Provider Network Management Agenda

Date: ***October 14, 2025***	***Location: TEAMS***

Time: 10AM – 12PM	***Dial-in Number:*** 1 (248) 333-6216 ***Conference ID:*** 952 875 519#

Participants

☐	**Wellvance** Teresa McGee Julie Streeter
☐	**Centra Wellness Network** Chip Johnston Pat Kozlowski Kacey Kidder

☐	**North Country CMH** Kim Rappleyea Katie Lorence Angie Balberde
☐	**Northern Lakes CMH** Hillary Rappuhn Mark Crane Kari Barker Jessica Williams

☐	**Northeast Michigan CMH** Connie Caderette Jennifer Walburn Vicky DeRoven Jen Wieczorkowski
☐	**NMRE** Eric Kurtz Chris VanWagoner Carol Balousek

1. Introductions
2. September 9, 2025 Meeting Minutes Approval
3. Prior Action Items
    a. Contact hospitals for FY2026, ensure contract boilerplate and rates on schedule (Chris)
    b. Update directory: NCCMH machine readability, NLCMH address independent facilitation, CW organize by county, all add telehealth
4. Contract Materials Review
    a. Contract
    b. W9
    c. DOO
    d. Credentialing Materials
5. Universal credentialing (standing item)
    a. FY2025 (full year) Credentialing Report
6. HSAG Compliance CAP
7. Provider Directories (HSAG 2024)
    a. Telehealth
    b. Machine Readability (HSAG 2024 S1, E20)
    c. Organized by county, Elements provided compliant with 42 CFR 438 (HSAG 2024, S1, E18)
    d. Addresses Independent facilitation (via list, or link to webpage, etc)
8. Hospitals
    a. MyMichigan (Rate update/review)
    b. Trinity St. Marys and Muskegon (3% increase)
9. HCBS update
10. MDHHS PIHP RFP update
11. Conferences, trainings, and events
    a. CMHAM Fall Conference – October 27th – 28th in Traverse City.
    b. Improving Outcomes, December 4th and 5th at Ann Arbor Marriot, Ypsilante
12. Ongoing Group TEAMS Posts
13. Open discussion

Next scheduled meeting November 11, 2025

NORTHERN MICHIGAN REGIONAL ENTITY
PROVIDER NETWORK MANAGERS MEETING
10:00AM – SEPTEMBER 9, 2025
VIA TEAMS

Centra Wellness:	☐ Chip Johnston	Executive Director
	☒ Kacey Kidder-Snyder	Provider Network Specialist
	☒ Pat Kozlowski	Access and Emergency Service Director
North Country:	☒ Angie Balberde	Provider Network Manager
	☒ Katie Lorence	Contract Manager
	☒ Kim Rappleyea	Chief Operating Officer
Northeast Michigan:	☒ Connie Cadarette	Chief Financial Officer
	☒ Vicky DeRoven	Quality Improvement
	☒ Jen Walburn	Compliance Officer
	☒ Jennifer Wieczorkowski	Contract Manager
Northern Lakes:	☒ Mark Crane	Contract and Procurement Manager
	☒ Trapper Merz	Business Intelligence Specialist
	☒ Hillary Rappuhn	Project Coordinator
	☒ Jessica Williams	Performance Improvement Specialist
Wellvance:	☒ Teresa McGee	Chief Clinical Officer
	☒ Julie Streeter	Contracts Specialist
NMRE:	☒ Carol Balousek	Executive Administrator
	☐ Eric Kurtz	Chief Executive Officer
	☐ Heidi McClenaghan	Quality Manager
	☐ Brandon Rhue	Chief Information Officer/Operations Director
	☒ Chris VanWagoner	Contract and Provider Network Manager

INTRODUCTIONS
Chris welcomed committee members to the meeting and attendance was taken.

REVIEW AGENDA & ADDITIONS
No additions to the meeting agenda were requested.

APPROVAL OF PREVIOUS MEETING MINUTES
The August 12th minutes were included in the meeting materials and approved by consensus.

PRIOR ACTION ITEMS
Contact Hospitals for FY26, Ensure Contract Boilerplate and Rates are on Schedule
This topic will be discussed under the Hospital Status Update.

Update Directory
During the review of Provider Directories during the August meeting, it was noted that North Country did not have a machine-readable file uploaded, Northern Lakes' directory did not address Independent Facilitation, and Centra Wellness' directory was not organized by county.

All five Provider Directories did not address telemedicine as that is a new requirement. This topic will be discussed in detail under a later agenda item.

CMH RATE FREEZE DISCUSSION

A memorandum from Region 4 PIHP/Southeast Michigan Behavioral Health was shared during the regional Provider Network meeting. SWMBH took a regional approach to alert providers that no increases to rates will be given for FY26. The question was asked whether the NMRE would like to take this sort of regional approach to a FY26 rate freeze. After some discussion, the decision was made to forward this topic to the regional Operations Committee for input.

UNIVERSAL CREDENTIALING

Chris stressed that credentialing and recredentialing needs to be done within the CRM; if CMHSPs are not yet doing this need to do so as soon as possible.

