3, 4.4 pg. 11,	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN UM department initiates Single Case Agreement (SCA) for services with any out of network provider. Credentialing information is received and an SCA is sent to the provider for execution and implementation.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
42 CFR §438.206(b)(6) requires the PIHP to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VII: Provider Selection.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Timely Access[2]		
7. *The Access System must operate or arrange an access line that is available 24 hours per day, seven days per week, including in-person and by-telephone access for hearing impaired individuals.* a. *Telephone lines are toll-free; accommodate limited English proficiency; are accessible for individuals with hearing impairments, using interpreters, text messaging, or videophone access; and have electronic caller identification, if locally available.* b. *Callers encounter no telephone "trees" and are not put on hold or sent to voicemail until they have spoken with a live representative from the Access System, and it is determined, following an empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.* c. *All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.* d. *For non-emergent calls, a person's time on hold awaiting a screening must not exceed three minutes without being offered an option for callback or talking with a non-professional in the interim.* e. *All non-emergent callbacks must occur within one business day of initial contact.*	**HSAG Required Evidence:** • Policies and procedures • Telephone system triage workflow • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • Access System Procedure, Section B, pp.1 • Montcalm Behavioral Health 2023 DMC Review, Section 3, pp. 6-10 • Telephone Timeliness Monitoring Report	☒ Met ☐ Not Met ☐ NA

[2] The PIHP meets and requires its network providers to meet MDHHS standards for timely access to care and services, taking into account the urgency of the need for services.

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
f. *For organizations with decentralized Access Systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to redial.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards I(B)		
PIHP Description of Process: MSHN delegates access to its CMHSP providers. The Access Procedure outlines the 24/7 access requirements. MSHN monitors delegated access functions through the delegated managed care (DMC) site review process. A copy of a DMC review for Montcalm CMH is included as evidence, as well as the supporting evidence which was reviewed to verify compliance with the requirements (Telephone Timeliness Monitoring Report). A Telephone System Triage Workflow was not required/requested by MSHN from Montcalm CMH as the other evidence submitted during the DMC review demonstrated the required elements were met.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** To enhance the PIHP's monitoring processes of its CMHSPs, HSAG recommends that the PIHP consider developing a standardized reporting template for its CMHSPs to report data pertaining to the access standards to the PIHP.		
Required Actions: None.		

8. *The Access System shall provide a timely, effective response to all individuals who walk in.*
a. *For individuals who walk in with urgent or emergent needs, an intervention shall be immediately initiated.*
b. *Individuals with routine needs must be screened or other arrangements made within 30 minutes.*
 	
42 CFR §438.206(c)(1)(i)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)
MDHHS Behavioral Health and Developmental Disabilities Administration
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Monitoring reports
	
	Evidence as Submitted by the PIHP:
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (2)
	  ○ Pg. 19 (C)
	• Access Procedure, Section C, pp.1
		☒ Met
		☐ Not Met
		☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Access Standards I(C)(1-2)	• Walk In Timeliness Monitoring Report • Montcalm Behavioral Health 2023 DMC Review, Section 3, pp.6-10	
PIHP Description of Process: MSHN delegates access to its CMHSP providers. The Access Procedure outlines the access requirements. MSHN monitors delegated access functions through the delegated managed care (DMC) site review process. A copy of a DMC review for Montcalm CMH is included as evidence, as well as the supporting evidence which was reviewed to verify compliance with the requirements (Walk In Timeliness Monitoring Report).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** To enhance the PIHP's processes for monitoring its CMHSPs and SUD providers, HSAG recommends that the PIHP consider developing a standardized reporting template for its CMHSPs and SUD providers to report data pertaining to access standards to the PIHP.		
Required Actions: None.		

9. *Pregnant injecting drug user:*
a. *Screened and referred within 24 hours for admission*
b. *Detoxification, methadone, or residential—offer admission within 24 business hours.*
c. *Other levels of care—offer admission within 48 business hours.*
 	
42 CFR §438.206(c)(1)(i)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Timeliness monitoring reports
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 73 (Exhibit G)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (4)
	  ○ Pg. 32 (3)
	• Access Procedure, Section III, pp.3
	• Priority Population Access Report FY24 Q2
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: MSHN delegates SUD access to its CMHSP providers and SUD providers. The Access Procedure outlines the SUD priority population access requirements. The MSHN SUD Care Navigator completes a quarterly Priority Population Access Report which is shared internally with		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
the MSHN Quality Manager, SUD Treatment Team, and Utilization Management Team to develop additional quality improvement strategies, as needed. Technical Assistance occurs with individual provider organizations to address undesirable performance.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

10. *Pregnant substance user:*
a. *Screened and referred within 24 hours for admission.*
b. *Detoxification, methadone, or residential—offer admission within 24 business hours.*
c. *Other levels of care—offer admission within 48 business hours.*
 	
42 CFR §438.206(c)(1)(i)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Timeliness monitoring reports
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 73 (Exhibit G)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (4)
	  ○ Pg. 32 (3)
	• Access Procedure, Section III, pp.3
	• Priority Population Access Report FY24 Q2
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: Same process as noted above.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**

11. *Injecting drug user:*
a. *Screened and referred within 24 hours for admission.*
b. *Offer admission within 14 days.*
 	
42 CFR §438.206(c)(1)(i)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Timeliness monitoring reports
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 73 (Exhibit G)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (4)
	  ○ Pg. 32 (3)
	• Access Procedure, Section III, pp.3
	• Priority Population Access Report FY24 Q2
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: Same process as noted above.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
12. *Parent at risk of losing children:* a. *Screened and referred within 24 hours for admission.* b. *Offer admission within 14 days.* 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Schedule A–1(E)(7) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Timeliness monitoring reports **Evidence as Submitted by the PIHP:** • MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III ○ Pg. 73 (Exhibit G)	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**

	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (4)
	  ○ Pg. 32 (3)
	• Access Procedure, Section III, pp.3
	• Priority Population Access Report FY24 Q2	

PIHP Description of Process: Same process as noted above.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

13. *Individual under supervision of Michigan Department of Corrections (MDOC) and referred by MDOC or individual being released directly from MDOC without supervision and referred by MDOC:*
a. *Screened and referred within 24 hours for admission.*
b. *Offer admission within 14 days.*
42 CFR §438.206(c)(1)(i)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Timeliness monitoring reports
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 73 (Exhibit G)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (4)
	  ○ Pg. 32 (3)
	  ○ Pg. 33-35 (12)
	• Priority Population Access Report FY24 Q2
	• Access Procedure, Section III, pp.3
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: Same process as noted above.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		

14. *All other populations:*
a. *Screened and referred within seven calendar days.*
b. *Capacity to offer admission within 14 days.*
 	
42 CFR §438.206(c)(1)(i)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards III(A)
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Timeliness monitoring reports
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 73 (Exhibit G)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 32 (3)
	• Priority Population Access Report FY24 Q2
	• Access Procedure, Section III, pp.3
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: Same process as noted above.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
15. The PIHP ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. 42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports **Evidence as Submitted by the PIHP:** • MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III ○ Pg. 7 (XI)(B)	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	○ Pg. 30 (XXX) (A-D) ○ Pg. 43 (VI. Provider Network) • FY24 SUD Treatment – Standard III ○ Pg. 9 (2) ○ Pg. 12 (1) ○ Pg. 14 (11) • PNM_Provider_Network_Mgmt_Policy Pg. 1-2 • FY24 MSHN Guide To Services.LifeWays, pg. 62 • TBHS 2023 Delegated Managed Care, 1.7 pg. 3, 4.3, 4.4 pg. 11	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** To enhance the PIHP's monitoring processes of its providers, HSAG recommends that the PIHP consider developing a secret shopper survey or other mechanism for monitoring provider office hours as required in contract.		
Required Actions: None.		
16. The PIHP makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards (I)(B)	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Results of provider monitoring mechanisms • Audit or secret shopper results/reports **Evidence as Submitted by the PIHP:** • MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III ○ Pg. 7 (XI)(B) ○ Pg. 30 (XXX) (A-D) ○ Pg. 43 (VI. Provider Network)	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**

	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (2)
	  ○ Pg. 12 (1)
	  ○ Pg. 14 (11)
	• PNM_Provider_Network_Mgmt_Policy Pg. 1-2
	• TRD_2023 Delegated Managed Care – Audit 3734 Final
	  ○ 3.1, page 47
	• Arbor Circle_2023 Delegated Functions -Final
	  ○ 1.1, page 1
	• Telephone Timeliness Monitoring Report
	• Walk In Timeliness Monitoring Report	

PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

17. The PIHP establishes mechanisms to ensure compliance with timely access to care and services standards by network providers.
a. The PIHP monitors network providers regularly to determine compliance.
b. The PIHP takes corrective action if there is a failure to comply by a network provider.
 	
42 CFR §438.206(c)(1)(iv-vi)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(7)(a)
MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards (IX)(C)
	HSAG Required Evidence:
	• Policies and procedures
	• Results of provider monitoring mechanisms
	• Audit or secret shopper results/reports
	• Three examples of corrective action taken when a provider fails to meet timely access standards
	
	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 7 (XI)(B)
	  ○ Pg. 30 (XXX) (A-D)
	  ○ Pg. 43 (VI. Provider Network)
	• FY24 SUD Treatment – Standard III
		☒ Met
		☐ Not Met
		☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	○ Pg. 9 (2) ○ Pg. 12 (1) ○ Pg. 14 (11) • PNM_Provider_Network_Mgmt_Policy Pg. 1 • TRD_2023 Delegated Managed Care – Audit 3734 – Final ○ 3.2 – 3.5 pages 6-7 ○ 3.17 page 9 • Telephone Timeliness Monitoring Report • Walk In Timeliness Monitoring Report • Example #1 KPEP TA 10-5-23 • Example #2 2-27-24 Technical Assistance Meeting • Example #3- SATP TA Log	
PIHP Description of Process: The complete screening document for SUD services in the EHR is named the Level of Care (LOC) Determination. Providers are required to complete this document when a person requests services to determine if they are eligible, get them scheduled for an appointment, or referred to an appropriate provider.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
18. *The PIHP (for the Access System):* a. *Routinely measures telephone answering rates, call abandonment rates, and timeliness of appointments and referrals; and* b. *Any resulting performance issues are addressed through the PIHP's Quality Improvement Plan.* Contract Schedule A–1(E)(7)(a) MDHHS Behavioral Health and Developmental Disabilities Administration Access Standards (IX)(C)(5)	**HSAG Required Evidence:** • Policies and procedures • Results of Access System monitoring • Timeliness reports • Two examples of quality improvement plans related to the Access System **Evidence as Submitted by the PIHP:** • MSHN QAPIP MMBPIS Project Description FY24 • MSHN QAPIP ○ e) Performance Indicators, page 16	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• TRD_2023 Delegated Managed Care – Audit 3734 – CAP Approved ○ 3.11 page 12-13 • Telephone Timeliness Monitoring Report • Walk In Timeliness Monitoring Report • Priority Population Access Report FY24 Q2	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Access and Cultural Considerations		

19. The PIHP participates in MDHHS's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.
 	
42 CFR §438.206(c)(2)
42 CFR §457.1230(a)
Contract Schedule A–1(E)(9)(a)
Contract Schedule A–1(E)(9)(c)
	HSAG Required Evidence:
	• Policies and procedures
	• Provider materials, such as the provider manual and provider contract
	• Cultural competency plan
	• Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory
	• Analysis of provider network linguistic capabilities
	• Analysis of provider network cultural competence
	
	Evidence as Submitted by the PIHP:
	• MSHN Cultural Competency Policy
	• MSHN Training Grid FY 24
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 7 (X)(A)
	  ○ Pg. 43-44 (VI. Provider Network)
	• FY24 SUD Treatment – Standard III
		☒ Met
		☐ Not Met
		☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	○ Pg. 19 (C) • FY24 MSHN Guide to Services.LifeWays, pg. 31 • Assessment_of_Network_Adequacy_2023, pgs. 55-56 • MSHN QAPIP, ○ e) Cultural Competence, pg 22 • MSHN Official DEI Statement • MSHN Provider Directory Example • TRD_2023 Delegated Managed Care – Audit 3734 – Final ○ 4.6 and 4.10 page 11 • Arbor Circle_2023 Delegated Functions- Final ○ 7.13 page 18	
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Accessibility Considerations		
20. The PIHP ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a) Contract Schedule A–1(E)(20)(c)	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations [e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment]) on provider directory • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results	☒ Met ☐ Not Met ☐ NA

Standard III—Availability of Services		
Requirement	**Supporting Documentation**	**Score**

	Evidence as Submitted by the PIHP:
	• MSHN FY 2024 Medicaid Subcontracting Agreement – Standard III
	  ○ Pg. 19 (XX)(C)
	  ○ Pg. 72 (Exhibit G)
	• FY24 SUD Treatment – Standard III
	  ○ Pg. 9 (2)
	  ○ Pg. 19 (C)
	• FY24 MSHN Guide to Services.LifeWays, pgs. 10, 31
	• PNM Provider Network Management Policy
	  ○ C. Page 2
	• MSHN PNM Provider Directory Policy
	• MSHN Provider Directory Example Columns N-P, X
	• TRD_2023 Delegated Managed Care – Audit 3734 – Final 1.7 page 3, 4.2 Page 10	

PIHP Description of Process: In addition to the contractual requirements of all providers, the MSHN provider directory on the MSHN website provides information about each provider's linguistic capabilities and if the physical space is ADA compliant. MSHN and its CMHSP participants and SUDSP providers use the standard Guide to Services Consumer Handbook to provide information about accessible services and how to request accommodations.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard III—Availability of Services						
Met	=	18	X	1	=	18
Not Met	=	0	X	0	=	18
Not Applicable	=	2				
Total Applicable	=	18	Total Score		=	18
Total Score ÷ Total Applicable					=	100%