FY25 Credentialing Report

The FY25 Credentialing Report is due to MDHHS on November 15th.

MDHHS Meeting

A PIHP Universal Credentialing Leads meeting took place on August 20th. Chris shared on September 9th a FAQ document with guidance from MDHHS in draft form. Also shared was the UC Leads meeting "Suggestions for Improvements" supplement document.

PROVIDER DIRECTORIES (HSAG 2024)

Telehealth

An update has been added to 42 CFR 438.10(h)(1)(ix) that states that Provider Directories must include whether the provider offers covered services via telehealth. This has not yet been audited on but will likely be added to the HSAG checklist for future audits. All five CMHSPs are in the process of adding this to their Provider Directory.

Machine Readability

Chris confirmed that all five CMHSPs have uploaded Provider Directories in machine readable formats.

Organized by County – Elements Provided Compliant with 42 CFR 438 (HSAG 2024, S1, E18)
Chris confirmed that four of the five CMHSP Provider Directories are sorted by county. The pdf version of Centra Wellness' Provider Directory is not sorted by county. There is an Excel version of the Directory available on the website, however, that can be sorted by service location.

Addresses Independent Facilitation (via list, link to webpage, etc.)
Chris confirmed that all five CMHSPs' Provider Directories address Independent Facilitation.

Network Adequacy Validation (NAV) and Data Integrity

Chris reviewed feedback from HSAG regarding the Network Adequacy Validation report.

"Provider data elements and demographic information were manually entered from credentialing applications into the RECON system by NMRE's staff. Although NMRE had quality

assurance checks and validations in place, HSAG recommends that NMRE explore options to have the data automatically or systematically uploaded from one system to another to mitigate the potential for human data entry error."

A response is due to HSAG by September 29, 2025.

HOSPITALS

Status: Rate Requests for FY26

The following hospital rate requests for FY26 will be presented to the regional Operations Committee for approval on September 16th.

Trinity St. Mary's

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,236.00	$1,273.00	3%
Partial Hospitalization (0912)	$527.00	$543.00	3%
ECT (0901 while receiving 0100)	$871.00	$897.00	3%

Trinity Muskegon

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,082.00	$1,114.00	3%

Cedar Creek

	FY25 Rate	Proposed FY26 Rate	% Increase
Adult Psychiatric Inpatient (0100)	$1,107.25	$1,140.00	3%
Partial Hospitalization (0912)	$453.20	$467.00	3%

Once rates are approved by the Operations Committee, Chris will drop boilerplates into the Teams folders.

For hospitals that have not communicated a rate change with the NMRE, FY26 Contracts will be generated using FY25 rates.

HCBS UPDATE

Region 9 did an internal review of Flatrock cases and all the settings that were reviewed had issues, including changing from open to secured settings with full lockdown on windows doors and even going as far as placing plexiglass over windows so individuals can't open them or look out. MDHHS intends to keep us updated. More to come

MDHHS RFP UPDATE

On August 4, 2025, the Michigan Department of Health and Human Services (MDHHS) announced the release of a Request for Proposals (RFP) to competitively bid the state's public mental health managed care system. Proposals are due by October 13, 2025.

On August 28, 2025, Christopher Ryan (Taft, Stettinius & Hollister, LLP) filed an injunction on behalf of Region 10 PIHP, Southwest Michigan Behavioral Health, Mid-State Health Network, St. Clair County Community Mental Health Authority, Integrated Services of Kalamazoo, And

Saginaw County Community Mental Health Authority (Plaintiffs) against State of Michigan, State of Michigan Department of Health And Human Services, a Michigan State Agency, and State of Michigan Department of Technology, Management & Budget, a Michigan State Agency (Defendants) in the Court of Claims. The Defendants have responded to the injunction arguing that the plaintiffs are "not entitled to the entry of a preliminary injunction," as Michigan law gives MDHHS the authority to choose which entity (or entities) will serve as a PIHP and requested that the injunction be denied.

REGIOINAL/STATEWIDE EVENTS, CONFERENCES, TRAININGS, NEWS

- **CMHAM Recipient Rights Conference** – September 17th – 19th in Kalamazoo.
- **CMHAM Fall Conference** – October 27th – 28th in Traverse City.
- **Improving Outcomes** – December 4th – 5th in Ann Arbor

NEXT MEETING

The next meeting was scheduled for October 14th at 10:00AM.

FY2026 Inpatient Psych Unit Status October 14, 2025

BCA Stonecrest

FY2026 rates	
Adult Psychiatric Inpatient (0100)	$825.00
Enhanced Rate 1:1 Staffing (0100)	$1093.00

Brightwell Behavioral Health

FY2026 rates	
Adult Psychiatric Inpatient (0100)	$750.00

Bronson Behavioral Health

FY2026 rates	
Adult Psychiatric Inpatient (0100)	$1,112.00
ECT (0901)	$1,350.00

Cedar Creek

FY2026 rates (Pending Ops approval 9/16/25)	
Adult/Child Psychiatric Inpatient (0100)	$1,140.00
Partial Hospitalization (0912)	$467.00