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Basic Rule		
1. The PIHP gives assurances to MDHHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance MDHHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The PIHP submits documentation to MDHHS, in a format specified by the State, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b) Contract Schedule A–1(E)(2)(a) MDHHS Network Adequacy Standards—Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR) • S.IV E1-4 Provider Network Management Policy (pg. 1, item B, C, E) • S.IV E1 PNM_SUD_Direct_Service_Procurement Policy • Service_Delivery_System_Out_of_State_Placement Policy • S.IV E1-3 FY24 SUD Provider Manual (pg. 24, Capacity) • S.IV E1-3 FY24 SUD Treatment (pg. 9, bullet 6 Waitlist; pg. 19 bullet C Accessibility; pg. 21 bullet 6 Notification of Staffing Changes) • S.IV E1-3 FY 2024 Medicaid Subcontracting Agreement (pg. 32, Bullet B; pg. 43 & 44 Provider Network Delegation)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: In 2024, MSHN contracted with TBD Solutions consultants to conduct GeoMaps to produce time and distance compliance results by identifying location of the region's population compared with the providers locations to determine where gaps may exist.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
MSHN completes an annual assessment of adequacy (moving to biennial) to determine whether or not it offers an appropriate range of services, and whether those services are adequate for the anticipated number of members in the region. To achieve this, the NAA includes a review of utilization trends/persons served trends as well as enrollment trends to determine if current provider network can meet needs of persons served (pg.10-30, 44-47). The most recent assessment was reviewed and received by the MSHN BOD in May of 2024. As part of this process, and in accordance with the contract, CMHSPs conduct annual local needs assessments to assess local needs within their catchment areas and identify priorities (pg.48). MSHN ensures availability of all SUD levels of care (pg. 31-41). Review of Access timeliness is included to address sufficiency (pg. 51) and an overview of Time and Distance Standards included to comply with the MDHHS standards (pg. 52 and Appendix B). A review of mix of providers also includes cultural competency, analysis of enrollees race and penetration rates, accommodations including ADA and LEP (pg. 55-59). Recommendations are included with the NAA plan along with updates from prior year recommendations (pg. 86-90). An action plan for FY24 results is under development to monitor implementation (pg. 91).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Timing		
2. The PIHP submits the documentation in 42 CFR §438.207(b) as specified by MDHHS, but no less frequently than the following: a. At the time it enters into a contract with MDHHS. b. On an annual basis. c. At any time there has been a significant change (as defined by MDHHS) in the PIHP's operations that would affect the adequacy of capacity in services, including: i. Changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the PIHP. 42 CFR §438.207(c) 42 CFR §457.1230(b)	**HSAG Required Evidence:** • Policies and procedures • Assurances of adequate capacity and services submissions to MDHHS (most recent annual submission) • Assurances of adequate capacity and services submission(s) to MDHHS due to a significant change **Evidence as Submitted by the PIHP:** • S.IV E1-4 PNM_Provider_Network_Management_Policy (#3, pg. 2, B and C, Pg. 1-2) • S.IV E2 MDHHS Confirmation CCSGC SUD Tx Termination • S.IV E1-3 FY24 SUD Provider Manual (pg. 24, Capacity) • S.IV E1-3 FY24 SUD Treatment (pg. 9, bullet 6 Waitlist; pg. 19 bullet C Accessibility; pg. 21 bullet 6 Notification of Staffing Changes)	☒ Met ☐ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
	• S.IV E1-3 FY 2024 Medicaid Subcontracting Agreement (pg. 32, Bullet B; pg. 43 & 44 Provider Network Delegation) • S.IV E2-3Termination Checklist - Bullet 5 • S.IV E2 PIHP Network Adequacy Data Request ASAM • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	
PIHP Description of Process: MSHN notifies MDHHS when it is informed by a provider that they intend to terminate their SUD contract with MSHN or when informed by a CMHSP that a provider in their network has given notice. MSHN requires its network to provide notice of such per contract language and provider manual reference. MSHN utilizes the checklist to ensure appropriate notifications and closing process. Examples of notifications and reports have been provided.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. *The PIHP must notify MDHHS within seven days of any changes to the composition of the provider network organizations that negatively affect access to care.* a. *The PIHP must have procedures to address changes in its network that negatively affect access to care.* Contract Schedule A–1(E)(3)(a)	**HSAG Required Evidence:** • Policies and procedures • Example of notification to MDHHS regarding provider network change that negatively affected access to care, including date of change to the provider network and date MDHHS was notified • Tracking mechanisms for timely notification to MDHHS of network change, including date of change to the provider network and date MDHHS was notified **Evidence as Submitted by the PIHP:** • S.IV E2 MDHHS Confirmation CCSGC SUD Tx Termination • S.IV E1-3 FY24 SUD Provider Manual (pg. 24, Capacity) • S.IV E1-4 PNM_Provider_Network_Management_Policy (pg. 1-2, item B & C)	☒ Met ☐ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
	• S.IV E1-3 FY24 SUD Treatment (pg. 9, bullet 6 Waitlist; pg. 19 bullet C Accessibility; pg. 21 bullet 6 Notification of Staffing Changes) • S.IV E1-3 FY 2024 Medicaid Subcontracting Agreement (pg. 32, Bullet B; pg. 43 & 44 Provider Network Delegation) • S,UV E2-3 Termination Checklist - Bullet 5 • S.IV E3 FY24_April_Priority_Populations_Waiting_List_Deficiencies_Report	
PIHP Description of Process: Contracts with SUD providers and CMHSPs include notification requirements. SUD providers are required to provide a waitlist report to MSHN to identify access issues; however, providers do not report individuals being waitlisted. In instances when a provider contract is terminated, MSHN always notifies MDHHS even if it does not negatively impact access. Examples of such notification has been included; However, if a CMHSP has network changes impacting access to care, they are to notify MSHN along with a plan to address access.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. *The PIHP must submit a plan on how the* [network adequacy] *standards will be effectuated by region. Understanding their diversity, MDHHS expects to see nuances within the PIHPs to best accommodate the local populations served. The PIHP must consider at least the following parameters for their plans*: a. *Maximum time and distance* b. *Timely appointments* c. *Language, cultural competence, and physical accessibility—§438.68(c)(vii-viii)* Contract Schedule A–1(E)(20)(c) MDHHS Network Adequacy Standards—Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Regional network adequacy plan **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR) • S.IV E1-4 Provider Network Management Policy (pg. 1-2, item B, C)	☒ Met ☐ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: MSHN completes an annual assessment of adequacy (moving to biennial) to determine whether or not it offers an appropriate range of services, and whether those services are adequate for the anticipated number of members in the region. To achieve this, the NAA includes a review of utilization trends/persons served trends as well as enrollment trends to determine if current provider network can meet needs of persons served (pg.10-30, 44-47). The most recent assessment was reviewed and received by the MSHN BOD in May of 2024. As part of this process, and in accordance with the contract, CMHSPs conduct annual local needs assessments to assess local needs within their catchment areas and identify priorities (pg.48). MSHN ensures availability of all SUD levels of care (pg. 31-41). Review of Access timeliness is included to address sufficiency (pg. 51) and an overview of Time and Distance Standards included to comply with the MDHHS standards (pg. 52 and Appendix B). A review of mix of providers also includes cultural competency, analysis of enrollees race and penetration rates, accommodations including ADA and LEP (pg. 55-59). Recommendations are included with the NAA plan along with updates from prior year recommendations (pg. 86-90). An action plan for FY24 results is under development to monitor implementation (pg. 91).		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the documents submitted by the PIHPs for this element were not consistent; therefore, HSAG recommended to MDHHS that it provide clarification about its expectations for the PIHPs as it pertains to submission of a network adequacy plan, and specifically, whether a separate network adequacy plan is required in addition to the submission of the network adequacy reporting template. As such, the PIHP should adhere to any guidance provided by MDHHS and incorporate the guidance into the PIHP's network adequacy planning and reporting processes.		
Required Actions: None.		
Network Adequacy Standards—Time/Distance		
5. *Inpatient psychiatric services for adults*: a. *Frontier: 150 minutes/125 miles* b. *Rural: 90 minutes/60 miles* c. *Urban: 30 minutes/30 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	☒ Met ☐ Not Met ☐ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**

PIHP Description of Process: MSHN contracted with TBD Solutions to take a geographical approach to do analysis on the entire population of the MSHN 21 county region. Details for "Distance" and "Drive Time" below:

Calculating Distance:
Data from the 2020 Census allows us to estimate the population centers within MSHN's region. Population centers are the estimated number of individuals residing within a custom-mile hexagonal boundary. There are thousands of these population centers across MSHN's region. Each population center is assigned to its nearest provider. The nearest provider is determined by finding the provider location with the shortest straight-line distance (in miles) to the population center of interest.

Once all population centers are assigned to their nearest provider, network adequacy is calculated by measuring the proportion of the population centers that fall below a certain acceptable mile-distance threshold. For instance, if the maximum allowable distance to the nearest provider is 30 miles, and 933 out of our estimated 1,000 residents travel less than 30 miles to reach their nearest provider, then 93.3% of the population falls within acceptable coverage. For this example, the county network adequacy is 93.3%.

Calculating Drive Time:
Calculating the drive times between coordinate pairs on a mass scale is a balance between accuracy and resource consumption. On the one hand, accuracy is maximized using commercial APIs to gather near real-time feedback on drive times, considering weather, traffic conditions, and construction. On the other hand, resource consumption (time and compute) is minimized by calculating the straight-line distance between two coordinate pairs "as-the-crow-flies'. The goal is to consider the pros and cons of each approach to find the balance that minimizes resource consumption while not materially sacrificing the accuracy of the calculation.

Commercial APIs (Google, Microsoft) provide the most accurate method of calculating the drive-time distance between two coordinates, assuming that the derived addresses are recorded perfectly. The primary drawback is the cost of processing hundreds of thousands of coordinate pairs necessary to derive a network adequacy calculation. These costs can quickly run into thousands of dollars, making this approach cost prohibitive in many instances. A straight-line distance metric provides a measure of distance quickly and with little costs but needs to consider the uneven nature of driving on roads.

A modified straight-line distance that applies a drive-time constant provides a cost-efficient alternative while not materially sacrificing the accuracy of the drive-time calculation. To achieve these results, approximately one hundred randomly selected coordinate pairs in the MSHN geographic region were computed. The difference between the API and straight-line calculations showed a medium differential of 25%. Therefore, as a proxy for API calculations,

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
the drive-time constant of 1.25 was applied to all distance metrics. The approach builds off the insight from several studies that show a high correlation between drive-time and straight-line distance metrics as a proxy (Boscoe, F., Henry, K., & Zdeb, M. (2012), Phibbs, C., & Luft, H. (1995)). Designating geographic boundaries comes from the Code of Federal Regulations Title 42 Chapter IV Subchapter B part 422 subpart C which outlines in detail county type designations as it relates to Network Adequacy. CFR uses Large Metro, Metro, Micro, Rural and CEAC. The CEAC (Counties with Extreme Access Considerations) are frontier locations and Large Metro, Metro, Micro are simply further stratifications of Urban. The results are summaries in the Network Adequacy Assessment, the New Adequacy Report and geomaps are located in the Network Adequacy Assessment. The reports are reviewed with multiple regional council and committees and include follow up on identified gap areas.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG network adequacy validation (NAV) activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		
6. *Inpatient psychiatric services for pediatrics*: a. *Frontier: 330 minutes/355 miles* b. *Rural: 120 minutes/125 miles* c. *Urban: 60 minutes/60 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: See above, same process		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG NAV activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		
7. *Assertive community treatment, crisis residential programs, opioid treatment programs, psychosocial rehabilitation (clubhouses) programs for adults*: a. *Frontier: 90 minutes/90 miles* b. *Rural: 60 minutes/60 miles* c. *Urban: 30 minutes/30 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: See above, same process		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG NAV activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
8. *Crisis residential programs, home-based services, and wraparound services for children*: a. *Frontier: 90 minutes/90 miles* b. *Rural: 60 minutes/60 miles* c. *Urban: 30 minutes/30 miles* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: See above, same process		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP submitted documentation confirming that it maintained policies and contracts with providers, and that it monitored its network in accordance with the required time and distance standards, which resulted in the PIHP receiving a *Met* score for this element. **Recommendations:** HSAG recommends that the PIHP review the results, findings, and recommendations determined through the HSAG NAV activity, and take action to ensure that the PIHP fully aligns with MDHHS' expectations regarding the methodology and calculation of time and distance standards.		
Required Actions: None.		
Network Adequacy Standards—Member-to-Provider Ratios		
9. *For adults*: a. *Assertive community treatment—30,000:1* b. *Psychosocial rehabilitation (clubhouse)—45,000:1* c. *Opioid treatment programs—35,000:1* d. *Crisis residential—16 beds per 500,000 total population* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2)	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	☐ Met ☐ Not Met ☒ NA

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure		
PIHP Description of Process: MSHN includes an analysis of the MDHHS standards in the Network Adequacy Assessment. Data is gathered for each area as explained in the NAA. ACT pg. 10; Psychosocial pg. 11, OTPs pg. 38 Crisis Residential pg. 13		
HSAG Findings: HSAG has determined that this element is *Not Applicable* for the time period of this review, as MDHHS did not require the PIHPs to report member-to-provider ratios in the new network adequacy reporting template required to be completed and submitted to MDHHS by May 31, 2024 (i.e., outside of the time period under review for this compliance review). Additionally, MDHHS has not provided the PIHPs with specifications for consistently calculating member-to-provider ratios. **Recommendations:** HSAG recommends that the PIHP adhere to any specifications provided by MDHHS in the future to calculate and report member-to-provider ratio standards.		
Required Actions: None.		
10. *For pediatrics*: a. *Home-based—2,000:1* b. *Wraparound—5,000:1* c. *Crisis residential—8–12 beds per 500,000 total population* 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1218 Contract Schedule A–1(E)(20) MDHHS Network Adequacy Standards— Medicaid Specialty Behavioral Health Services Procedure	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports and analyses **Evidence as Submitted by the PIHP:** • S.IV E1-E10 2023 Network Adequacy Assessment (NAA) • S.IV. E.1-10 2023 Network Adequacy Report (NAR)	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process: MSHN includes an analysis of the MDHHS standards in the Network Adequacy Assessment. Data is gathered for each area as explained in the NAA. Home Based pg. 17; Wraparound pg. 19 Crisis Residential pg. 13		
HSAG Findings: HSAG has determined that this element is *Not Applicable* for the time period of this review, as MDHHS did not require the PIHPs to report member-to-provider ratios in the new network adequacy reporting template required to be completed and submitted to MDHHS by May 31, 2024 (i.e., outside of the time period under review for this compliance review). Additionally, MDHHS has not provided the PIHPs with specifications for consistently calculating member-to-provider ratios.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP adhere to any specifications provided by MDHHS in the future to calculate and report member-to-provider ratio standards.		
Required Actions: None.		
Indian Health Care Providers		
11. The PIHP must demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the provider network to ensure timely access to services available under the Contract from such providers for Indian members who are eligible to receive services. a. If timely access to covered services cannot be ensured due to few or no IHCPs, the PIHP must: i. Allow Indian members to access out-of-state IHCPs or show good cause for disenrollment from both the PIHP and MDHHS' managed care program in accordance with 42 CFR §438.56(c). ii. Permit Indian members to obtain services covered under the Contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services. iii. Permit an out-of-network IHCP to refer an Indian member to a network provider. 42 CFR §438.14(b)(1-6) 42 CFR §438.56(c) Contract A-1(E)(2)(e)	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports **Evidence as Submitted by the PIHP:** • S.IV E11 Service Delivery-Indian Health Services/Tribally-Operated Facility/Urban Indian Clinic Services (I/T/U) Policy • S.IV E11 Saginaw Chippewa Indian Tribe MOU • S.IV E11 Saginaw Chippewa Coordination Agreement with CEICMH • S.IV E11Isabella County Interagency MOU	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN policy includes the requirements noted above that applies to the region's Network. Examples of CMHSPs specific MOUs/Coordinating Agreements have been included to demonstrate the local collaboration with IHCPs.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard IV—Assurances of Adequate Capacity and Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP develop a detailed procedure that outlines the steps for ensuring that Indian members have timely access to covered services as required under federal rule.		
Required Actions: None.		

Standard IV—Assurances of Adequate Capacity and Services						
Met	=	9	X	1	=	9
Not Met	=	0	X	0	=	0
Not Applicable	=	2				
Total Applicable	=	9	**Total Score**		=	9
Total Score ÷ Total Applicable					=	100%

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination and Services		
1. The PIHP ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or example of a member notice • Screenshot of fields designating the assigned case manager **Evidence as Submitted by the PIHP:** • Access Policy, pp. 1 • FY24 MSHN Guide to Services Consumer Handbook, pp. 14, 36-38, pp. 45 • REMI Client Chart Header Screenshot	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN delegates access to services and care coordination to each Community Mental Health Service Program (CMHSP) as part of a formal Organized Health Care Arrangement (OHCA). The Access Policy describes the availability of the access system 24/7/365 for all individuals seeking information, services, or support. This information is also available on the MSHN website, and all new beneficiaries are provided with a Guide to Services handbook containing the customer service information for their local CMHSP as well as information on care coordination. The MSHN Regional Electronic Medical Information (REMI) system contains a header at the top of each client chart showing the CMHSP entity a member is open to (if applicable) and any other service providers the member has received care from. A Care Management program description was not provided as evidence for this element since MSHN delegates primary responsibility for care management and service coordination to its provider network.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
2. The PIHP coordinates the services the PIHP furnishes to the member: a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid. d. With the services the member receives from community and social support providers. 42 CFR §438.208(b)(2) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Three examples of coordination of services related to this element (examples should include different entity types) • Transition of care program • Workflow for coordinating with other MCOs/PIHPs/PAHPs • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources **Evidence as Submitted by the PIHP:** • Service Philosophy & Treatment Policy, pp. 1, 2, 4 • Population Health & Integrated Care Policy, pp.1 • Care Coordination Planning Procedure, Section A, pp.1 • Follow Up After Hospitalization Procedure, pp.1 • Complex Care Coordinator Job Description • Standard V.2 Example 1_Weekly Inpatient Hospital Report • Standard V.2 Example 2_Priority Health Monthly Care Coordination • Standard V.2 Example 3_Case Consultation Tracking	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Service Philosophy & Treatment Policy and Population Health & Integrated Care Policy describe MSHN's overall approach to care coordination and expectations for its provider network. The Care Coordination Planning Procedure describes the workflow used to coordinate services for mutual members with other payers/providers. A Care Coordination monthly meeting agenda is provided as an example of this type of coordination. The Follow Up After Hospitalization Procedure describes the workflow used to coordinate transitions of care between settings. A weekly inpatient hospital report is provided as an example of coordination for transitions of care. Additionally, although MSHN delegates care coordination responsibilities to its provider network, MSHN created a Complex Care Coordinator staff position in 2023 to support and expand care coordination functions within the region. The MSHN provider network and other community partners such as hospital systems can request consultation services with the PIHP Complex Care Coordinator if they are experiencing barriers to successful coordination or need additional support navigating a complex case. A copy		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
of the Complex Care Coordinator job description is provided for reference as well as a Case Consultation Tracking sheet as an example of this type of coordination.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Information Sharing		
3. The PIHP shares with MDHHS or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. 42 CFR §438.208(b)(4) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Workflow for sharing assessment results with MDHHS • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description • Three examples of sharing assessment results with MDHHS and/or appropriate MCOs, PIHPs, and/or PAHPs **Evidence as Submitted by the PIHP:** • Service Philosophy & Treatment Policy, pp. 1, 2 • 1915i SPA Enrollment and Annual Recertification Procedure, Section C, pp. 3-4 • Care Coordination Planning Procedure, Section A, pp.1 • Standard V.3 Case Example 1 • Standard V.3 Case Example 2 • Standard V.3 Case Example 3	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN shares the results of assessments and identified needs of beneficiaries with MDHHS and other Medicaid payers on an ongoing basis through multiple pathways. The Service Philosophy & Treatment Policy outlines the requirement to share results of any identification and assessment of a member's needs with MDHHS and other payers/providers of service to the individual. The 1915i SPA Enrollment and Annual Recertification Procedure outlines a workflow for sharing assessment results with MDHHS. The Care Coordination Planning Procedure outlines a workflow for sharing assessment results and identified member needs with Medicaid Health Plans.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
4. The PIHP ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Provider materials, such as the provider manual and provider contract • Results of medical record reviews (MRRs) or other oversight mechanisms for monitoring provider health record practices **Evidence as Submitted by the PIHP:** • FY 24 Medicaid Subcontracting Agreement, Exhibit A, Section IV, pp.40-41 • Medicaid Information Management Policy pp.1 • Montcalm Behavioral Health 2023 DMC Review, Section 14, pp. 40-43 • Tuscola Behavioral Health 2023 DMC Review, Section 14, pp. 50-53 • The Right Door 2023 DMC Review, Section 14, pp. 42-44	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: Requirements regarding health information systems are clearly defined in the FY24 Medicaid Subcontracting Agreement Delegation Grid as well as the Medicaid Information Management Policy. Adherence to requirements is monitored through site review activity. Results of site review activity specific to these required elements is provided for 3 subcontracted providers.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
5. The PIHP ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E Contract Schedule A–1(Q)(4) Contract Schedule A–1(Q)(9) Contract Schedule B	**HSAG Required Evidence:** • Policies and procedures • Care management program description **Evidence as Submitted by the PIHP:** • Care Coordination Planning Procedure, Section C, pp.2 • Enrollee Rights Policy, pp. 1	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Initial Health Risk Screening		
6. The PIHP makes a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *Since the PIHP is not an enrollment model, screening once an individual presents for services would meet this requirement.* 42 CFR §438.208(b)(3) 42 CFR §457.1230(c) Contract Schedule A–1(H)(2)(a)(iii)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Initial screening template • Initial screening tracking and monitoring mechanisms and subsequent results/reports **Evidence as Submitted by the PIHP:** • Service Philosophy & Treatment Policy, Section B, pp. 1-2 • Access Procedure, Section IV, pp. 5 • Initial Screening Template	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The PIHP delegates screening activities to its CMHSP participants and SUD service providers (SUDSP). Basic health information is collected as a standard part of all initial screenings at the time an individual makes a request for service. Provider network requirements regarding screening are outlined in the Access Procedure (p. 5). All individuals who contact the access system participate in the initial screening, therefore screening occurs 100% of the time and subsequent attempts to contact the member are not needed. Initial screening tracking and monitoring reports are not provided as evidence since screening occurs 100% of the time for all members who present for services.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** As the PIHPs were not consistently applying the same screenings or assessments to this initial screening requirement, HSAG recommends that the PIHPs consult with MDHHS to confirm which screening or assessment (e.g., screening at access, assessment conducted within 14 days of a request for services) aligns to this element. After receiving MDHHS' guidance, the PIHP should ensure that its policies and procedures are updated to reference the appropriate screening or assessment and align associated time frames to the federal regulations for this element (i.e., 42 CFR §438.208[b][3] and 42 CFR §457.1230[c]) and maintain a monitoring process to demonstrate that all members receive initial screenings in a timely manner and in accordance with federal regulations and MDHHS' expectations.		
Required Actions: None.		
Comprehensive Assessment		
7. The PIHP implements mechanisms to comprehensively assess each Medicaid member identified by MDHHS and identified to the PIHP by MDHHS as needing long-term services and supports (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 use appropriate providers or individuals meeting the LTSS service coordination requirements of MDHHS or the PIHP, as appropriate. 42 CFR §438.208(c)(2) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Documentation (e.g., program description, quality strategy) defining members with special health care needs and members needing LTSS • Comprehensive assessment template • Three case examples of completed comprehensive assessments • Job descriptions and/or training requirements for staff conducting comprehensive assessments **Evidence as Submitted by the PIHP:** • Habilitation Supports Waiver Policy, pp.1	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• 1915i SPA Enrollment and Annual Recertification Procedure, Section C, pp. 3-4 • HSW Private Duty Nursing Procedure, pp.1 • FY24 QAPIP Plan, Section IX, pp.22 • MSHN Training Grid FY24 • Habilitation Supports Waiver Initial Application and Eligibility Procedure • Standard V.7 Case Example 1 • Standard V.7 Case Example 2 • Standard V.7 Case Example 3	
PIHP Description of Process: The FY24 Quality Assessment and Performance Improvement Program (QAPIP) Plan defines the specific services that are considered LTSS as well as the PIHP's strategy to ensure LTSS are appropriately assessed and furnished to members. The following policies and procedures define the eligibility requirements for members to receive LTSS through various waiver and state plan programs, as well as qualification requirements of individuals performing assessments: Habilitation Supports Waiver (HSW) Policy, 1915i SPA Enrollment and Annual Recertification Procedure, and HSW Private Duty Nursing Procedure. Additionally, the MSHN Training Grid FY24 outlines training requirements for individuals conducting assessments. A comprehensive assessment template was not provided as evidence for this element because MSHN does not require its provider network to use one specific assessment template. Case examples are provided for 3 individuals receiving LTSS.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** As PIHPs were not consistently defining LTSS, HSAG recommends that the PIHPs collaborate with MDHHS to develop a definition for LTSS that will be used by all PIHPs. As part of the definition, MDHHS and the PIHPs could develop a list of services and benefits under the PIHPs' scope of work (SOW) that are considered LTSS. Based on this collaboration and, with confirmation by MDHHS, the PIHP should update its policies and procedures and other utilization management (UM)-related program documents, as well as its quality assessment and performance improvement program (QAPIP) description to include the State's definition of LTSS. The PIHP should also ensure that its policies and procedures, UM-related program documents, and QAPIP description identify which members it has identified as having special health care needs (e.g., all members, a subset of members). If MDHHS declines to define LTSS and/or members having special health care needs, the PIHP should ensure that it has defined LTSS and members with special health care needs in its program documents. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Person-Centered Planning/Service Plan		
8. The member leads the person-centered planning process where possible. a. The member's representative has a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. b. All references to members include the role of the member's representative. 42 CFR §441.301(c)(1) Person-Centered Planning Practice Guideline–Section VI	**HSAG Required Evidence:** • Policies and procedures • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) • Oversight and monitoring documentation • HSAG will also use the results of the system demonstration **Evidence as Submitted by the PIHP:** • Person & Family-Centered Plan of Service Policy, Section E-F, pp. 1 • Montcalm Behavioral Health 2023 DMC Review, Standard 7.1-7.2, pp. 18-19 • Tuscola Behavioral Health 2023 DMC Review, Standard 7.1-7.2, pp. 21-22 • The Right Door 2023 DMC Review, Standard 7.1-7.2, pp. 19 • Standard V.8 PCP Example 1_The Right Door • Standard V.8 PCP Example 2_Montcalm • Standard V.8 PCP Example 3_Shiawassee	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Person & Family-Centered Plan of Service Policy outlines the requirements related to person-centered planning. Adherence to requirements is monitored through site review activity. Results of site review activity specific to these required elements is provided for 3 subcontracted providers. Additionally, example service plans are provided as evidence from 3 different CMHSPs. MSHN fully delegates responsibility for person-centered planning to its CMHSP participants, so there is not a service plan example provided from the PIHP.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** Although the member's Individual Plan of Service (IPOS) for *PCP Example 3_Shiawassee* included evidence that the member's guardian provided input into the IPOS, the guardian was not documented in the list of attendees who participated in the person-centered planning meeting. After the site review, the PIHP provided a copy of the guardian's consent to the IPOS and explained that although the guardian attended the IPOS meeting,		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
the guardian was not included in the IPOS attendee list. HSAG recommends that the PIHP reiterate to its staff members and/or its delegates the importance of ensuring that the IPOS includes documentation of the names of all IPOS meeting attendees and their roles in the meeting (e.g., member's guardian). If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP may receive a *Not Met* score.		
Required Actions: None.		
9. The person-centered service plan reflects that the setting in which the member resides is chosen by the member. The PIHP ensures that the setting chosen by the member is integrated in, and supports full access of, the member receiving Medicaid home- and community-based services (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as members not receiving Medicaid HCBS. a. The setting is selected by the member from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the member's needs; preferences; and, for residential settings, resources available for room and board. 42 CFR §441.301(c)(2)(i) 42 CFR §441.530(a)(1)(ii) 42 CFR §441.710(a)(1)(ii) Person-Centered Planning Practice Guideline–Section VI	**HSAG Required Evidence:** • Policies and procedures • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) • Oversight and monitoring documentation • HSAG will also use the results of the system demonstration **Evidence as Submitted by the PIHP:** • Service Philosophy & Treatment Policy. Section D, pp. 2-3 • Montcalm Behavioral Health 2023 DMC Review, Standard 7.22, pp. 22 • Montcalm 2023 Program-Specific Waiver Review, Standards 2.5-2.14, pp.3-5 • Tuscola Behavioral Health 2023 DMC Review, Standard 7.22, pp. 27 • Tuscola 2023 Program-Specific Waiver Review, Standards 2.5-2.14, pp.3-5 • The Right Door 2023 DMC Review, Standard 7.22, pp. 23 • The Right Door 2023 Program-Specific Waiver Review, Standards 2.5-2.14, pp.3-5 • Standard V.9_HCBS Choice_IPOS • Standard V.9_JCIPOS	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• Standard V.9_TWIPOS	
PIHP Description of Process: The Service Philosophy & Treatment Policy outlines the requirements for assisting members with selecting housing options and ensuring members have opportunities for meaningful community inclusion. Adherence to requirements is monitored through site review activity. Results of site review activity specific to these required elements is provided for 3 subcontracted providers. Additionally, example service plans are provided as evidence from 3 different CMHSPs. MSHN fully delegates responsibility for person-centered planning to its CMHSP participants, so there is not a service plan example provided from the PIHP.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
10. The PIHP produces a treatment or service plan for members who require LTSS and, if MDHHS requires, members with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. 42 CFR §438.208(c)(3) 42 CFR §457.1230(c) Contract Schedule A–1(K)(2)(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Person-centered service plan template • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) **Evidence as Submitted by the PIHP:** • Person/Family Centered Plan of Service Policy, Section E, pp.1 • Standard V.10 PCP Example 1_Hope Network • Standard V.10 PCP Example 2_CMH for Central MI • Standard V.10 PCP Example 3_LifeWays PDN • HSW Private Duty Nursing Procedure	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Person & Family-Centered Plan of Service Policy outlines the requirements related to person-centered planning. The HSW Private Duty Nursing Procedure outlines the process by which PDN services are assessed and authorized for members with special health care needs who need regular care monitoring for a medical condition. Additionally, example service plans are provided as evidence from 3 different contracted providers for members receiving LTSS, including one service plan for a member receiving PDN services. MSHN fully delegates responsibility for person-centered planning to its CMHSP participants, so there is not a service plan example provided from the PIHP.		

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Requirement	**Supporting Documentation**	**Score**
A person-centered service plan template was not provided as evidence for this element because MSHN does not require its provider network to use one specific person-centered service plan template.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
11. The treatment or service plan is: 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 planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the PIHP in a timely manner, if this approval is required by the PIHP. d. In accordance with any applicable MDHHS quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) Contract Schedule A–1(K)(2)(c)	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process • Mechanisms to actively involve the member and the member's formal and informal supports in the development of the service plan • Mechanisms to actively involve the member's primary care provider (PCP) (and any other providers involved in the member's care) in the development of the service plan • Three case examples of completed service plans (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) **Evidence as Submitted by the PIHP:** • Person/Family Centered Plan of Service Policy, pp.1 • MSHN Training Grid FY24 • MSHN UM Plan FY24, pp. 7-8, 10-11 • Standard V.11 PCP Example 1_CEI CMH • Standard V.11 PCP Example 2_BABH • Standard V.11 PCP Example 3_CMHCM	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: The Person & Family-Centered Plan of Service Policy outlines the requirements related to person-centered planning. The MSHN Training Grid FY24 outlines the training requirements for case managers, supports coordinators, and other staff who have responsibility for service planning activities. The training grid is provided in lieu of a job description. The MSHN UM Plan FY24 describes the service plan approval process, including any services which require prior authorization or specialized testing. Additionally, example service plans are provided as evidence from 3 different contracted providers for members receiving LTSS.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG consulted with MDHHS regarding its expectation for who should be signing the person-centered plan besides the member and/or guardian and the case holder/case manager/supports coordinator, and whether all providers responsible for providing services under the person-centered plan should receive a copy of the plan. After receiving confirmation from MDHHS, the PIHP had to demonstrate that it was obtaining signatures from the member and/or guardian and the case holder/case manager/supports coordinator to receive a *Met* score related to the signatures. To receive a *Met* score related to the distribution of the person-centered plan, the PIHP had to demonstrate that the individual and/or guardian was receiving a copy of the plan, and that the PIHP had a method to ensure that applicable providers (e.g., provider owned residential homes) were also receiving a copy of the plan (whether through distribution or through training signatures). However, HSAG recommends that if MDHHS provides additional guidance related to obtaining signatures and/or the distribution of the person-centered plan, that the PIHP prioritize implementation of such guidance and that policies and procedures are updated immediately to reflect any new guidance from MDHHS.		
Required Actions: None.		
12. The treatment or service plan is 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 per 42 CFR §441.301(c)(3). 42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Care plan and service plan review and revision tracking mechanism • Three case examples of completed service plans and subsequent updates (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) **Evidence as Submitted by the PIHP:** • Person/Family Centered Plan of Service Policy, Section F, pp. 2 • MSHN Training Grid FY24	☒ Met ☐ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	• Standard V.12 Case Example 1 • Standard V.12 Case Example 2 • Standard V.12 Case Example 3	
PIHP Description of Process: The Person & Family-Centered Plan of Service Policy outlines the requirements for reviewing and revising person-centered plans every 12 months at minimum, or more frequently as needed due to changes in a member's condition or at the request of the member or their authorized representative. A care plan review and revision tracking mechanism is not provided for evidence because MSHN delegates responsibility for monitoring person-centered plans to its provider network, including timeliness tracking for reviews.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Home and Community-Based Settings		
13. Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), is supported by a specific assessed need and justified in the person-centered service plan. The following requirements are documented in the person-centered service plan: a. Specific and individualized assessed need. b. Positive interventions and supports used prior to any modifications to the person-centered service plan. c. Less intrusive methods of meeting the need that have been tried but did not work. d. Clear description of the condition that is directly proportionate to the specific assessed need. e. Regular collection and review of data to measure the ongoing effectiveness of the modification. f. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.	**HSAG Required Evidence:** • Policies and procedures • Three case examples of completed service plans with restrictions to the member's freedom (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) • Oversight and monitoring documentation • Reporting and tracking mechanisms • HSAG will also use the results of the system demonstration **Evidence as Submitted by the PIHP:** • Behavior Treatment Plan Procedure, pp. 1-3 • MSHN Behavior Treatment Review Data FY24 Q1 • Montcalm Behavioral Health 2023 DMC Review, Standard 7.23, pp. 22-23 • Tuscola Behavioral Health 2023 DMC Review, Standard 7.23, pp. 27	☐ Met ☐ Not Met ☒ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
g. Informed consent of the member. h. Assurance that interventions and supports will cause no harm to the member. 42 CFR §441.301(c)(4)(vi)(F)(1-8) 42 CFR §441.530(a)(1)(vi)(F)(1-8) 42 CFR §441.710(a)(1)(vi)(F)(1-8) Person-Centered Planning Practice Guideline–Section VII	• The Right Door 2023 DMC Review, Standard 7.23, pp. 24 • Standard V.13_Restrictions_IPOS_1 • Standard V.13_Restrictions_IPOS_2 • Standard V.13_Restrictions_IPOS_3	
PIHP Description of Process: The Behavioral Treatment Plan Procedure outlines the requirements for using techniques that can be considered intrusive or restrictive, including documentation requirements. Adherence to requirements is monitored through site review activity. Results of site review activity specific to these required elements is provided for 3 subcontracted providers. Additionally, example service plans are provided as evidence from 3 different CMHSPs. Lastly, behavior review data is reported to MSHN on a quarterly basis by the CMHSPs and aggregated into a regional report which is monitored by the Quality Improvement Council and Regional Medical Directors' Committee. The MSHN Behavior Treatment Review Data FY24 Q1 report is also provided as evidence of the regional reporting and tracking mechanism.		
HSAG Findings: HSAG has determined that this element is *Not Applicable* for the time period of this review, as MDHHS sent clarifying guidance to the PIHPs on May 17, 2024 (i.e., outside of the time period under review for this compliance review), that included detailed instructions for complying with the requirements under this element and is currently not penalizing the PIHPs for noncompliance with the expectations under 42 CFR §441.301(c)(4)(vi)(F)(1–8). **Recommendations:** As MDHHS' expectation is that all PIHPs will be in compliance with the requirements under 42 CFR §441.301(c)(4)(vi)(F)(1–8) by the end of calendar year 2024, and because MDHHS has added two performance measures for SFY 2025 with the waiver renewal that will assess whether completed person-centered plans with identified restrictions/modifications comply with Home and Community-Based Settings requirements and that the PIHP has effective administrative policies in place regarding Home and Community-Based Settings compliance and monitoring processes, HSAG strongly recommends that the PIHP prioritize the inclusion of all required documentation when there is a modification of the conditions that are required for Home and Community-Based Settings directly within the person-centered plan. HSAG also recommends that the PIHP consider developing a modifications section template within the person-centered plan that will be required to be used by all PIHP staff and/or its delegated entities when there is a modification to the Home and Community-Based Settings required under 42 CFR §441.301(c)(4). The template should have sections that address sub-elements (a) through (h) of this element, with detailed instructions for the documentation that must be included for each section to ensure compliance with the expectations set by MDHHS and the requirements under federal rule. Further, the PIHP must ensure that it maintains a robust and ongoing auditing process to confirm that its delegated entities are also complying with the modification requirements stipulated by federal rule and in alignment with the		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
expectations required by MDHHS and the PIHP. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will likely receive a *Not Met* score.		
Required Actions: None.		
Direct Access to Specialists		
14. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the PIHP must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) 42 CFR §457.1230(c) Contract Schedule A–1(F)(9)(a)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts **Evidence as Submitted by the PIHP:** • Utilization Management Procedure, pp.5 • Person/Family Centered Plan of Service Policy, Section F, pp. 2	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Utilization Management Procedure includes the requirement to have a mechanism in place to allow individuals with special health care needs direct access to a specialist. The Person/Family Centered Plan of Service Policy outlines the requirement to include the amount, scope, and duration of medically-necessary services authorized by the CMHSP in the member's plan of service (ie: the approved number of visits). Member Materials and Provider Materials are not provided as evidence for this standard due to the fact that all plans of service are highly individualized so there is not a standard number of approved visits; the number of approved visits is dependent on the person-centered planning process and the member's needs and preferences.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Integrated Physical and Mental Health Care		
15. *The PIHP initiates affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid members. These efforts must focus on persons who have a chronic condition such as a serious mental health illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability and who have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.* a. *The PIHP implements practices to encourage all members eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care, and referrals for appropriate services. (The physical health assessment will be coordinated through the consumer's Medicaid health plan [MHP]as defined in Contract Schedule A–1[H][1]).* b. *As authorized by the member, the PIHP includes the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the PCP process.* Contract Schedule A–1(H)(1) Contract Schedule A–1(H)(2)(a)(i-ii)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Algorithm to identify members eligible for Medicaid Specialty Mental Health Services and Supports • Three case examples of completed physical health assessments, coordinated through the MHP, within a member's health record (if the requirement is also a delegated function, one example must pertain to the PIHP, and two examples must pertain to different delegates) **Evidence as Submitted by the PIHP:** • Service Philosophy & Treatment Policy, Section B.3.i, vi, pp. 1-2 • Standard V.15 Case Example 1 • Standard V.15 Case Example 2 • Standard V.15 Case Example 3	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The Service Philosophy & Treatment Policy outlines the requirements related to physical health assessments. The PIHP did not provide evidence of an algorithm to identify members eligible for specialty services and supports because all members who approach the PIHP/CMHSP system are screened and assessed to determine their eligibility for specialty services and supports.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Recommendations: The PIHP demonstrated its efforts to integrate primary and specialty behavioral health services for Medicaid members through integrated care plan meetings with the MHPs and through outreach to members' PCPs. However, although there was some evidence provided to demonstrate that the assessment information from members' PCPs and/or integrated care plan meetings was integrated into the members' IPOSs, not all medical concerns addressed by the meetings with the MHPs or by information obtained from PCPs was addressed by the person-centered planning process and/or included in members' IPOS. HSAG recommends that the PIHP provide additional education to its staff members or contracted CMHSPs reminding them of the importance of including the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered process and include physical health goals in the IPOS, as agreed upon by the member. If members have physical health care needs that they do not wish to include as goals in their IPOS, the PIHP and its delegates should document this in the IPOS or in a separate progress note.		
Required Actions: None.		
Primary Care Coordination		
16. *In accordance with 42 CFR Part 2, the PIHP takes all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care.* a. *Care coordinating agreements or joint referral agreements, by themselves, are not sufficient to show that the PIHP has taken all appropriate steps related to coordination of care.* b. *Member treatment case file documentation is also necessary.* c. *Member treatment case files must include, at minimum:* i. *The PCP's name and address;* ii. *A signed release of information for purposes of coordination; or* iii. *A statement that the member has refused to sign a release.* d. *The PIHP must coordinate the services furnished to the member with the services the member receives with FFS Medicaid.*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Algorithm to identify members eligible for Medicaid Specialty Mental Health Services and Supports • Three case examples of completed physical health assessments, coordinated through the MHP, within a member's health record (each example must pertain to a different Community Mental Health Services Program [CMHSP]/provider) **Evidence as Submitted by the PIHP:** • FY24 SUD Treatment Contract, Attachment A.7, pp. 33 • FY24 SUD Provider Manual, pp.32 • Mid Michigan Recovery FY23 SUD Combined Chart Review Tool, Section 4, pp.3 • Recovery Pathways FY23 SUD Combined Chart Review Tool, Section 4, pp.3	☐ Met ☒ Not Met ☐ NA