Forest View

FY2026 rates	
Adult and child/adolescent Psychiatric Inpatient (0100)	$1,144.70
Partial Hospitalization (0912)	$511.00

Harbor Oaks

FY2026 rates	
Adult Psychiatric Inpatient (0100) 3% increase	$840.00
Specialized Pediatric Unit (0100) 3% increase	$1,431.00

Havenwyck

FY2026 rates	
Adult/Adolescent Psychiatric Inpatient (0100)	$1,029.00
Partial Hospitalization (0912)	$453.00
Enhanced Rate 1:1 Staffing (0100**)** **SCA ONLY**	$1,149.01

Henry Ford Kingswood

FY2026 rates	
Adult Psychiatric Inpatient (0100)	$1,123.00

Specialized Inpatient Pediatric Unit (code?)	$1,442.00
ECT (0901)	$1,350.00

Healthsource

FY2026 rates

Adult Psychiatric Inpatient (0100) (2% increase)	$1,103.13
Adolescent Psychiatric Inpatient (0100) (3% increase)	$1,113.95
Geriatric Psychiatric Inpatient (0100) (3% increase)	$1,113.95
Enhanced Rate 1:1 Staffing (0100**)** **SCA ONLY**	$1,500.00

Kalamazoo Behavioral Health Hospital (Potential NEW FY2026)

FY2026 rates

This is Neuropsychiatric Hospital (Indiana) owned. Justin Donato is contact; correspondence from FY2024 (last year) indicates a rate of $975 for adults and $1150 for adults with IDD. I have requested clarification on how they would be billed, with a modifier? No contracts were made for FY2025. For FY2026, NMRE was provided codes of 0124 and 0114 (semi private and private inpatient) at $1400, but nothing for our standard 0100 for all inclusive room and board. NMRE has requested clarification on if they would bill 0100, and if this rate would be similar to the rate provided last year, or if they do not plan to bill 0100 at all. More to come pending the hospital's response.

McLaren Healthcare

FY2026 rates

Adult Psychiatric Inpatient (0100) 3% increase	$1068.00
Partial Hospitalization (0912) 3% increase	$535.00
*Still working to remove force majeure	

Munson Medical Center

FY2026 rates

Adult Psychiatric Inpatient (0100) 1.5% increase	$1,193.50
Partial Hospitalization (0912) 1.5% increase	$487.28
ECT (Pending final approval for addition)	*$811.27*

MyMichigan

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,138.35
Partial Hospitalization-Non-intensive (0912)	$651.30
Electroshock Therapy- (0901)	$1000.00

Pine Rest

FY2026 rates

Adult Psychiatric Inpatient (0100)	$1,294.00
Child and Adolescent (0100)	$1,421.00
Older Adult Unit (0100)	$1,294.00
Partial Hospitalization for adults and children (0912)	$594.00
Partial for child with eating disorder (new) (0912)	$771.00
ECT Inpatient (0901,in addition to (0100)	$897.00
ECT Outpatient (0901)	$1,159.00

Southridge Behavioral Health Hospital (Potential NEW FY2026)

FY2026 rates	
Adult Psychiatric Inpatient (0100)	$1,000.35

Trinity - Muskegon

FY20256rates	
Adult Psychiatric Inpatient (0100)	$1,114.00

Trinity – St. Mary's

FY2026 rates	
Adult Psychiatric Inpatient (0100)	$1,273.00
Partial Hospitalization (0912)	$543.00
ECT (0901, while receiving 0100)	$897.00

UP Health – Marquette

SINGLE-CASE AGREEMENT BASIS ONLY FOR FY2025, CURRENTLY PLANNING THE SAME FOR FY2026. AS A NOTE: NORTHCARE WAS PAYING UP HEALTH-MARQUETTE $695 FOR MEDICAID AND $675 FOR ECT IN FY2025; I HAVE REQUESTED AN UPDATE FOR FY2026 FOR REGION 2 TO FOLLOW SUIT.

Standard II—Emergency and Poststabilization Services

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
13. The PIHP's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An PIHP representative and the treating physician reach an agreement concerning the member's care. d. The member is discharged. 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the PIHP:** • SII_E11-E12-E13_P.P. NLCMHA UM Plan • SII_E11-E13_Case example- CSR 2024_example 1 • SII_E11-E13_Case example- CSR 2024_example 2 • SII_E11-E13_Case example- CSR 2024_example 3 • SII_E11-E13_Case example-Example 4 • SII_E13_ Hospital Liaison Procedure • SII_E13_Case example-UM.Communication.1 • SII_E13_Continued stay denial • SII_E13_End of episode.discharge • SII_E5 through E13_CWN_page6,19,20	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: PIHP and its 5 CMHSPs define Post-stabilization services as covered specialty services, related to an emergency medical condition and that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or to improve or resolve the beneficiary's condition. PIHP/CMHSPs are responsible for payment for services they authorize. Services cannot be delayed or denied as a result of a dispute of payment responsibility between two or more CMHSPs. In the event of an unresolved dispute between CMHSPs, either one may request the PIHPs involvement to resolve the dispute and make a determination. Likewise, services are not to be delayed or denied as a result of a dispute of payment responsibility between the CMHSP and another agency. CMHSPs are financially responsible for post-stabilization specialty care services obtained within or outside the network that are preapproved by the CMHSP.		
HSAG Findings: While not specific to this element but to the entire standard in general, the PIHP did not adequately address HSAG's recommendations made during the SFY 2021 compliance review. While the PIHP could speak to its processes for implementation when prompted by questions from HSAG (which resulted in a *Met* score for Elements 1–12), the PIHP did not develop an emergency and poststabilization services policy or incorporate the federal provisions into existing policies as most of the federal provisions were missing from policies submitted by the PIHP for this standard, resulting in a *Not Met* score for this element.		