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A–1(H)(3)(a-b)	• Henry Ford Allegiance FY23 SUD Combined Chart Review Tool, Section 4, pp.3	
PIHP Description of Process: The FY24 SUD Provider Manual and FY24 SUD Treatment Contract outline the requirements related to coordination with primary health care for the SUD provider network. The PIHP did not provide evidence of an algorithm to identify members eligible for specialty services and supports because all members who approach the PIHP/CMHSP system are screened and assessed to determine their eligibility for specialty services and supports. Case examples of physical health assessment were not provided, however MSHN monitors this standard closely and verifies primary care coordination is occurring through annual site reviews. Copies of site review results relative to this requirement are included as evidence for 3 different SUD provider organizations.		
HSAG Findings: The PIHP demonstrated that it had a process to review charts for members diagnosed with a substance use disorder (SUD). However, while the chart review tool included a coordination of care section, there was no evidence that the PIHP was assessing whether the members' treatment case files included the name and address of members' PCPs as required by sub-element (c) of this element. During the site review, HSAG requested three examples of treatment case files that included documentation of the member's PCP name and address. After the site review, the PIHP provided one example in which a member did not consent to coordination with the member's PCP. Two additional case examples included evidence that the PIHP outreached to members' PCPs and that demonstrated that the members' consents to release information were obtained. However, the release of information form provided as part of *SUD Care Coordination Example 1* only included the PCP's name and fax number, but did not include the address. Additionally, the members' treatment case files associated with the examples were not provided to demonstrate that the PCPs' names and addresses were being documented directly within the treatment case files as required by the State contract. **Recommendations:** HSAG strongly recommends that the PIHP enhance its SUD chart review tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, HSAG strongly recommends that the PIHP educate its SUD treatment providers that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.		
Required Actions: In accordance with 42 CFR Part 2, the PIHP must take all appropriate steps to ensure that SUD treatment services are coordinated with the member's PCP. Member treatment case files must include, at minimum, both the PCP's name and address, and a signed release of information for purposes of coordination, or a statement that the member has refused to sign a release.		

Standard V—Coordination and Continuity of Care						
Met	=	14	X	1	=	14
Not Met	=	1	X	0	=	0
Not Applicable	=	1				
Total Applicable	=	15	Total Score		=	14
Total Score ÷ Total Applicable					=	93%

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		

1. The PIHP:
a. Identifies, defines, and specifies the amount, duration, and scope of each service that the PIHP is required to offer.
b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B.
c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.
 	
42 CFR §438.210(a)(1-2)
42 CFR §438.210(a)(3)(i)
42 CFR §440.230
42 CFR §441 Subpart B
42 CFR §457.1230(d)
Contract Schedule A–1(F)
Contract Schedule A–1(Q)(15)(a-c)
	HSAG Required Evidence:
	• Policies and procedures
	• Member materials, such as the member handbook and benefits grid
	• Utilization Management (UM) program description
	• Coverage guidelines/criteria
	
	Evidence as Submitted by the PIHP:
	• FY24 MSHN Guide to Services LifeWays, pp.64
	• Level of Care System (LOC) for Parity Procedure
	• Utilization Management Plan, pgs. 9-10, 12-13, and 14-16
	• FY24 MSHN SUD Benefit Plans (3 documents)
	  ○ FY24 MSHN SUD Benefit Plan Incarcerated Services
	  ○ FY24 MSHN SUD Benefit Plan Medicaid HMP Final
	  ○ FY24 MSHN SUD Benefit Plan Block Grant
		☒ Met
		☐ Not Met
		☐ NA

PIHP Description of Process: Under MDHHS-PIHP Contract the PIHP is responsible for provision of specialty behavioral health and substance use services to all Medicaid/Healthy Michigan Plan beneficiaries including individuals served under FFS Medicaid and for members under the age of 21, therefore there are no differences in the amount, duration and scope of services provided since it is all managed by the same entity, the PIHP. MSHN delegates UM to the CMHSPs in the region. This is monitored through site review process and within the Utilization Management Committee.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
2. The PIHP *must conform to professionally accepted standards of care and* may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) Contract Schedule A–1(F)(1)(a) Contract Schedule A–1(Q)(15)(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria **Evidence as Submitted by the PIHP:** • Utilization Management Policy, pg. 1 • Utilization Management Procedure, pgs. 1, 5 • Utilization Management Plan, pg. 6 • The Right Door Delegated Managed Care Tool- pg. 12 • Family Support Training Practice Guideline	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: The PIHP employs standardized level of care assessment tools required by MSHHS to guide authorization decision-making and determine medical necessity.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
3. The PIHP may place appropriate limits on a service on the basis of criteria applied under the State plan *(i.e., Medicaid policies and publications for coverages and limitations; medical necessity criteria/service guidelines specified by MDHHS and based on practice guidelines)*, such as medical necessity, or on utilization control procedures, provided that: a. The services furnished can reasonably achieve their purpose. b. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports. 42 CFR §438.210(a)(4)	**HSAG Required Evidence:** • Policies and procedures • UM plan • Member materials, such as the member handbook • Coverage guidelines/criteria **Evidence as Submitted by the PIHP:** • Level of Care System (LOC) for Parity Policy • Level of Care System (LOC) for Parity Procedure, Section G • Utilization Management Plan- pg. 6-8 • Utilization Management Procedure- pg. 4 • The Right Door Delegated Managed Care Tool, pg. 12-13 • Family Support Training Practice Guideline	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) Contract Schedule A–1(F)(1)(b) Contract Schedule A–1(Q)(15)(c) and (e) Person-Centered Planning Practice Guideline–VI		
PIHP Description of Process: The PIHP utilizes Level of Care assessment tools and benefit plans to manage this standard for all SUDSPs and this is delegated to the CMHSPs (see the CMHSP Delegated Managed Care Review tool for monitoring). A service request is placed into the appropriate electronic health record with documentation of medical necessity for the services being requested. When the systems detect a possible over-utilization of a particular service code, an appropriately credentialed and licensed person shall complete a targeted review of the request and the person's specific needs. Once this review is completed a decision is rendered for approval, denial, or reduction of a specific service.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
4. The PIHP specifies what constitutes "medically necessary services" in a manner that: a. Is no more restrictive than that used by the MDHHS Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes and regulations, the State Plan, and other MDHHS policies and procedures; and b. Addresses the extent to which the PIHP is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity.	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • Utilization Management Policy, Principles • Utilization Management Procedure, pg. 2-3 • Utilization Management Plan, pg. 6 • FY24 SUD Provider Manual, pg 51-52 • FY24 MSHN Guide to Services LifeWays, pp.64	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
iv. The opportunity for a member receiving LTSS to have access to the benefits of community living, achieve person-centered goals, and live and work in the setting of their choice. 42 CFR §438.210(a)(5)		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP include the federal Medicaid managed care definition of "medically necessary services," as outlined in this element, in its UM program description, or at minimum, cross-reference 42 CFR §438.210(a)(5) under the PIHP's internal definition of "medically necessary services."		
Required Actions: None.		
Authorization of Services		
5. The PIHP and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. 42 CFR §438.210(b)(1) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing UM • Delegation oversight of policies and procedures (e.g., audit results) **Evidence as Submitted by the PIHP:** • Utilization Management Policy, pg. 3 • Utilization Management Procedure, pgs. 1-2 • Level of Care System (LOC) for Parity Policy • Level of Care System (LOC) for Parity Procedure • Utilization Management Plan, pg. 3, 7 • FY24 SUD Provider Manual, pp. 55-56	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Family Support Training Practice Guideline • FY24 MSHN SUD Benefit Plans • The Right Door Delegated Managed Care Tool, pg. 13	
PIHP Description of Process: The Access Policy and Utilization Management Policy provide an overview of MSHN's regional utilization program including those functions which are delegated to CMHSP Participants and those functions which are retained by the PIHP. The Utilization Management Plan and Level of Care System (LOC) for Parity Policy and Procedure provide more detailed information regarding how MSHN and its CMHSP participants ensure consistent application of criteria when performing utilization management functions.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP continue to conduct ongoing and thorough monitoring of non-delegated and delegated UM service authorization functions, including the implementation of procedures that cover all elements of this standard. Oversight mechanisms should also include the validation of the accuracy of the information reported to the State via the MDHHS *Service Authorization Denials Reporting Template* (MDHHS denials reporting template); for example, review of the template for data anomalies, and case files reviews that include a comparison of the data included are the template. The PIHP should also continually evaluate its system reporting capabilities to ensure that the data being reported is accurate and to explore reporting enhancements that can be made to further assist the PIHP in overseeing and monitoring UM service authorization functions. Lastly, HSAG recommends that the PIHP work with its CMHSPs to explore the possibility of obtaining system access to records for the PIHP's membership, which would allow the PIHP to have immediate access to member records and enhance the PIHP's ability to monitor and oversee delegated functions.		
Required Actions: None.		
6. The PIHP has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Results of interrater reliability (IRR) activities • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy, pg. 3 • Utilization Management Procedure, pg. 2 • Level of Care System (LOC) for Parity Policy	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• Level of Care System (LOC) for Parity Procedure • Utilization Management Plan, pp.3, 7, 9 • UM Internal Procedure- Retrospective and Interrater Reliability Reviews • CMHSP DMC- 2023, pg. 12 • MSHN FY23 Q4 IRR Results • Family Support Training Practice Guideline • FY24 MSHN SUD Benefit Plans	
PIHP Description of Process: Utilization Management Policy provides an overview of MSHN's regional utilization program including those functions which are delegated to CMHSP Participants and those functions which are retained by the PIHP. The Utilization Management Plan and Level of Care System (LOC) for Parity Policy and Procedure provide more detailed information regarding how MSHN and its CMHSP participants ensure consistent application of criteria when performing utilization management functions. The UM Internal Procedure for Retrospective and Interrater Reliability Reviews notes how the MSHN UM staff monitors consistent application of review criteria.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While *The Right Door Delegated Managed Care Tool* included a review element to ensure that the CMHSP has "in effect mechanisms to ensure consistent application of review criteria for authorization decisions," the tool implied that the PIHP was only reviewing utilization management (UM) plans and policies and/or procedures and was not verifying implementation of interrater reliability (IRR) activities with the results of those activities. While the PIHP reported that it does verify that IRR activities were implemented, HSAG recommends that the PIHP enhance its tool to reflect this. Additionally, the PIHP could not confirm whether the CMHSPs conduct IRR activities for access-screening staff, and the PIHP did not include a review of this in its oversight and monitoring of the CMHSPs. The PIHP should ensure that IRR activities are conducted at all levels of the PIHP's scope of work (SOW) (i.e., decisions made by the PIHP, CMHSPs, and access centers, including eligibility determinations, inpatient and outpatient behavioral health services, inpatient and outpatient SUD services, and LTSS) that includes standardized test case scenarios in which all UM staff review, apply criteria, and render a decision. The PIHP should also consider directing the IRR process at all levels (i.e., PIHP, CMHSPs, access centers) to ensure consistent application of review criteria across the region. If the PIHP does not demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
7. The PIHP consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults **Evidence as Submitted by the PIHP:** • Utilization Management Policy, pg.1 and 3 • Utilization Management Procedure, pg. 2 • Utilization Management Plan, pg.6-7 • FY24 SUD Provider Manual, pp. 54 • Peer to Peer Consults 1-3 (Standard VI 7)	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The PIHP did not have a standardized process to ensure that its CMHSPs were implementing the requirements of this element. As such, HSAG recommends that the PIHP enhance oversight and monitoring of its CMHSPs to ensure that they are consulting with requesting providers when appropriate.		
Required Actions: None.		
8. The PIHP authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) Person-Centered Planning Practice Guideline–VI	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Three examples of authorized LTSS and copies of the corresponding person-centered service plans	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the PIHP: • Utilization Management Policy • Utilization Management Plan • Utilization Management Procedure, pg. 5-6 • HSAG LTSS IPOS #1 • HSAG LTSS IPOS #2 • HSAG LTSS IPOS Auth #2 • HSAG LTSS IPOS #3 • Community Living Supports Handbook Version 8	
PIHP Description of Process: The authorization for LTSS is delegated to the CMHSPs in the MSHN region.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** HSAG recommends that the PIHP include a list of services categorized as LTSS in its UM program description.		
Required Actions: None.		
9. The PIHP ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's condition. 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) Contract Schedule A–1(E)(13)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy, pg. 3 • Level of Care System (LOC) for Parity Policy • Level of Care System (LOC) for Parity Procedure • Utilization Management Plan • Utilization Management Procedure, pg. 2 • Utilization Management Specialist 12.2022, pg. 1	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: Utilization Management Policy provides an overview of MSHN's regional utilization program including those functions which are delegated to CMHSP Participants and those functions which are retained by the PIHP. The Utilization Management Plan and Level of Care System (LOC) for Parity Policy and Procedure provide more detailed information regarding how MSHN and its CMHSP participants ensure consistent application of criteria when performing utilization management functions. This item is specifically addressed on the Utilization Management Procedure, page 2.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element.		
Required Actions: None.		
Notice of Adverse Benefit Determination		
10. The PIHP notifies the requesting provider 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.* 42 CFR §438.210(c) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(a) Appeal and Grievance Resolution Processes Technical Requirement–IV(C)(2)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Plan • VI.6 - MSHN Adverse Benefit Determination – Template • VI.6 - BRH ABD 3.19.23 Example 1 • VI.6 - MSHN SUD ABD 4.11.23 Example 2 • VI.6 - VCS ABD 6.12.23 Example 3 • VI.6 - MSHN ABD Training.2022.final • VI.6 - 2023 CMH Delegated Managed Care Tool (pgs. 14-15) • VI.6 - NCMH 2023 DMC Results (pgs. 14-15) • REMI Automated Message- Notification of Denial	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: MSHN's electronic medical record informs the requesting SUD provider of a denial in an authorization via a system generated email.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The case file review identified one case that did not include clear documentation that the requesting provider was notified of the adverse benefit determination (ABD). While this case pertained to a pre-admission screening, in which case the hospital must be made aware of the results, HSAG recommends that the PIHP enhance its processes to ensure that all communication to requesting providers is clearly documented in the member's record, whether the communication occurred in writing or verbally (i.e., in person, or via telephone).		
Required Actions: None.		
11. The PIHP defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. d. Failure to make a standard service authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. e. Failure to make an expedited service authorization decision within 72 hours after receipt of a request for expedited service authorization. f. The failure to provide services in a timely manner, as defined by MDHHS *(i.e., failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning meeting and as authorized by the PIHP)*.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:D** • Utilization Management Procedure, pg. 4 • Utilization Management Policy • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • FY24 SUD Provider Manual, pp. 15-16 • FY24 MSHN Guide to Services.LifeWays, pgs. 40, 86	☒ Met ☐ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
g. Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. h. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. i. For a resident of a rural area with only one PIHP, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. j. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. 42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2) Appeal and Grievance Resolution Processes Technical Requirement–II		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The definition of an ABD in the *FY24 MSHN Guide to Services.LifeWays* did not include sub-elements (i) and (j); however, MDHHS' *Template #4: Glossary or Definition of Terms* does not include these sub-elements. HSAG has notified MDHHS of this finding. HSAG recommends that the PIHP implement updated terminology should it be issued by MDHHS in the future.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
12. The PIHP gives members written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: 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. The ABD the PIHP has made or intends to make. c. The reasons for the ABD. d. *The policy/authority relied upon in making the determination.* e. 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. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. f. The member's right to request an appeal of the PIHP's ABD, including information on exhausting the PIHP's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). g. The procedures for exercising the rights specified in 42 CFR §438.402(b). h. The circumstances under which an appeal process can be expedited and how to request it. i. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the member may be required to pay the costs of	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure, pg. 2, 4 • Utilization Management Plan • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • FY24 MSHN Guide to Services.LifeWays, pp. 40-42 • VI.6 - MSHN Adverse Benefit Determination – Template • VI.6 - BRH ABD 3.19.23 Example 1 • VI.6 - MSHN SUD ABD 4.11.23 Example 2 • VI.6 - VCS ABD 6.12.23 Example 3 • VI.6 - MSHN ABD Training.2022.final • VI.6 - 2023 CMH Delegated Managed Care Tool (pgs. 14-15) • VI.6 - NCMH 2023 DMC Results (pgs. 14-15)	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
these services *(only required when providing advance notice of an ABD).* j. *An explanation that the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* k. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) Contract Schedule A–1(L)(2)(a)(i-v) Appeal and Grievance Resolution Processes Technical Requirement–IV(A) Appeal and Grievance Resolution Processes Technical Requirement–IV(C)(1)		

PIHP Description of Process: N/A

HSAG Findings: The case file review identified the following opportunities for improvement, which apply to one or more ABD notices within the sample selection:

- The ABD notice did not explain the reason for the ABD and only informed the member that the member did not meet clinical eligibility criteria for services without context as to why and without meaningful information that explained the rationale for the ABD. The PIHP must provide the member with sufficient information as to why the service(s) were denied so that the member can make an informed decision about whether to appeal the ABD.
- The ABD notice included the following narrative: "You do not meet Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance abuse disorder." However, this general statement would not apply to every member (e.g., criteria as a person with a serious mental illness [SMI] would be irrelevant to a child, criteria for a child with a serious emotional disorder [SED] would be irrelevant to an adult.)
- The ABD notice included no citation or the incorrect citation for the policy/authority relied on in making the ABD. For example:
  - The ABD notice included "blanket" citations (i.e., policy/authority relied on in making the ABD); for example, Sections 330.1100(a–d) of the Michigan Mental Health Code (MMHC), which includes every definition included in the MMHC; Sections 330.1498e, 330.1705, and 330.1208 of

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**

the MMHC; 42 CFR §438.400(b)(1); and Section 2.5.A–D Medical Necessity Criteria under the Michigan Medicaid Provider Manual which were either irrelevant to the case and/or not specifically used to render the ABD.
  - The record indicated that the results of the Autism Diagnostic Observation Schedule Second Edition (ADOS-2) and the Medicaid Autism Benefit were used to make the denial determination; however, these policies/authorities were not included in the ABD notice.
  - The ABD notice cited sections 8.5.B, 8.5.C, and 8.5.D of the Michigan Medicaid Provider Manual pertaining to inpatient admission and continuing stay criteria for adults, children, and adolescents; however, the service being denied was not inpatient hospitalization but applied behavioral analysis (ABA) or intensive family services. The member was also a minor; therefore, citations to criteria related to adults are also irrelevant.
- The ABD notice was missing 42 CFR §440.230(d) that 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.
- The ABD notice included a future effective date, which is incorrect for an adequate notice. The 10-day advance notice is required for the termination, suspension, or reduction of a previously authorized service; however, this case applied to a pre-service request and was not a termination, reduction, or suspension of a previously authorized service.
- The ABD notice included a section related to second opinions, which is not part of MDHHS' required ABD model notice. It also included the heading "If you don't agree with the second opinion, you have the right to an internal appeal." This heading is misleading as it implies that the member must go through the second opinion process prior to requesting an appeal, which is inaccurate, as members can request an appeal as soon as the ABD is rendered.
- The ABD notice included duplicate citations (e.g., referencing 42 CFR §438.400(b)(1) and Sections 330.1498e and 330.1705 of the MMHC twice in the same notice).
- The ABD notice included acronyms or abbreviations (e.g., BHT/ABA, CMHS-CEI, w/o, CLS, APS, PMTO, TFBCT, SEDW, BABH). While some acronyms or abbreviations are common, the PIHP cannot assume a member would know the meaning. In support of plain language requirements, all acronyms and abbreviations must be spelled out at first use.
- The service identified in the ABD notice was not written in plain language. For example, "T1005 Respite Care Services, up to 15 minutes. 1:1 No modifier for non-skilled, Modifier TD for RN, Modifier TE for LPN… H0045 Respite on the per day in out of home care setting. 1:1" could have been simply identified as "Respite Services".
- The ABD notices included formatting errors or was not grammatically correct. For example, the notice included random spacing/punctuation, and/or the notice was not written in complete sentences.
- The content in the ABD notices suggested a lack of understanding and/or the intermingling of different service authorization provisions (i.e., extensions, failure to render a decision within the required time frame, failure to start authorized services in a timely manner). For example:
  - The member was mailed an ABD notice informing the member that services were denied. However, it was discovered that the ABD notice should not have been sent, as the member qualified for services. The UM reviewer on this case intended to send a "delay" notice but inadvertently sent the

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denial notice. However, it is unclear what a *delay* ABD notice is. If the PIHP was unable to make a decision within the required time frames and no extension was taken, this would constituent a *denial*; if the PIHP needed more information and applied an extension, this should not be considered a delay, as an extension is allowable under federal Medicaid managed care rules; and if the PIHP failed to start services after services have been authorized/approved, the PIHP would be required to send a ABD notice due to the PIHP's failure to start services in a timely manner.

  - The case was reported as an *untimely* denial in the universe file. However, the information included in the ABD notices (two were provided) was confusing. The ABD notices informed the member that services were delayed. However, if the service authorization decision is not rendered on time, it constitutes a *denial*. Therefore, the PIHP should have informed the member that the services were *denied* due to its failure to render a service authorization decision on time. While not reported as a case with an extension, the ABD notice dated February 29, 2024, informed the member that the service authorization was *delayed* more than 14 days from the receipt of the standard service request, suggesting that this notice was intended to be an extension notification. Of note, if it were intended to be an extension notice, the legal citation in the notice would be incorrect, and the ABD notice template is an inappropriate notice to use for an extension notification, as an extension is not an ABD and the ABD notice provided the member with appeal and State fair hearing (SFH) rights as opposed to grievance rights (i.e., members do not have appeal and SFH rights for extensions). The ABD notice dated March 21, 2024, informed the member that services were delayed, as the extended service authorization decision was delayed more than 14 days from the date of the extension, also suggesting that the first notice was intended to be an extension notice as opposed to an ABD notice. Further, the ABD notice dated March 21, 2024, cited the "Managed Care Rule 42 CFR 438.210(d)(2)" as the legal basis for the decision, which referenced the PIHP's failure to make an expedited service authorization with 72 hours. However, the case was reported as a standard case and not an expedited case. This ABD notice also informed the member that the decision was *delayed* due to the intake appointments being cancelled. However, based on the details provided, the ABD should have been a *denial* of services as the PIHP was unable to obtain the necessary information to determine medical necessity because the member did not keep scheduled appointments.

- The reading grade level was provided for one of the 10 sample selections despite being requested for all samples. No documentation was provided to demonstrate that the PIHP and its CMHSPs had standardized or consistent processes to check the reading grade level of non-MDHHS template language included in the ABD notices prior to mailing and/or that they attempted to reduce the reading grade level, when applicable, prior to mailing.
- While continuation of benefits information was included in the advance ABD notices, it did not include the circumstances in which the member may be required to pay for the cost of continued services. However, it should be noted that this language was not included in MDHHS' model notice applicable during the time period of review. MDHHS' updated model notice effective October 1, 2024, includes the required language and remediates this gap.

Recommendations:

- Based on the case file review and discussion with the PIHP, staff do not have the capability to alter text that is populated based on options selected in the system (e.g., service, reason for action, and legal basis for the decision). This limitation is a significant barrier to the PIHP being able to generate professional ABD notices that include meaningful and relevant information, and meet plain language requirements (e.g., by being able to remove

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service codes, simplify the service descriptions, and spell out acronyms included in the service description; and remove duplicate citations that are or those citations not relied on in making the ABD). HSAG recommends that the PIHP consider system enhancements to address these limitations. • In support of plain language requirements, HSAG recommends that the PIHP simplify the service description in the ABD notices. For example, "90791 Psychiatric Diagnostic Evaluation w/o Medical" could be simply stated as "Psychiatric Diagnostic Evaluation"; "90834 Individual Psychotherapy, 38-52 minutes" could be simply stated as "Psychotherapy"; and "99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making" could be simply stated as "New Patient Outpatient Visit." • HSAG recommends that the PIHP implement a regionwide performance improvement plan to improve the accuracy and/or specificity of the policy/authority included in the ABD notices and relied upon in making the ABD. The PIHP should avoid general citations that may support the provisions related to ABDs but were not specifically used by the UM reviewer and to support the reason for the ABD. The PIHP should reference the specific review criteria (e.g., service-specific sections of the Michigan Medicaid Provider Manual, internal UM review criteria, Millman Care Guidelines [MCG], and/or standardized assessment tools). This is particularly important for clinically based ABDs (i.e., based on medical necessity). For ABDs not based on medical necessity, the PIHP may cite process-based criteria (e.g., 42 CFR §438.404[c][5] for service authorization decisions not reached within the time frames, which constitutes a denial; and MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement*, which defines an ABD for untimely service provision as the failure to provide services within 14 calendar days of the start date that was agreed upon during the person-centered planning meeting and as authorized by the PIHP). • As MDHHS requires ABD notices to be written at or below the 6.9 reading grade level, the reading grade level of each ABD notice should be documented. HSAG recommends that the PIHP develop a process to ensure that the reading grade level is evaluated for all non-MDHHS model language in the ABD notices prior to mailing the notice to members. When the reading grade level is above 6.9, the UM reviewers should make every effort to reduce the reading grade level. As the MDHHS contract with the PIHP stipulates that in some situations it may be necessary to include medications, diagnoses, and conditions that would not meet the 6.9 grade-level criteria, the PIHP could develop criteria for what terminology may be excluded from the reading grade analysis in certain instances. The reading grade level, including exclusions, should be documented along with evidence that the UM reviewer made efforts to reduce the reading grade level to at or below 6.9 to the extent possible. • While continuation of benefits information is included in MDHHS' model notice, MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement* only requires this information for advance notices. HSAG recommends that the PIHP consult with MDHHS to determine if this section should be removed for adequate notices to avoid any potential member confusion since members can only request continuation of services for previously authorized services being terminated, reduced, or suspended (i.e., advance notice).		
Required Actions: The PIHP must ensure that each ABD notice meet federal and state-specific content requirements and is written at or below the 6.9 reading grade level.		

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Requirement	**Supporting Documentation**	**Score**
Time Frame for Decisions		
13. For standard authorization decisions, the PIHP provides notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan • Service Authorization Extension Template-Final • Service Authorization Denial Reporting and Monitoring Procedure • UM Internal Procedure- MDHHS Service Authorization Denials Report • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified multiple standard service authorizations that were not completed within 14 calendar days. The case file review also identified two cases that were not completed on time. **Recommendations:** The *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with the 14-calendar-day requirement for standard service authorizations. HSAG recommends that the PIHP update its review tool to ensure reviewers are evaluating this requirement. This could also be used as a mechanism to ensure that the data reported on the MDHHS denials reporting template are accurate. Additionally, HSAG recommends that the PIHP review the requirements under 42 CFR §438.210(d)(1), effective for rating periods on or after January 1,		

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Requirement	**Supporting Documentation**	**Score**
2026, which requires that each standard service authorization decision, and notice to members, be completed within seven calendar days after receiving the request for services. This is a significant change from the current 14-calendar-day requirement. HSAG recommends that the PIHP consult with MDHHS as it prepares to implement the new seven-calendar-day time frame for resolving standard service authorizations decisions. Currently, members contact the PIHP (i.e., via the access center) requesting services, which starts the process of determining whether the member is eligible for services and what services are medically necessary. As the PIHP has 14 calendar days to complete a biopsychosocial (BPS) assessment used to determine the member's service needs, the PIHP will have significant challenges in meeting the new seven-calendar-day standard. The PIHP should request guidance from MDHHS as to whether the expectation is that service authorizations are either approved or denied within seven days of the member's initial request for services (i.e., via the access center) or if services should be approved or denied once the member's service array has been identified; meaning, the BPS assessment is completed within 14 calendar days and the case manager develops the Individual Plan of Service (IPOS) that identifies the member's specific service needs, and then submits the service authorization request to UM, where UM staff members then have seven calendar days to review the request, apply criteria, and render a decision to approve or deny the request for services. Further, 42 CFR §438.210(f) will also require public reporting on prior authorization data beginning January 1, 2026. HSAG recommends that the PIHP immediately begin planning to implement these new requirements, and make all necessary system enhancements, to ensure compliance by the effective date. The PIHP should also consult with MDHHS on these new requirements and the implications for the service authorization quarterly reporting requirements (e.g., will the reporting requirements and reporting template be revised?). This recommendation applies to Elements 13, 14, and 15.		
Required Actions: For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service.		
14. For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Service Authorization Denial Reporting and Monitoring Procedure • Provider Authorization Outcomes Summary Dashboard • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified several expedited service authorizations that were not resolved within 72 hours. Additionally, the MDHHS denials reporting template confirmed that the PIHP was reporting most requests for inpatient hospitalization as a standard service authorization request and not an expedited request, although the PIHP must complete a pre-admission screening within three hours and subsequently approve or denial the request for services. As the PIHP must make an expedited authorization decision and provide notice "as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service," these cases meet the federal definition of an expedited service authorization. The PIHP confirmed that its expectation is for all inpatient psychiatric services to be reported as expedited cases and is working with its CMHSPs to ensure accurate reporting. As the MDHHS denials reporting template included multiple inpatient hospitalizations (reported as a standard or an expedited case) with the same date and time for the request and the notice, or the notice was reported with a time prior to receipt of the request, the PIHP should ensure it is collecting accurate data as it collaborates with its CMHSPs. The case file review also identified one case documented as an expedited case in error. The PIHP must ensure accurate implementation, documentation, tracking, and reporting of expedited cases. While there were inconsistencies among the PIHPs related to expedited service authorizations (i.e., tracking and reporting), after further review and discussion among HSAG reviewers following the site review, it was determined to score this element as *Not Met* to ensure timeliness and accurate reporting of expedited cases. **Recommendations:** HSAG recommends that the PIHP enhance processes related to the reporting of service authorization requests that should be categorized expedited, including service requests that MDHHS already requires to be completed expeditiously (e.g., inpatient hospitalization, and detoxification, methadone, and residential for priority populations).		
Required Actions: For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.		