Standard II—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: While not specific to this element but to the entire standard in general, HSAG recommends that the PIHP specifically include the requirements of each element in a standalone emergency and poststabilization services policy and expand on the applicability of the requirements as they relate to the PIHP and the Medicaid Behavioral Health Managed Care Program and how the PIHP meets the intent of the requirements. Within the policy, the PIHP must include: • The definitions of an emergency medical condition, emergency services, and poststabilization services (i.e., including the federal definitions under Elements 1–3 and as defined by MDHHS in the Michigan Medicaid Provider Manual [MMPM]). • A list of services considered to be emergency services covered under the PIHP's scope of work (e.g., preadmission screening, crisis intervention). Of note, emergency services do not require prior authorization (PA). • Examples of services considered to be poststabilization in accordance with the MMPM. • All federal provisions under Elements 4–13 (HSAG recommends including verbatim to the federal rule) with an explanation for how the PIHP meets the intent of each requirement. • The guidance issued by MDHHS in the *Clarification of the Michigan Mission Based Performance Indicator System (MMBPIS) three-hour prescreen decision indicator in relation to one-hour requirement for authorization of poststabilization care services (42 CFR 422.113 & 42 CFR 438.114)* memorandum dated September 26, 2024. HSAG recommends that the PIHP consult with MDHHS for further guidance as needed. If the PIHP does not demonstrate adequate implementation of HSAG's recommendation during future compliance reviews, the PIHP will automatically receive a *Not Met* score for each individual element within this standard if not addressed.		
Required Actions: The PIHP must develop a policy that incorporates all coverage and payment rules for emergency and poststabilization services.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard VII—Provider Selection

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
10. *For credentialing and recredentialing, the PIHP primary source verifies:* a. *Official National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:* i. *Minimum five-year history of professional liability claims resulting in a judgment or settlement.* ii. *Disciplinary status with regulatory board or agency.* iii. *Medicare/Medicaid sanctions.* 42 CFR §438.214(e) Credentialing and Re-credentialing Processes—C(3)(d)	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Definitions; Page 5 of PDF, B.4.d • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 2 and 4 • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 386	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: NMRE policy requires NPDB verification query at the time of credentialing and recredentialing, or in lieu of NPDB query, all of the requirements of 42 CFR 438.21. This requirement flows from the PIHP to our CMHSPs via our provider network agreement with them. We also review this when we pull samples during CMHSP monitoring. All of the CMHSPs contracted with the NMRE have NPDB logins and use NPDB.		
HSAG Findings: For one practitioner record, the PIHP's delegate did not check the NPDB prior to the practitioner's credentialing date. While the missing NPDB query was identified during an internal audit, and the NPDB was checked after the credentialing approval date, the PIHP's delegate did not perform PSV within the required time frame. **Recommendations:** For two case files, the NPDB was not included in the credentialing case files. The PIHP staff members stated during the site review that this was because the practitioners were not licensed professionals. As such, HSAG recommends that the PIHP consult with MDHHS to determine whether these unlicensed professionals fall under the scope of MDHHS' credentialing policy. Additionally, HSAG recommends that the PIHP clearly identify the requirements of this element for both credentialing and recredentialing within its credentialing policy.		
Required Actions: The PIHP must ensure that it, or its delegates on the PIHP's behalf, primary-source verifies for all practitioners, an NPDB/HIPDB query, or in lieu of a NPDB/HIPDB query, a minimum five-year history of professional liability claims resulting in a judgment or settlement, disciplinary status with a regulatory board or agency, and/or Medicare/Medicaid sanctions to ensure this requirement is met.		

Standard VII—Provider Selection		
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
12. *For credentialing and recredentialing, the PIHP conducts a search that reveals information substantially similar to information found on an Internet Criminal History Access Tool (ICHAT) check and a national and State sex offender registry check for each new direct-hire or contractually employed practitioner.* a. *ICHAT: https://apps.michigan.gov.* b. *Michigan Public Sex Offender Registry: https://mspsor.com.* c. *National Sex Offender Registry: http://www.nsopw.gov.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Page 4 of PDF, B.2, Page 6, E.3 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 2 at top, page 4 near top • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 340	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The NMRE Credentialing and Recredentialing Policy requires criminal search and sex offender verification. We monitor this at the CMH level to ensure these standards are reflected in their policies and we also verify that these are searched in case samples during monitoring.		
HSAG Findings: One case file was missing the National Sex Offender Registry search results, and a second case file was missing the Michigan Public Sex Offender Registry (MPSOR) search results.		
Required Actions: For credentialing and recredentialing, the PIHP must ensure it conducts a search on the national and State sex offender registries for each new directly hired or contractually employed practitioner.		