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Requirement	**Supporting Documentation**	**Score**
15. For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if: a. The member or the provider requests the extension; or b. The PIHP justifies a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure, pgs. 4-5 • Utilization Management Plan • Service Authorization Denial Reporting and Monitoring Procedure • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	☐ Met ☒ Not Met ☐ NA

PIHP Description of Process: N/A

HSAG Findings: The MDHHS denials reporting template identified three cases reported with an extension applied; however, the turnaround time (TAT) was reported as seven days or less, which would not require an extension. This suggests that extensions are being incorrectly applied or inaccurate information is being entered into the records. This suggestion was confirmed by the case file review, which identified two records in which an extension was documented in error. The MDHHS denials reporting template also identified two cases (which may have more than one service line reported in the template) that were reported as a standard authorization request with an extension applied. The TAT was reported as 16 days and 19 days, but the time frame requirement was reported as not being met. However, 28 days are allowed when an extension is applied, which would render these cases compliant with the time frame, or the cases were potentially reported with an extension in error. Further, the case file review identified one record that was not reported with an extension; however, the documentation in the record indicated that an extension was applied (i.e., the service authorization was "delayed" more than 14 days from the receipt of the request) but the extension notice (i.e., "delayed" ABD notice) was sent approximately seven weeks after the initial request for services, which is significantly passed the 14-calendar-day resolution time frame (i.e., an extension should be applied no later than 14 calendar

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Requirement	**Supporting Documentation**	**Score**
days after the initial request for services). Lastly, the *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with service authorization extension requirements. As a result of these findings, enhanced oversight and monitoring are needed. The PIHP should update its review tool to ensure reviewers are evaluating the extension provisions.		
Required Actions: For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if the member of provider requests the extension, or the PIHP justifies a need for additional information and how an extension is in the member's interest.		
16. If the PIHP meets the criteria set forth for extending the time frame for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: a. Gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries 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)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure, pg. 5 • Utilization Management Plan • Service Authorization Denial Reporting and Monitoring Procedure • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • Service Authorization Extension Template-Final	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified two records reported with an extension; however, no oral or written notice were included in the record. It was determined that these cases were reported with an extension in error. Additionally, the case file review identified one record that was not reported with an extension; however, the documentation within the record indicated that an extension was applied (i.e., service authorization was "delayed" more than 14 days from receipt of the request). While an extension notice (i.e., "delayed" ABD notice) was sent, evidence of oral notice of the extension was not		

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Requirement	**Supporting Documentation**	**Score**
provided. An ABD notice with appeal rights is also an inappropriate notice to send to members when the PIHP applies an extension on a service authorization request. An extension is not an ABD and is allowable under federal Medicaid managed care rule. Further, members do not have appeal rights when an extension is applied; rather, members have grievance rights. Discussion during the site review and the case file review confirmed that a "Delayed" ABD notice is to be sent when an extension is applied; however, an extension notice and an ABD notice are not interchangeable. Further, if the PIHP is considering extensions as ABDs, the PIHP may be overreporting service authorization denials (e.g., the service may be approved after the extension of the time frame; therefore, no ABD actually occurred). Lastly, the *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with service authorization extension requirements. As a result of these findings, enhanced oversight and monitoring are needed. The PIHP should update its review tool to ensure reviewers are evaluating the extension provisions. **Recommendations:** During the site review, the PIHP presented an extension notice template that meets the intent of the requirement. HSAG recommends that the PIHP confirm that the notice has been implemented at each CMHSP.		
Required Actions: When the PIHP extends a service authorization resolution time frame, it must give the member oral and 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.		
17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA). a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. 42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A)	**HSAG Required Evidence:** • Not applicable **Evidence as Submitted by the PIHP:** • Not applicable	☐ Met ☐ Not Met ☒ NA
PIHP Description of Process: Not applicable		
HSAG Findings: This element is *Not Applicable* to the PIHP.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PIHP mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract Schedule A–1(L)(6)(a)(i) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(2)(a-b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan • Service Authorization Denial Reporting and Monitoring Procedure • MSHN SUD Adverse Benefit Determination • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** While the *2024 MDHN ABD-Grievance-Appeal Review Tool* included a scoring element "Is a description provided? - action taken and effective date," the tool did not specifically indicate that the scoring included a review against the 10-day advance notice requirement or the exceptions to the 10-day advance notice requirement, as applicable. HSAG recommends that the PIHP update its tool to ensure that reviewers are assessing compliance with this standard.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
19. The PIHP sends a notice not later than the date of action 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: i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown, and the post office returns agency mail directed to the member indicating no forwarding address; e. The PIHP establishes the fact 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 Social Security Act; or h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days' notice requirements of §483.15(b)(4)(i). 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member that meets one of the criteria of this element • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan • Service Authorization Denial Reporting and Monitoring Procedure • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • MSHN SUD Adverse Benefit Determination • 2024 MSHN ABD-Grievance-Appeal Review Tool • MSHN SUD ABD Exception #1 • MSHN SUD ABD Exception #2 • MSHN SUD ABD Exception #3	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7) Contract Schedule A–1(L)(6)(a)(ii) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(2)(c)(i-viii)		
PIHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, after the site review, the PIHP submitted case examples of ABD notices in cases when a member requested to terminate services. While a written statement signed by the member was not provided, which is required for an adequate notice, an advance notice was provided instead (i.e., 10-day advance notice); therefore, the PIHP received a *Met* score for this element.		
Required Actions: None.		
20. The PIHP may shorten the period of advance notice to five days before the date of action if: a. The PIHP has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract Schedule A–1(L)(6)(a)(iii) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(2)(c)(ix)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member due to probable fraud • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • Service Authorization Denial Reporting and Monitoring Procedure	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• MSHN SUD Adverse Benefit Determination	
PIHP Description of Process: Mid-State Health Network's providers have not sent any Adverse Benefit Determination Notices with a shorten advance notice period due to probable fraud by the member.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. Of note, the PIHP reported that it had no instances of probable member fraud that would necessitate sending an ABD notice.		
Required Actions: None.		
21. The PIHP mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(c) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(a)	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • FY24 MSHN Guide to Services.LifeWays, pp. 40-42 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • Utilization Management Policy, pp.3	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The MSHN REMI system has an automated process that conducts an initial screening of claims as they are submitted. The screening identifies inaccuracies or incomplete claims, and the system automatically rejects (denies) them from entering the system and the payment queue. The provider will receive notification of the claim being rejected by the payment system. The notification would not be sent to the beneficiary. The provider should review the claim to amend the inaccurate or incomplete information before resubmitting the claim for payment. MSHN CMHSPs have a similar process in their systems, but it does not impact the individual served.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The PIHP reported that it had no claim payment denials to report. However, based on the evidence submitted by the PIHP, the "PIHP Description of Process" in this tool, and discussion with PIHP staff members, the PIHP did not provide sufficient assurances that an ABD notice would be generated and sent to a member when payment, whole or in part, is denied on a claim submitted by a provider, whether an in-network or out-of-network provider. While the PIHP's policies suggested that an ABD notice would be sent for the denial of payment, they did not give any context as to the business rules or scenarios that would trigger an ABD notice when a claim payment denial is made. The narrative entered by the PIHP in the "PIHP Description of Process" suggested a lack of understanding of the requirements of this element, as the PIHP described processes for when a claim is inaccurate or incomplete (i.e., not a "clean" claim); however, the requirements of this element only apply to the denial of payment on "clean" claims. While the PIHP explained that claim payment denials do not occur often, the PIHP indicated that it did have a recent case example, which was requested by HSAG. HSAG also requested additional information about how CMHSPs are handling claim payment denials (e.g., when a claim is received with no prior authorization, or a claim is submitted by a hospital for dates of service beyond what was authorized during the continuing stay review). After the site review, the PIHP explained that the referenced case example was an ABD for the partial denial of a service and was not a claim payment denial. No additional information related to the PIHP's CMHSPs' processes were provided as had been requested. **Recommendations:** HSAG recommends that the PIHP develop a procedure document that outlines the criteria for sending an ABD notice for a denial of payment as well as the coordination efforts between the UM and claims teams to ensure that an ABD notice is sent to the member on the date that the decision to deny the payment on the claim is made. HSAG also recommends that the PIHP conduct staff training to ensure their understanding of the requirements of this element and how the requirements should be implemented. Further, HSAG recommends that the PIHP conduct a review to validate that the CMHSPs have no claim payment denials for the Medicaid program, and that the CMHSPs have adequate mechanisms to ensure that ABD notices are sent when a claim payment denial occurs. HSAG recommends that the PIHP periodically (e.g., quarterly) review reports that display the number of claims received and paid for in full, and the number of claims received in which payment, in full or in part, were denied. For any payment denials, the PIHP must confirm that an ABD notice was provided to the member. If the PIHP does not provide evidence to demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: The PIHP must mail an ABD notice for denial of payment at the time of any action affecting the claim.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
22. For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP provides notice on the date that the time frames expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(f) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • FY24 MSHN Guide to Services.LifeWays, pp. 40-42 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_ FY24 • Utilization Management Policy, pg.3 • Utilization Management Procedure, pg. 4 • Utilization Management Plan • UM Internal Procedure- UM Specialist Daily Work Plan, pgs. 1, 5 • Screenshot of Dashboard for PIHP Denials • MSHN SUD Adverse Benefit Determination	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified multiple cases that were not completed in a timely manner (i.e., not completed within 72 hours or 14 calendar days [plus the 14-calendar-day extension, if applicable]). This finding confirmed that the PIHP is not adhering to this requirement, which constitutes a *denial* and requires that an ABD notice be mailed on the date the time frame expires if a service authorization decision is not reached in a timely manner. Additionally, the content within the ABD notices and discussion with PIHP staff members suggested a lack of understanding and/or the intermingling of different service authorization provisions (i.e., extensions, failure to render a decision within the required time frame, failure to start authorized services timely) considered to be a "delay." However, if the PIHP fails to render a decision within the required time frame, it constitutes a *denial*.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Further, the *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with untimely service authorization requirements; and specifically, that for decisions not made on time, the service is denied, and an ABD notice is mailed to the member on the date the time frame expires. Based on these findings, enhanced oversight and monitoring are needed.		
Required Actions: For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP must provide notice on the date that the time frames expire.		
Compensation for Utilization Management Activities		
23. The PIHP provides that compensation to individuals or entities that conduct UM 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) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) Contract Schedule A–1(K)(1)	**HSAG Required Evidence:** • Policies and procedures • UM program description • New hire and ongoing training for staff • Three examples of staff attestations **Evidence as Submitted by the PIHP:** • Utilization Management Plan • Utilization Management Procedure, pg. 5 • FY24 MSHN Guide to Services.LifeWays, pp. 62 • The Right Door Delegated Managed Care Tool, pg. 10 • Conflict Free Case Management Policy	☒ Met ☐ Not Met ☐ NA
PIHP Description of Process: New hire and ongoing training as well as staff attestations were not included. The Right Door Delegated Managed Care Tool and Conflict Free Case Management Policy were included instead to show how MSHN ensures CMHSPs are following this standard.		
HSAG Findings: HSAG has determined that the PIHP met the requirements for this element. **Recommendations:** The *Utilization Management Procedure* included the requirements of this element. However, while *The Right Door Delegated Managed Care Tool* was submitted, it did not confirm that the PIHP implemented oversight and monitoring of the requirements of this element for its CMHSPs. Evidence of staff awareness was also not provided. Additionally, during the SFY 2021 compliance review, HSAG recommended that the PIHP and its CMHSPs develop a mechanism to confirm staff awareness, such as an affirmation or attestation that UM staff members making authorization decisions are required to sign upon employment and annually specifying that they understand they will not be incentivized for denying, limiting, or discontinuing medically necessary services to any member. The PIHP did not demonstrate implementation of HSAG's recommendations. During the site review, PIHP staff members explained that they believed that staff attestations were not necessary, as the structure of its system allows for no incentives for staff to deny, limit, or discontinue medically necessary services to any member. However, HSAG continues to recommend the implementation of		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
mechanisms to ensure staff awareness of the requirement (e.g., staff attestations, new hire training for UM staff, or adding a statement to UM job descriptions that staff are required to sign [per PIHP staff members' suggestion during the site review]). After the site review, the PIHP indicated that it will update future versions of staff trainings. Implementation of HSAG's recommendations will be reviewed during the next compliance review cycle, and the PIHP may receive a *Not Met* score if HSAG's recommendations are not adequately addressed.		
Required Actions: None.		

Standard VI—Coverage and Authorization of Services						
Met	=	15	X	1	=	15
Not Met	=	7	X	0	=	0
Not Applicable	=	1				
Total Applicable	=	22	**Total Score**		=	15
Total Score ÷ Total Applicable					=	68%

Appendix B. Compliance Review Corrective Action Plan

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
6. The PIHP uses MDHHS-developed model member handbooks and member notices. 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(k)(i)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, and grievance and appeal letter templates **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Customer_Handbook_FY24 • FY24 MSHN Guide to Services.LifeWays • MSHN Guide to Services Handbook Approval Letter 12.08.2023 • MSHN SUD Adverse Benefit Determination • MSHN SUD Notice of Receipt of Appeal • MSHN SUD Notice of Appeal Denial • MSHN SUD Notice of Receipt of Grievance • MSHN SUD Notice of Grievance Resolution	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: The PIHP's member handbook did not include all of the items in the MDHHS-developed model member handbook, *Template #6: Language Assistance and Accommodations* of the *PIHP Customer Service Standards*; specifically, the PIHP's member handbook did not include information about Computer Assisted Realtime Translation (CART). The PIHP's member handbook also did not include all of the information in *Template #8: Person-Centered Planning*; specifically, the PIHP's member handbook did not inform members to contact the PIHP's customer service unit to file a grievance if they do not believe they have received appropriate information regarding psychiatric advance directives from the PIHP. Further, *Template #11: Service Array* of the MDHHS template listed a service as Methadone and LAAM Treatment; however, the PIHP's member handbook listed this service as		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Medication Assisted Treatment (MAT) (such as Methadone and Suboxone). Lastly, the PIHP's member handbook also did not include all of the information in *Template #13: Taglines*; specifically, the PIHP's member handbook did not contain the sentence, "You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost," as included in the MDHHS template. After further review and discussion among HSAG reviewers following the site review, it was determined to score this element as *Not Met* to ensure that the PIHP's member handbook fully aligns to the MDHHS-developed model member handbook as required.		
Required Actions: The PIHP must use MDHHS-developed model member handbooks and member notices and ensure that the PIHP's member handbook and member notices include all MDHHS-developed template language.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
7. The PIHP makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State in a conspicuously visible font size explaining the availability of	**HSAG Required Evidence:** • Policies and procedures • Provider directory in prevalent languages • Member handbook in prevalent languages • Definition of "conspicuously visible font" • Mechanisms to ensure taglines are included as part of all critical member materials • All template notices required to include taglines **Evidence as Submitted by the PIHP:** • CS_Information_Accessiblity_LEP_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs. 6,7, 10	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the PIHP's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)	• 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • FY24 MSHN Guide to Services LIFEWAYS_es • MSHN_FY_2024_MEDICAID_SUBCONTRACTING_AGREEMENT • 2024 MSHN ABD-Grievance-Appeal Review Tool • MSHN_Advance_Directive_Brochure.06.24-ES • GIHN ABD_Spanish • MSHN SUD Adverse Benefit Determination • MSHN SUD Notice of Receipt of Appeal • MSHN SUD Notice of Appeal Denial • MSHN SUD Notice of Receipt of Grievance • MSHN SUD Notice of Grievance Resolution	
PIHP Description of Process: Mid-State Health Network (MSHN) maintains an annual process to have the MSHN Guide to Services translated into Spanish. In 2018, regional Customer Service staff through the MSHN Customer Service Committee (CSC) determined that the need is infrequent for LEP formatted appeal and grievance notices and denial and termination notices. The CSC decided that providers should work with their contracted LEP translation service to translate Notices and extend the effective date to accommodate the additional timeframe for the translation of the notice. This process has effectively been utilized to make written materials critical to obtaining services available to individuals engaged in services. Mid-State Health Network defines "conspicuously visible font" as a font greater than the minimum font size of 12pt, is not a large font, and is more pronounced than the adjacent font.		
HSAG Findings: Although the PIHP's electronic provider directory included a link for the taglines on the PIHP's website, the PIHP's paper provider directory did not include taglines with information about how to request auxiliary aids and services nor the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number of the PIHP's member/customer services unit when printed from the PIHP's website. Additionally, many of the PIHP's CMHSPs had their own provider directories on their websites, and when printed, these did not contain taglines explaining the availability of written translation or oral interpretation to understand the information provided, nor information on how to request auxiliary aids and services, nor the toll-free and TTY/TDD telephone number of the PIHP's or CMHSPs' member/customer services unit. **Recommendations:** During the site review, PIHP staff members explained their process for annually assessing the prevalent languages of its members; however, the PIHP's policies and procedural documents did not include this specific process, nor the frequency of the PIHP's assessment. As such, HSAG recommends that the PIHP list its procedures for identifying prevalent languages in its service regions to ensure that its written materials critical to obtaining services include taglines in a conspicuously visible font for any languages spoken by more than 5 percent of the population. Additionally, HSAG		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
recommends that the PIHP continue to routinely assess the languages of its region. Further, although the PIHP did not identify a "prevalent non-English language," defined by MDHHS as any language spoken as the primary language by more than 5 percent of the population in the PIHP's region, HSAG strongly recommends that the PIHP include taglines in larger than 12 point font (i.e., conspicuously visible) in its written materials that are critical to obtaining services to ensure that non-English speaking members are informed of the availability of language assistance services in their prevalent language, and ensure effective communication for individuals with disabilities. Lastly, to enhance the PIHP's monitoring of delegated functions to contracted CMHSPs, HSAG strongly recommends that the PIHP include an evaluation of the CMHSPs' written member materials in its *CMHSP Delegated Managed Care Tool* to ensure all of the CMHSPs' written materials that are critical to obtaining services contain appropriate taglines as several of the CMHSPs' paper provider directories did not contain taglines.		
Required Actions: The PIHP, and its delegated CMHSPs, must ensure that written materials that are critical to obtaining services include at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, include taglines explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, as well as the toll-free and TTY/TDD telephone number of the PIHP's or CMHSPs' member/customer services unit.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
10. The PIHP provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. *Written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis, and conditions that do not meet the 6.9 grade reading level criteria).* c. Use a font size no smaller than 12 point. d. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. e. The PIHP shall also identify additional languages that are prevalent among the PIHP's membership. *For purposes of this requirement, "prevalent non-English language" is defined as any language spoken as the primary language by more than five percent (5%) of the population in the PIHP's region*. f. *Material must not contain false, confusing, and/or misleading information*. "Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. 42 CFR §438.10(d)(6) 42 CFR §457.1207 Contract Schedule A–1(B)(4)(e) Contract Schedule A–1(M)(2)(a)(i)-(ii)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and member newsletter • Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) • Examples of member notices (in Microsoft Word), such as an ABD notice, grievance resolution letter, appeal resolution letter, etc. • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Mechanism to assess prevalent languages in the PIHP's region **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_FY24 • CS_Information_Accessiblity_LEP_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs., 10, 90 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.2, 1.3, 1.5, 1.6 • MSHN Regional Grade Level Technical Advisory Guidelines • CustomerServiceCommitteeMeetingSnapshot 22_07_18 • MSHN SUD Adverse Benefit Determination • MSHN SUD Notice of Receipt of Appeal • MSHN SUD Notice of Appeal Denial • MSHN SUD Notice of Receipt of Grievance • MSHN SUD Notice of Grievance Resolution • MSHN Regional Grade Level Technical Advisory Guidelines • Determining Local Language Needs Technical Guidelines	☐ Met ☒ Not Met ☐ NA

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Contract Schedule A–1(M)(2)(a)(iv) Contract Schedule A–1(M)(2)(b)(i)		
PIHP Description of Process: N/A		
HSAG Findings: Many of the PIHP's written materials for potential members and members did not contain text with the minimum 12-point font size in all areas of the document, such as the PIHP's member handbook, paper provider directory, and member notices. Following the site review, the PIHP acknowledged in the *Post Site Review Documentation Tracker* that not all written member materials contained text with the minimum 12-point font size, and that the PIHP was currently investigating the discrepancy. **Recommendations:** HSAG strongly recommends that the PIHP include an evaluation of the CMHSPs' written member materials in its *CMHSP Delegated Managed Care Tool* to ensure that the CMHSPs' member materials use a font size no smaller than 12 point and do not contain false, confusing, and/or misleading information.		
Required Actions: The PIHP, and any delegated CMHSP, must ensure that all written materials for potential members and members use a font size no smaller than 12 point.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
11. The PIHP makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) 42 CFR §457.1207 Contract Schedule A–1(M)(2)(b)(ii)(3)	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Three examples of written notices to members of provider termination (include a copy of the notice of termination, with the date of notice) • Tracking or reporting mechanism that demonstrates timeliness **Evidence as Submitted by the PIHP:** • CS_Customer_Consumer_Service_FY24 • 2023 CMHSP Delegated Managed Care Tool, INFORMATION, Pgs. 1-2, items 1.9 • CCJLH Closure Notification Letter • CCJLH Termination Notice - Eff. 12.29.23 • CCJLH Termination Checklist - Eff. 12.26.23 • CCSGC Closure Notification Letter • CCSGC Contract Cancellation Notification - Eff. 2.29.24 • CCSGC Termination Checklist - Eff. 2.29.24 • FCS SUD Admissions Detail.No current consumers • FCS Termination Checklist - Eff. 1.31.24 • FCS Termination Research	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The evidence provided by Mid-State Health Network details the existing process.		
HSAG Findings: The PIHP was unable to demonstrate that the PIHP, or any delegated entity sending notifications on its behalf, made a good faith effort to give timely written notice to members of the termination of contracted providers as required. The PIHP provided two examples of written notices sent to members by the PIHP; however, neither example notice was provided to members 30 calendar days prior to the effective date of the terminations, nor within 15 calendar days of receipt of the termination notice. Following the site review, the PIHP provided additional examples related to termination of contracted providers. In one example, the PIHP provided a letter from a CMHSP to a provider informing them that the CMHSP made the decision to terminate their contract; however, no evidence that members were given written notice of the provider termination was included in this example.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Recommendations: During the site review, PIHP staff members discussed their oversight and monitoring process for its CMHSPs related to written notices to members regarding the termination of contracted providers, and explained that this process includes reviewing the date the CMHSP received notification of the termination of a contracted provider and the effective date of the termination; however, the PIHP's *CMHSP Delegated Managed Care Tool* only listed a policy or description of written notice of termination as evidence of implementation of this requirement. As such, HSAG strongly recommends the PIHP update its audit tool to require evidence of when the CMHSP was notified of the provider termination (e.g., notice sent to CMHSP from provider informing them of the termination), and the effective date of the termination, to confirm that written notices are being sent by the later of 30 calendar days prior to the effective date of the termination, or within 15 calendars of receipt or issuance of the termination notice. HSAG further recommends the PIHP develop a tracking or reporting mechanism to track timeliness related to this requirement.		
Required Actions: The PIHP, or a delegated CMHSP, must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
18. The PIHP makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 Contract Schedule A–1(M)(1) Contract Schedule A–1(M)(2)(a)(iii)	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory • Copy of provider directory in Word format or PDF (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the PIHP:** • MSHN Provider Directory Website - https://midstatehealthnetwork.org/provider-network-resources/provider-information/directory • Print Directory Example (midstate_directory_result_2024_06_28.xlsx) - Example of the download produced from the website on 6.28.24 • PNM_Provider_Directory • CS_Customer_Consumer_Service_FY24 • FY24 MSHN Guide to Services.LifeWays, pgs. 15, 31 • R5-MSHN_MI2024_PIHP_CR_Standard I_Provider Directory Checklist_D1	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: CMHSPs are to submit their electronic directory on the 4th Friday of the month. The following week, MSHN exports the directories along with the SUD Network directory into a single CSV file and uploads the entire file into the MSHN website which is machine readable. Any person who visits the MSHN web-based directory can download/print the directory by clicking on the 'Download/Print Directory' link. An excel file will download and can be further customized/formatted for a print version.		
HSAG Findings: Although the PIHP's machine-readable provider directory included information related to accommodations for members with special needs, the PIHP's electronic provider directory on its website, as well as the printed PDF version, only listed "ADA Compliant Accommodations: Yes" or "ADA Compliant Accommodations: No" and did not include the same details as the machine-readable version of the provider directory, such as exam room(s), and equipment. All versions of the PIHP's provider directory should contain all required information.		

Standard I—Member Rights and Member Information		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the PIHP develop definitions for provider types that must be in the PIHP's provider directory (e.g., medical suppliers, ancillary health providers) for clarity about the services that fall under each provider type (e.g., occupational therapy and physical therapy are considered ancillary health providers). Further, as some of the website Uniform Resource Locators (URLs) listed for providers incorrectly routed members back to another webpage on the PIHP's website instead of the provider's website, HSAG strongly recommends the PIHP ensure that all URLs listed in its provider directory function correctly. Lastly, although the PIHP's provider directory contained most required information, many of the CMHSPs' provider directories on their websites did not consistently contain required information such as languages, whether the provider's office is accepting new members, accommodation information for members with special needs, or URLs; or were not sorted by county. As such, HSAG strongly recommends that the PIHP confirm that all its CMHSPs' provider directories, if maintained separately, include all requirements under 42 CFR §438.10 and ensure that its oversight process for monitoring its CMHSPs includes a robust process for evaluating any separately maintained provider directories. Implementation of HSAG's recommendations related to the CMHSPs' provider directories will be reviewed during the next compliance review cycle, and the PIHP will automatically receive a *Not Met* score if HSAG's recommendations are not adequately addressed.		
Required Actions: The PIHP must ensure that its provider directory, and any delegated CMHSPs' provider directories, include all of the required information from the Provider Directory Checklist.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
16. *In accordance with 42 CFR Part 2, the PIHP takes all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care.* a. *Care coordinating agreements or joint referral agreements, by themselves, are not sufficient to show that the PIHP has taken all appropriate steps related to coordination of care.* b. *Member treatment case file documentation is also necessary.* c. *Member treatment case files must include, at minimum:* i. *The PCP's name and address;* ii. *A signed release of information for purposes of coordination; or* iii. *A statement that the member has refused to sign a release.* d. *The PIHP must coordinate the services furnished to the member with the services the member receives with FFS Medicaid.* Contract Schedule A–1(H)(3)(a-b)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Algorithm to identify members eligible for Medicaid Specialty Mental Health Services and Supports • Three case examples of completed physical health assessments, coordinated through the MHP, within a member's health record (each example must pertain to a different Community Mental Health Services Program [CMHSP]/provider) **Evidence as Submitted by the PIHP:** • FY24 SUD Treatment Contract, Attachment A.7, pp. 33 • FY24 SUD Provider Manual, pp.32 • Mid Michigan Recovery FY23 SUD Combined Chart Review Tool, Section 4, pp.3 • Recovery Pathways FY23 SUD Combined Chart Review Tool, Section 4, pp.3 • Henry Ford Allegiance FY23 SUD Combined Chart Review Tool, Section 4, pp.3	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The FY24 SUD Provider Manual and FY24 SUD Treatment Contract outline the requirements related to coordination with primary health care for the SUD provider network. The PIHP did not provide evidence of an algorithm to identify members eligible for specialty services and supports because all members who approach the PIHP/CMHSP system are screened and assessed to determine their eligibility for specialty services and supports. Case examples of physical health assessment were not provided, however MSHN monitors this standard closely and verifies primary care coordination is occurring through annual site reviews. Copies of site review results relative to this requirement are included as evidence for 3 different SUD provider organizations.		
HSAG Findings: The PIHP demonstrated that it had a process to review charts for members diagnosed with a substance use disorder (SUD). However, while the chart review tool included a coordination of care section, there was no evidence that the PIHP was assessing whether the members' treatment case files included the name and address of members' PCPs as required by sub-element (c) of this element. During the site review, HSAG requested three examples of treatment case files that included documentation of the member's PCP name and address. After the site review, the PIHP provided one example		

Standard V—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
in which a member did not consent to coordination with the member's PCP. Two additional case examples included evidence that the PIHP outreached to members' PCPs and that demonstrated that the members' consents to release information were obtained. However, the release of information form provided as part of *SUD Care Coordination Example 1* only included the PCP's name and fax number, but did not include the address. Additionally, the members' treatment case files associated with the examples were not provided to demonstrate that the PCPs' names and addresses were being documented directly within the treatment case files as required by the State contract. **Recommendations:** HSAG strongly recommends that the PIHP enhance its SUD chart review tool to specifically review a sample of treatment case files to ensure that both the PCP's name and address are documented in the member's treatment plan. Additionally, HSAG strongly recommends that the PIHP educate its SUD treatment providers that the treatment case files must specifically include the PCP's name and address, in addition to having the copy of the signed release of information in the treatment case file.		
Required Actions: In accordance with 42 CFR Part 2, the PIHP must take all appropriate steps to ensure that SUD treatment services are coordinated with the member's PCP. Member treatment case files must include, at minimum, both the PCP's name and address, and a signed release of information for purposes of coordination, or a statement that the member has refused to sign a release.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
12. The PIHP gives members written notice of any decision by the PIHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: 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. The ABD the PIHP has made or intends to make. c. The reasons for the ABD. d. *The policy/authority relied upon in making the determination.* e. 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. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. f. The member's right to request an appeal of the PIHP's ABD, including information on exhausting the PIHP's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). g. The procedures for exercising the rights specified in 42 CFR §438.402(b). h. The circumstances under which an appeal process can be expedited and how to request it. i. The member's right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with State policy, under which the member may be required to pay the costs of	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure, pg. 2, 4 • Utilization Management Plan • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • FY24 MSHN Guide to Services.LifeWays, pp. 40-42 • VI.6 - MSHN Adverse Benefit Determination – Template • VI.6 - BRH ABD 3.19.23 Example 1 • VI.6 - MSHN SUD ABD 4.11.23 Example 2 • VI.6 - VCS ABD 6.12.23 Example 3 • VI.6 - MSHN ABD Training.2022.final • VI.6 - 2023 CMH Delegated Managed Care Tool (pgs. 14-15) • VI.6 - NCMH 2023 DMC Results (pgs. 14-15)	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
these services *(only required when providing advance notice of an ABD).* j. *An explanation that the member may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman.* k. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) Contract Schedule A–1(L)(2)(a)(i-v) Appeal and Grievance Resolution Processes Technical Requirement–IV(A) Appeal and Grievance Resolution Processes Technical Requirement–IV(C)(1)		
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified the following opportunities for improvement, which apply to one or more ABD notices within the sample selection: • The ABD notice did not explain the reason for the ABD and only informed the member that the member did not meet clinical eligibility criteria for services without context as to why and without meaningful information that explained the rationale for the ABD. The PIHP must provide the member with sufficient information as to why the service(s) were denied so that the member can make an informed decision about whether to appeal the ABD. • The ABD notice included the following narrative: "You do not meet Medicaid eligibility criteria for services as a person with a serious mental illness, a person with a developmental disability, a child with a serious emotional disorder or a person with a substance abuse disorder." However, this general statement would not apply to every member (e.g., criteria as a person with a serious mental illness [SMI] would be irrelevant to a child, criteria for a child with a serious emotional disorder [SED] would be irrelevant to an adult.) • The ABD notice included no citation or the incorrect citation for the policy/authority relied on in making the ABD. For example: – The ABD notice included "blanket" citations (i.e., policy/authority relied on in making the ABD); for example, Sections 330.1100(a–d) of the Michigan Mental Health Code (MMHC), which includes every definition included in the MMHC; Sections 330.1498e, 330.1705, and 330.1208 of		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**

the MMHC; 42 CFR §438.400(b)(1); and Section 2.5.A–D Medical Necessity Criteria under the Michigan Medicaid Provider Manual which were either irrelevant to the case and/or not specifically used to render the ABD.
  - The record indicated that the results of the Autism Diagnostic Observation Schedule Second Edition (ADOS-2) and the Medicaid Autism Benefit were used to make the denial determination; however, these policies/authorities were not included in the ABD notice.
  - The ABD notice cited sections 8.5.B, 8.5.C, and 8.5.D of the Michigan Medicaid Provider Manual pertaining to inpatient admission and continuing stay criteria for adults, children, and adolescents; however, the service being denied was not inpatient hospitalization but applied behavioral analysis (ABA) or intensive family services. The member was also a minor; therefore, citations to criteria related to adults are also irrelevant.
- The ABD notice was missing 42 CFR §440.230(d) that 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.
- The ABD notice included a future effective date, which is incorrect for an adequate notice. The 10-day advance notice is required for the termination, suspension, or reduction of a previously authorized service; however, this case applied to a pre-service request and was not a termination, reduction, or suspension of a previously authorized service.
- The ABD notice included a section related to second opinions, which is not part of MDHHS' required ABD model notice. It also included the heading "If you don't agree with the second opinion, you have the right to an internal appeal." This heading is misleading as it implies that the member must go through the second opinion process prior to requesting an appeal, which is inaccurate, as members can request an appeal as soon as the ABD is rendered.
- The ABD notice included duplicate citations (e.g., referencing 42 CFR §438.400(b)(1) and Sections 330.1498e and 330.1705 of the MMHC twice in the same notice).
- The ABD notice included acronyms or abbreviations (e.g., BHT/ABA, CMHS-CEI, w/o, CLS, APS, PMTO, TFBCT, SEDW, BABH). While some acronyms or abbreviations are common, the PIHP cannot assume a member would know the meaning. In support of plain language requirements, all acronyms and abbreviations must be spelled out at first use.
- The service identified in the ABD notice was not written in plain language. For example, "T1005 Respite Care Services, up to 15 minutes. 1:1 No modifier for non-skilled, Modifier TD for RN, Modifier TE for LPN… H0045 Respite on the per day in out of home care setting. 1:1" could have been simply identified as "Respite Services".
- The ABD notices included formatting errors or was not grammatically correct. For example, the notice included random spacing/punctuation, and/or the notice was not written in complete sentences.
- The content in the ABD notices suggested a lack of understanding and/or the intermingling of different service authorization provisions (i.e., extensions, failure to render a decision within the required time frame, failure to start authorized services in a timely manner). For example:
  - The member was mailed an ABD notice informing the member that services were denied. However, it was discovered that the ABD notice should not have been sent, as the member qualified for services. The UM reviewer on this case intended to send a "delay" notice but inadvertently sent the

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**

denial notice. However, it is unclear what a *delay* ABD notice is. If the PIHP was unable to make a decision within the required time frames and no extension was taken, this would constituent a *denial*; if the PIHP needed more information and applied an extension, this should not be considered a delay, as an extension is allowable under federal Medicaid managed care rules; and if the PIHP failed to start services after services have been authorized/approved, the PIHP would be required to send a ABD notice due to the PIHP's failure to start services in a timely manner.