Standard VII—Provider Selection		
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
18. *For credentialing and recredentialing, the PIHP confirms that the provider is not excluded from participation:* a. *In Medicare, Medicaid, or federal contracts.* b. *Through the MDHHS Sanctioned Provider List.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—D(1)(e–f)	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Page 3 of PDF, A.3; Page 7 of PDF, E.3 • Excluded Provider Screening: Page 2 of PDF, Policy 1)-5) • FY2024_NMRE_CWN_Agreement: Page 28, XII. Provider Procurement, C; Page 45, XIX 2 • NMRE and SUD Entities EPS Summary for April 2024 • NMRE and SUD Entities EPS Summary for May 2024 • NMRE and SUD Entities EPS Summary for February 2024 • 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 2 (middle), Page 4 (middle)	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The NMRE, via policy and contracts with CMHSPs, requires that the Michigan Sanctioned Provider list, OIG Exclusions Database, and System for Award management is checked for each and evert provider in our network. We monitor this as part of our site review process; we		

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
verify Valenz checks monthly for each current (recredentialed) provider, and either an upfront Valenz check of PSV from the exclusions database initially (before the provider is onboarded and added to the Valenz report). We have a separate policy for this, and also reference this in our credentialing policy.		
HSAG Findings: For two organizational credentialing case files, Medicare and Medicaid sanction/exclusion checks were completed after the credentialing approval date. While these deficiencies were identified during internal reviews, these case files did not meet the requirements of this element.		
Required Actions: The PIHP must ensure that all providers are not excluded from participation in Medicare, Medicaid, or federal contracts or included on the MDHHS Sanctioned Provider List prior to the credentialing decision.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
22. *The PIHP ensures that the credentialing process provides for mandatory recredentialing at least every two years.* *Note: While recredentialing is required every three years with implementation of universal credentialing, during the look-back period for the file review, PIHPs were required to recredential providers every two years.* 42 CFR §438.214(e) Credentialing and Re-Credentialing Processes—C Credentialing and Re-Credentialing Processes—D	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms for timeliness • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Reviews **Evidence as Submitted by the PIHP:** • Credentialing Policy and Procedure: Page 6 of PDF (4 of policy), D. Recredentialing, first sentence; Page 7 of PDF, E. Organizational Providers, 3. • FY2024_NMRE.CWN_Agreement: Page 28, E.	☐ Met ☒ Not Met ☐ NA

Standard VII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• 2024_CMHSP_Staff_Cred ReCred Monitoring Tool: Page 5, 3rd row from bottom • 2024_CMHSP_Delegated_Managed_Care_Tool:Row 394, Row 348/349 • Wellvance Practitioner Credentialing Log • Wellvance Organizations Credentialing checklist • NCCMH Organizational Provider checklist • NCCMH Practitioner Application date tracking	
PIHP Description of Process: The NMRE's policies and procedures require timeliness standards as defined in the MDHHS Credentialing and Recredentialing processes. The NMRE monitors organizations and case samples of our CMHSPs during annual monitoring. We also train our CMH contractors and lead credentialing staff on this element, both in roundtable discussions in 2023, and also in a training in January 2025. The NMRE uses the MDHHS credentialing report as an indicator of CMHSP and PIHP compliance. The NMRE and CMHSPs use a variety of tracking methods; a separate log is in use as evidenced in the samples provided; examples include Ausable Valley (Wellvance) and North Country CMHs logs are good examples of this to track materials and dates for their organizational providers. The CMHSPs also use tracking loge for each individual application, example included (from case sample) is [redacted] facesheet for the application, with dates for when documents are received.		
HSAG Findings: For one organizational case file, recredentialing did not occur within the required two-year time frame that was in effect during the time period under review.		
Required Actions: The PIHP must ensure that the credentialing process is completed within the required time frame for all providers.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard VIII—Confidentiality

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
11. The PIHP, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the PIHP to have been accessed, acquired, used, or disclosed as a result of such breach. a. Breach and unsecured PHI are as defined in 45 CFR §164.402. b. Except as provided in 45 CFR §164.412, the PIHP must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach. 45 CFR §164.404(a)(1) 45 CFR §164.402 45 CFR §164.404(b) 45 CFR §164.412	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members **Evidence as Submitted by the PIHP:** • S8_E11_Breach Notification Policy_pages 2_3 • S8_E11_E13_Breach Notificiation page 9_Risk Assessment • S8_E11_E13_E20_Breach Tracking	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: When the NMRE discovers a breach of PHI, the NMRE notifies each beneficiary who is affected or reasonably believes has been affected, the NMRE notifies the beneficiary of the breach without delay, but no later than 60 days from the breach.		
HSAG Findings: Although the PIHP submitted its *Breach Notification* policy outlining the requirements under this element and confirmed the CMHSPs are responsible for providing notification to its members, PIHP staff members were not able to speak to the PIHP's processes and/or its oversight procedures in monitoring its delegates' processes for tracking unauthorized disclosures of PHI and breaches. Further, the PIHP was not able to confirm appropriate action was taken in providing notification to affected individuals as outlined under the federal requirements. Lastly, the PIHP was unable to provide sufficient evidence for its delegates' unauthorized disclosures of PHI and breaches that occurred during the review period (e.g., providing notification to the member, notifying the PIHP, and notifying the U.S. Department of Health and Human Services [HHS]). **Recommendations:** HSAG strongly recommends that the PIHP develop procedures that outline all requirements related to the Breach Notification Rule and ensure that its policies and procedures are reviewed and approved regularly. Additionally, although the PIHP provided the PIHPs *Breach Tracking* document, HSAG strongly recommends that the PIHP develop a formal process to receive and track its delegates' unauthorized disclosures of PHI and breaches to ensure its delegates are providing notification to affected individuals, and the media as applicable, and notifying the PIHP as well as the Secretary as required.		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The PIHP, following the discovery of a breach of unsecured PHI, must notify each individual whose unsecured PHI has been, or is reasonably believed by the PIHP to have been, accessed, acquired, used, or disclosed as a result of such a breach. Except as provided in 45 CFR §164.412, the PIHP must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
14. Except as provided in 45 CFR §164.412, the PIHP must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach. 45 CFR §164.404(b) 45 CFR §164.412	**HSAG Required Evidence:** • Policies and procedures • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members • Three examples of breach notification letters to members **Evidence as Submitted by the PIHP:** • S8_E12_E13_E14_Breach Notification page 2 of 10 • S8_E14_E15_Breach Notification Example 1 • S8_E14_Breach Notification Ex. 2 • S8_E14_E15_Breach Notification Example 3	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The NMRE provides notification of a breach as soon as possible to the affected beneficiary, but no later than 60 days from the date of discovery of the breach.		
HSAG Findings: The PIHP initially submitted three examples of unauthorized disclosures of PHI/breaches from two of its CMHSPs; however, no evidence was provided showing the members in *Breach Notification Example 1* and *Breach Notification Example 3* were notified. Following the site		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
review, HSAG requested the PIHP provide evidence of the breach letters sent to the individuals for *Breach Notification Example 1* and *Breach Notification Example 3*. The PIHP submitted a document titled *Breach Notification Example* in follow up, which was a breach notification letter to a different member and did not demonstrate that appropriate action was taken for notifying the individuals in *Breach Notification Example 1* and *Breach Notification Example 3* initially submitted. **Recommendations:** Although the PIHP submitted its *Breach Notification* policy outlining the requirements under this element, and confirmed the CMHSPs are responsible for providing notification to its members, HSAG strongly recommends that the PIHP develop a formal process to receive and track its delegates' unauthorized disclosures of PHI and breaches to ensure its delegates are providing notification to affected individuals, and the media as applicable, and notifying the PIHP as well as the Secretary as required. 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: Except as provided in 45 CFR §164.412, the PIHP must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
15. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible: a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach. d. A brief description of what the PIHP is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address. 45 CFR §164.404(c) 45 CFR §164.406(c)	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template • Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period **Evidence as Submitted by the PIHP:** • S8_E15_Breach Notification page 2 of 10 • S8_E15_Screenshot Template Reading Level • S8_E11_E15_Breach Notification Template CMHSP • S8_E14_E15_Breach Notification Example 1 • S8_E14_Breach Notification Ex. 2 • S8_E14_E15_Breach Notification Example 3	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: When the NMRE notifies beneficiaries of the breach, the NMRE ensures the notice includes a brief description of the breach, the type of PHI that was breached, steps that can be taken to protect themselves, a brief description of what the NMRE is doing to investigate the breach and contact information for the NMRE so people involved may reach out with questions.		
HSAG Findings: Although the PIHP initially submitted three examples of unauthorized disclosures of PHI/breaches from two of its CMHSPs, only *S8_E14_Breach Notification Ex. 2* contained evidence supporting that the affected individual was notified. However, the notification sent to the individual did not contain sub-element (b). Under 45 CFR §164.404(c) and 45 CFR §164.406(c), the notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible, sub-elements (a) through (d) in the content of the notification. Additionally, there was no evidence provided showing the members in *Breach Notification Example 1* and *Breach Notification Example 3* were notified. Following the site review,		

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Requirement	**Supporting Documentation**	**Score**
HSAG requested the PIHP provide evidence of the breach letters to the individuals for *Breach Notification Example 1* and *Breach Notification Example 3*. The PIHP submitted a document titled *Breach Notification Example* in follow up, which was a breach notification letter to a different member and did not demonstrate that appropriate action was taken for notifying the individuals in *Breach Notification Example 1* and *Breach Notification Example 3* initially submitted. **Recommendations:** Although the PIHP submitted its *Breach Notification* policy outlining the requirements under this element, and confirmed the CMHSPs are responsible for providing notification to its members and media outlets as required, HSAG strongly recommends that the PIHP develop a formal process to receive and track its delegates' unauthorized disclosures of PHI and breaches to ensure its delegates are providing notification to affected individuals, and the media as applicable, and notifying the PIHP as well as the Secretary as required. Additionally, HSAG strongly recommends that the PIHP develop a breach notification letter template to ensure this written material adheres to contract requirements (e.g., be written at or below the 6.9 grade reading level, when possible). 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: The PIHP must ensure notification (to individuals, and to media outlets, if required) is written in plain language and includes, to the extent possible: • A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. • A description of the types of unsecured PHI that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). • Any steps individuals should take to protect themselves from potential harm resulting from the breach. • A brief description of what the PIHP is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. • Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted	