  - The case was reported as an *untimely* denial in the universe file. However, the information included in the ABD notices (two were provided) was confusing. The ABD notices informed the member that services were delayed. However, if the service authorization decision is not rendered on time, it constitutes a *denial*. Therefore, the PIHP should have informed the member that the services were *denied* due to its failure to render a service authorization decision on time. While not reported as a case with an extension, the ABD notice dated February 29, 2024, informed the member that the service authorization was *delayed* more than 14 days from the receipt of the standard service request, suggesting that this notice was intended to be an extension notification. Of note, if it were intended to be an extension notice, the legal citation in the notice would be incorrect, and the ABD notice template is an inappropriate notice to use for an extension notification, as an extension is not an ABD and the ABD notice provided the member with appeal and State fair hearing (SFH) rights as opposed to grievance rights (i.e., members do not have appeal and SFH rights for extensions). The ABD notice dated March 21, 2024, informed the member that services were delayed, as the extended service authorization decision was delayed more than 14 days from the date of the extension, also suggesting that the first notice was intended to be an extension notice as opposed to an ABD notice. Further, the ABD notice dated March 21, 2024, cited the "Managed Care Rule 42 CFR 438.210(d)(2)" as the legal basis for the decision, which referenced the PIHP's failure to make an expedited service authorization with 72 hours. However, the case was reported as a standard case and not an expedited case. This ABD notice also informed the member that the decision was *delayed* due to the intake appointments being cancelled. However, based on the details provided, the ABD should have been a *denial* of services as the PIHP was unable to obtain the necessary information to determine medical necessity because the member did not keep scheduled appointments.

- The reading grade level was provided for one of the 10 sample selections despite being requested for all samples. No documentation was provided to demonstrate that the PIHP and its CMHSPs had standardized or consistent processes to check the reading grade level of non-MDHHS template language included in the ABD notices prior to mailing and/or that they attempted to reduce the reading grade level, when applicable, prior to mailing.
- While continuation of benefits information was included in the advance ABD notices, it did not include the circumstances in which the member may be required to pay for the cost of continued services. However, it should be noted that this language was not included in MDHHS' model notice applicable during the time period of review. MDHHS' updated model notice effective October 1, 2024, includes the required language and remediates this gap.

Recommendations:

- Based on the case file review and discussion with the PIHP, staff do not have the capability to alter text that is populated based on options selected in the system (e.g., service, reason for action, and legal basis for the decision). This limitation is a significant barrier to the PIHP being able to generate professional ABD notices that include meaningful and relevant information, and meet plain language requirements (e.g., by being able to remove

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
service codes, simplify the service descriptions, and spell out acronyms included in the service description; and remove duplicate citations that are or those citations not relied on in making the ABD). HSAG recommends that the PIHP consider system enhancements to address these limitations. • In support of plain language requirements, HSAG recommends that the PIHP simplify the service description in the ABD notices. For example, "90791 Psychiatric Diagnostic Evaluation w/o Medical" could be simply stated as "Psychiatric Diagnostic Evaluation"; "90834 Individual Psychotherapy, 38-52 minutes" could be simply stated as "Psychotherapy"; and "99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making" could be simply stated as "New Patient Outpatient Visit." • HSAG recommends that the PIHP implement a regionwide performance improvement plan to improve the accuracy and/or specificity of the policy/authority included in the ABD notices and relied upon in making the ABD. The PIHP should avoid general citations that may support the provisions related to ABDs but were not specifically used by the UM reviewer and to support the reason for the ABD. The PIHP should reference the specific review criteria (e.g., service-specific sections of the Michigan Medicaid Provider Manual, internal UM review criteria, Millman Care Guidelines [MCG], and/or standardized assessment tools). This is particularly important for clinically based ABDs (i.e., based on medical necessity). For ABDs not based on medical necessity, the PIHP may cite process-based criteria (e.g., 42 CFR §438.404[c][5] for service authorization decisions not reached within the time frames, which constitutes a denial; and MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement*, which defines an ABD for untimely service provision as the failure to provide services within 14 calendar days of the start date that was agreed upon during the person-centered planning meeting and as authorized by the PIHP). • As MDHHS requires ABD notices to be written at or below the 6.9 reading grade level, the reading grade level of each ABD notice should be documented. HSAG recommends that the PIHP develop a process to ensure that the reading grade level is evaluated for all non-MDHHS model language in the ABD notices prior to mailing the notice to members. When the reading grade level is above 6.9, the UM reviewers should make every effort to reduce the reading grade level. As the MDHHS contract with the PIHP stipulates that in some situations it may be necessary to include medications, diagnoses, and conditions that would not meet the 6.9 grade-level criteria, the PIHP could develop criteria for what terminology may be excluded from the reading grade analysis in certain instances. The reading grade level, including exclusions, should be documented along with evidence that the UM reviewer made efforts to reduce the reading grade level to at or below 6.9 to the extent possible. • While continuation of benefits information is included in MDHHS' model notice, MDHHS' *Appeal and Grievance Resolution Processes Technical Requirement* only requires this information for advance notices. HSAG recommends that the PIHP consult with MDHHS to determine if this section should be removed for adequate notices to avoid any potential member confusion since members can only request continuation of services for previously authorized services being terminated, reduced, or suspended (i.e., advance notice).		
Required Actions: The PIHP must ensure that each ABD notice meet federal and state-specific content requirements and is written at or below the 6.9 reading grade level.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
13. For standard authorization decisions, the PIHP provides notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan • Service Authorization Extension Template-Final • Service Authorization Denial Reporting and Monitoring Procedure • UM Internal Procedure- MDHHS Service Authorization Denials Report	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified multiple standard service authorizations that were not completed within 14 calendar days. The case file review also identified two cases that were not completed on time. **Recommendations:** The *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with the 14-calendar-day requirement for standard service authorizations. HSAG recommends that the PIHP update its review tool to ensure reviewers are evaluating this requirement. This could also be used as a mechanism to ensure that the data reported on the MDHHS denials reporting template are accurate. Additionally, HSAG recommends that the PIHP review the requirements under 42 CFR §438.210(d)(1), effective for rating periods on or after January 1, 2026, which requires that each standard service authorization decision, and notice to members, be completed within seven calendar days after receiving the request for services. This is a significant change from the current 14-calendar-day requirement. HSAG recommends that the PIHP consult with MDHHS as it prepares to implement the new seven-calendar-day time frame for resolving standard service authorizations decisions. Currently, members contact the PIHP (i.e., via the access center) requesting services, which starts the process of determining whether the member is eligible for services and what services are medically necessary. As the PIHP has 14 calendar days to complete a biopsychosocial (BPS) assessment used to determine the member's service needs, the PIHP will have significant challenges in meeting the new seven-calendar-day standard. The PIHP should request guidance from MDHHS as to whether the expectation is that service authorizations are either approved or denied within seven days of the member's initial request for services (i.e., via the access center) or if services should be approved or denied once the member's service array has been identified; meaning, the BPS assessment is completed within 14 calendar days and the case manager develops the Individual Plan of Service (IPOS) that identifies the member's specific service needs, and then submits the service authorization request to UM, where UM staff members then have seven calendar days to review the request, apply criteria, and render a decision to approve or deny the request for services. Further, 42 CFR §438.210(f) will also require public reporting on prior authorization data beginning January 1, 2026. HSAG recommends that the PIHP immediately begin planning to implement these new requirements, and make all necessary system enhancements, to ensure compliance by the effective date. The PIHP should also consult with MDHHS on these new requirements and the implications for the service authorization quarterly reporting requirements (e.g., will the reporting requirements and reporting template be revised?). This recommendation applies to Elements 13, 14, and 15.		
Required Actions: For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service.		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
14. For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(2)(b) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(b)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure • Utilization Management Plan • Service Authorization Denial Reporting and Monitoring Procedure • Provider Authorization Outcomes Summary Dashboard • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified several expedited service authorizations that were not resolved within 72 hours. Additionally, the MDHHS denials reporting template confirmed that the PIHP was reporting most requests for inpatient hospitalization as a standard service authorization request and not an expedited request, although the PIHP must complete a pre-admission screening within three hours and subsequently approve or denial the request for services. As the PIHP must make an expedited authorization decision and provide notice "as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service," these cases meet the federal definition of an expedited service authorization. The PIHP confirmed that its expectation is for all inpatient psychiatric services to be reported as expedited cases and is working with its CMHSPs to ensure accurate reporting. As the MDHHS denials reporting template included multiple inpatient hospitalizations (reported as a standard or an expedited case) with the same date and time for the request and the notice, or the notice was reported with a time prior to receipt of the request, the PIHP should ensure it is collecting accurate data as it collaborates with its CMHSPs. The case file review also identified one case documented as an expedited case in error. The PIHP must ensure accurate implementation, documentation, tracking, and reporting of expedited cases. While there were inconsistencies among the PIHPs related to expedited service authorizations (i.e., tracking and reporting), after further review and discussion among HSAG reviewers following the site review, it was determined to score this element as *Not Met* to ensure timeliness and accurate reporting of expedited cases. **Recommendations:** HSAG recommends that the PIHP enhance processes related to the reporting of service authorization requests that should be categorized expedited, including service requests that MDHHS already requires to be completed expeditiously (e.g., inpatient hospitalization, and detoxification, methadone, and residential for priority populations).		
Required Actions: For cases in which a provider indicates, or the PIHP determines, that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the PIHP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
15. For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if: a. The member or the provider requests the extension; or b. The PIHP justifies a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure, pgs. 4-5 • Utilization Management Plan • Service Authorization Denial Reporting and Monitoring Procedure • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified three cases reported with an extension applied; however, the turnaround time (TAT) was reported as seven days or less, which would not require an extension. This suggests that extensions are being incorrectly applied or inaccurate information is being entered into the records. This suggestion was confirmed by the case file review, which identified two records in which an extension was documented in error. The MDHHS denials reporting template also identified two cases (which may have more than one service line reported in the template) that were reported as a standard authorization request with an extension applied. The TAT was reported as 16 days and 19 days, but the time frame requirement was reported as not being met. However, 28 days are allowed when an extension is applied, which would render these cases compliant with the time frame, or the cases were potentially reported with an extension in error. Further, the case file review identified one record that was not reported with an extension; however, the documentation in the record indicated that an extension was applied (i.e., the service authorization was "delayed" more than 14 days from the receipt of the request) but the extension notice (i.e., "delayed" ABD notice) was sent approximately seven weeks after the initial		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
request for services, which is significantly passed the 14-calendar-day resolution time frame (i.e., an extension should be applied no later than 14 calendar days after the initial request for services). Lastly, the *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with service authorization extension requirements. As a result of these findings, enhanced oversight and monitoring are needed. The PIHP should update its review tool to ensure reviewers are evaluating the extension provisions.		
Required Actions: For standard and expedited authorization decisions, the PIHP may extend the resolution time frame up to an additional 14 calendar days if the member of provider requests the extension, or the PIHP justifies a need for additional information and how an extension is in the member's interest.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
16. If the PIHP meets the criteria set forth for extending the time frame for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: a. Gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries 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)(ii) 42 CFR §438.210(d)(2)(ii)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • Utilization Management Policy • Utilization Management Procedure, pg. 5 • Utilization Management Plan	☐ Met ☒ Not Met ☐ NA

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(e) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	• Service Authorization Denial Reporting and Monitoring Procedure • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • Service Authorization Extension Template-Final	
PIHP Description of Process: N/A		
HSAG Findings: The case file review identified two records reported with an extension; however, no oral or written notice were included in the record. It was determined that these cases were reported with an extension in error. Additionally, the case file review identified one record that was not reported with an extension; however, the documentation within the record indicated that an extension was applied (i.e., service authorization was "delayed" more than 14 days from receipt of the request). While an extension notice (i.e., "delayed" ABD notice) was sent, evidence of oral notice of the extension was not provided. An ABD notice with appeal rights is also an inappropriate notice to send to members when the PIHP applies an extension on a service authorization request. An extension is not an ABD and is allowable under federal Medicaid managed care rule. Further, members do not have appeal rights when an extension is applied; rather, members have grievance rights. Discussion during the site review and the case file review confirmed that a "Delayed" ABD notice is to be sent when an extension is applied; however, an extension notice and an ABD notice are not interchangeable. Further, if the PIHP is considering extensions as ABDs, the PIHP may be overreporting service authorization denials (e.g., the service may be approved after the extension of the time frame; therefore, no ABD actually occurred). Lastly, the *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with service authorization extension requirements. As a result of these findings, enhanced oversight and monitoring are needed. The PIHP should update its review tool to ensure reviewers are evaluating the extension provisions. **Recommendations:** During the site review, the PIHP presented an extension notice template that meets the intent of the requirement. HSAG recommends that the PIHP confirm that the notice has been implemented at each CMHSP.		
Required Actions: When the PIHP extends a service authorization resolution time frame, it must give the member oral and 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.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		

Standard VI—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	
21. The PIHP mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(c) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(a)	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • FY24 MSHN Guide to Services.LifeWays, pp. 40-42 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_FY24 • Utilization Management Policy, pp.3	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The MSHN REMI system has an automated process that conducts an initial screening of claims as they are submitted. The screening identifies inaccuracies or incomplete claims, and the system automatically rejects (denies) them from entering the system and the payment queue. The provider will receive notification of the claim being rejected by the payment system. The notification would not be sent to the beneficiary. The provider should review the claim to amend the inaccurate or incomplete information before resubmitting the claim for payment. MSHN CMHSPs have a similar process in their systems, but it does not impact the individual served.		
HSAG Findings: The PIHP reported that it had no claim payment denials to report. However, based on the evidence submitted by the PIHP, the "PIHP Description of Process" in this tool, and discussion with PIHP staff members, the PIHP did not provide sufficient assurances that an ABD notice would be generated and sent to a member when payment, whole or in part, is denied on a claim submitted by a provider, whether an in-network or out-of-network provider. While the PIHP's policies suggested that an ABD notice would be sent for the denial of payment, they did not give any context as to the business		

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Requirement	**Supporting Documentation**	**Score**
rules or scenarios that would trigger an ABD notice when a claim payment denial is made. The narrative entered by the PIHP in the "PIHP Description of Process" suggested a lack of understanding of the requirements of this element, as the PIHP described processes for when a claim is inaccurate or incomplete (i.e., not a "clean" claim); however, the requirements of this element only apply to the denial of payment on "clean" claims. While the PIHP explained that claim payment denials do not occur often, the PIHP indicated that it did have a recent case example, which was requested by HSAG. HSAG also requested additional information about how CMHSPs are handling claim payment denials (e.g., when a claim is received with no prior authorization, or a claim is submitted by a hospital for dates of service beyond what was authorized during the continuing stay review). After the site review, the PIHP explained that the referenced case example was an ABD for the partial denial of a service and was not a claim payment denial. No additional information related to the PIHP's CMHSPs' processes were provided as had been requested. **Recommendations:** HSAG recommends that the PIHP develop a procedure document that outlines the criteria for sending an ABD notice for a denial of payment as well as the coordination efforts between the UM and claims teams to ensure that an ABD notice is sent to the member on the date that the decision to deny the payment on the claim is made. HSAG also recommends that the PIHP conduct staff training to ensure their understanding of the requirements of this element and how the requirements should be implemented. Further, HSAG recommends that the PIHP conduct a review to validate that the CMHSPs have no claim payment denials for the Medicaid program, and that the CMHSPs have adequate mechanisms to ensure that ABD notices are sent when a claim payment denial occurs. HSAG recommends that the PIHP periodically (e.g., quarterly) review reports that display the number of claims received and paid for in full, and the number of claims received in which payment, in full or in part, were denied. For any payment denials, the PIHP must confirm that an ABD notice was provided to the member. If the PIHP does not provide evidence to demonstrate adequate implementation of HSAG's recommendations during future compliance reviews, the PIHP will automatically receive a *Not Met* score.		
Required Actions: The PIHP must mail an ABD notice for denial of payment at the time of any action affecting the claim.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

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Requirement	**Supporting Documentation**	**Score**
22. For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP provides notice on the date that the time frames expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) Contract Schedule A–1(L)(5)(f) Appeal and Grievance Resolution Processes Technical Requirement–IV(B)(1)(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the PIHP:** • CS_Medicaid_Enrollee_Appeals_Grievances_FY24 • FY24 MSHN Guide to Services.LifeWays, pp. 40-42 • CS_Medicaid_Enrollee_Appeals_Grievances_Procedure_ • FY24 • Utilization Management Policy, pg.3 • Utilization Management Procedure, pg. 4 • Utilization Management Plan • UM Internal Procedure- UM Specialist Daily Work Plan, pgs. 1, 5 • Screenshot of Dashboard for PIHP Denials • MSHN SUD Adverse Benefit Determination	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: N/A		
HSAG Findings: The MDHHS denials reporting template identified multiple cases that were not completed in a timely manner (i.e., not completed within 72 hours or 14 calendar days [plus the 14-calendar-day extension, if applicable]). This finding confirmed that the PIHP is not adhering to this requirement, which constitutes a *denial* and requires that an ABD notice be mailed on the date the time frame expires if a service authorization decision is not reached in a timely manner. Additionally, the content within the ABD notices and discussion with PIHP staff members suggested a lack of understanding and/or the intermingling of different service authorization provisions (i.e., extensions, failure to render a decision within the required time frame, failure to start authorized services timely) considered to be a "delay." However, if the PIHP fails to render a decision within the required time frame, it constitutes a *denial*.		

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Requirement	**Supporting Documentation**	**Score**
Further, the *2024 MSHN ABD-Grievance-Appeal Review Tool* did not include a scoring element to confirm compliance with untimely service authorization requirements; and specifically, that for decisions not made on time, the service is denied, and an ABD notice is mailed to the member on the date the time frame expires. Based on these findings, enhanced oversight and monitoring are needed.		
Required Actions: For standard and expedited service authorization decisions not reached within the required time frames specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PIHP must provide notice on the date that the time frames expire.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	