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
		☐ Accepted With Recommendations ☐ Not Accepted
20. The PIHP must, following the discovery of a breach of unsecured PHI, notify the Secretary. a. For breaches of unsecured PHI involving 500 or more individuals, the PIHP must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the HHS website. b. For breaches of unsecured PHI involving less than 500 individuals, the PIHP must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS website. 45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members • Annual notification to HHS of breaches of unsecured PHI, including the date of notification **Evidence as Submitted by the PIHP:** • S8_E19_E20_Breach Notification page 6 of 10 • S8_E11_E13_E20_Breach Tracking	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The NMRE notifies the appropriate entities as specified by regulations. In instances of more than 500 individuals breached, the NMRE uses the HHS website for guidance. In the instances of less than 500 individuals being involved in a breach, the NMRE tracks the breach via a tracking spreadsheet.		
HSAG Findings: Although the PIHP's *Breach Notification* policy included many of the requirements under federal rule, PIHP staff members indicated that the delegated entities were responsible for providing notification to the Secretary for breaches of unsecured PHI. The PIHP did not initially provide evidence supporting sub-element (b), "for breaches of unsecured PHI involving less than 500 individuals, the PIHP must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS website." Following the site review, HSAG requested the PIHP provide evidence for the three examples of unauthorized disclosures of PHI and breaches demonstrating that the CMHSPs notified HHS and evidence of the submission to HHS website. Following the site review, the PIHP responded that there is "no evidence for this element" and that "NMRE will work with CMHSPs for training and technical assistance to meet requirements."		

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Requirement	**Supporting Documentation**	**Score**
Recommendations: Although the PIHP submitted its *Breach Notification* policy outlining the requirements under this element, and confirmed the CMHSPs are responsible for providing notification to HHS, HSAG strongly recommends that the PIHP develop a formal process to receive and track its delegates' unauthorized disclosures of PHI and breaches to ensure its delegates are providing notification to affected individuals, and the media as applicable, and notifying the PIHP as well as the Secretary as required. 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: The PIHP must, following the discovery of a breach of unsecured PHI, notify the Secretary. For breaches of unsecured PHI involving 500 or more individuals, the PIHP must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the HHS website. For breaches of unsecured PHI involving less than 500 individuals, the PIHP must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS website.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
21. The PIHP must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the PIHP of such breach. a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI reported by subcontractors • One example of executed business associate agreement • One example of executed subcontractor contract	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate. b. Except as provided in 45 CFR §164.412, the PIHP must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. c. The notification must include, to the extent possible, the identification of each individual whose unsecured protected health information has been or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. d. The PIHP must require a business associate to provide the PIHP with any other available information that the PIHP is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available. 45 CFR §164.410 45 CFR §164.404(c) 45 CFR §164.412	**Evidence as Submitted by the PIHP:** • BAA Boilerplate: Page 2, 4.c and d • Gogolin_NMRE_BAA_DRAFT_2_13_24	
PIHP Description of Process: The NMRE's BAA template, and executed copies of templates, require Business Associates to report to the NMRE's designated Privacy Office of Covered Entity any use or disclosure of protected health information not provided for by the Agreement of which they become aware of, including breaches of unsecured PHI as required at 45 CFR § 164, and any security incident of which they becomes aware and involving the NMRE's PHI they use and disclose within ten (10) days from the date they become aware (or would have become aware). Business Associates report this to the NMRE designated Privacy Office; any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware,		

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Requirement	**Supporting Documentation**	**Score**
including breaches of unsecured PHI as required at 45 CFR § 164 and any security incident of which they becomes aware and involving Covered Entity PHI used and disclosed by a Business Associate within ten (10) days from the date they becomes aware (or would have become aware)		
HSAG Findings: Although the PIHP's *Breach Notification* policy included many of the requirements under federal rule and PIHP staff members indicated that the delegated entities were responsible for providing notification to the PIHP of breaches of unsecured PHI, the PIHP did not initially provide evidence supporting the requirements under this element. The PIHP initially submitted *BAA Boilerplate* and *Gogolin_NMRE_BAA_DRAFT*, which outlined its expectations to receive notice of unauthorized disclosures and breaches from its subcontractors; however, no evidence was provided demonstrating the PIHP received notification of the unauthorized disclosures provided as evidence from the CMHSPs. HSAG requested that the PIHP provide evidence of any documentation received from its CMHSPs (e.g., email notification) for the unauthorized disclosures that occurred during the review period in follow-up. Following the site review, the PIHP responded that there is "no evidence for this element" and that "NMRE will work with CMHSPs for training and technical assistance to meet requirements." **Recommendations:** Although the PIHP provided its *Breach Tracking* document, HSAG strongly recommends that the PIHP develop a formal process to receive and track its delegates' unauthorized disclosures of PHI and breaches to ensure its delegates are providing notification to affected individuals, and the media as applicable, and notifying the PIHP as well as the Secretary as required. 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: The PIHP must require its business associates (i.e., subcontractors), following the discovery of a breach of unsecured PHI, to notify the PIHP of such a breach. A breach shall be treated as discovered by a business associate as of the first day on which such a breach is known to the business associate, or by exercising reasonable diligence would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person other than the person committing the breach who is an employee, officer, or other agent of the business associate. Except as provided in 45 CFR §164.412, the PIHP must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. The PIHP must require a business associate to provide the PIHP with any other available information that the PIHP is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		

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Requirement	**Supporting Documentation**	**Score**
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
22. The PIHP's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the PIHP, and of the member's rights and the PIHP's legal duties with respect to PHI. a. The PIHP provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1). b. The PIHP makes the notice available to its members on request as required by 45 CFR §164.520(c). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110	**HSAG Required Evidence:** • Policies and procedures • Copy of Notice of Privacy Practices • Link to Notice of Privacy Practices on the PIHP's website • Staff training materials **Evidence as Submitted by the PIHP:** • S8_E22_Notice of Privacy Practices (page 2) • S8_E22_Breach Notification Policy page 5 of 10 • S8_E22_Screenshot_Website Privacy Practices • S8_E22_Resources | NMRE	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The NMRE provides written notice in in plain language according to regulation, for the disclosure of PHI. The notice is available to all beneficiaries via the NMRE website.		
HSAG Findings: The PIHP submitted an outdated version of its Notice of Privacy Practices (NOPP) as evidence (revised March 2021) and was unable to confirm during the site review whether the outdated version or the version on the PIHP's website (revised January 12, 2023) was provided to its members during the review period (i.e., January 1, 2024, through December 31, 2024). HSAG requested the PIHP verify which version was used during the 2024 review period as follow-up. Following the site review, the PIHP responded that there is "no evidence," and that the PIHP "will work with staff to review the NOPP and ensure that consistent versions are being used." Additionally, the revised notice on the PIHP's website still did not contain the header to read exactly as required under 45 CFR §164.520(b)(1)(i), or at least one example of the types of uses and disclosures that the covered entity is permitted to make for the purposes of payment. Finally, the revised notice on the PIHP's website did not contain a description for the types of use and disclosure that requires an authorization under §164.508(a)(2)–(4). **Recommendations:** HSAG strongly recommends that the PIHP proceed with its plan to work with its staff to review the NOPP and ensure consistent versions are being used. Additionally, HSAG continues to strongly recommend that the PIHP review and revise its NOPP to reflect the requirements under		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.520(b)(1), e.g., update the header statement to mirror federal requirements under 45 CFR §164.520(b)(1)(i), include at least one example of the types of uses and disclosures that the covered entity is permitted to make for the purposes of payment under 45 CFR §164.520(b)(1)(ii)(A), as well as include a description of the types of uses and disclosures that require an authorization under §164.508(a)(2)–(4), which relate to psychotherapy notes, marketing, and sale of PHI as required for the NOPP under 45 CFR §164.520(b)(1)(ii)(E). Further, part of the PIHP's prior CAP was to update its "compliance and ethics training to include that the NOPP will be provided to beneficiaries when they register for service, when privacy practice changes, and at least every three years or upon request." While this was evident in the PIHP's *S8_E6_Compliance_Training_18*, it was not evident in CMHSP *S8_E4 Training 2024_slides*. HSAG strongly recommends the PIHP ensure its delegates' training outline all requirements for providing the NOPP to its members under this element. Furthermore, the formatting of the NOPP could be improved overall. HSAG continues to strongly recommend the PIHP review published examples of the NOPP and determine whether it could be updated to be more user friendly and possibly have some of the headers stand out to the reader, such as information regarding: why the PIHP would use or share PHI (for treatment, for payment, for health care operations); when the PIHP can use or share PHI without getting written authorization (approval) from the member; when the PIHP needs written authorization (approval) to use or share PHI; the member's health information rights; and what the member can do if rights have not been protected. Moreover, HSAG continues to strongly recommend that the PIHP's formal oversight process of its delegated entities include a component for assessing each entity's procedures for providing a NOPP and confirm that each delegated entity's NOPP includes the required components as indicated in 45 CFR §164.520(b)(1)(i-viii). The PIHP should also confirm that its website and its delegated entities' websites have the NOPP in a conspicuous location so that members can easily retrieve a copy of the NOPP as necessary. Finally, although the new requirements outlined in 45 CFR §164.520 effective in February 2026 were discussed during the site review, HSAG strongly recommends that the PIHP ensure it is adhering to updates made to 45 CFR §164.520, as applicable, and ensure it includes a statement regarding the federal requirements outlined under 42 CFR Part 2 for protecting and prohibiting the sharing of SUD treatment records without prior written consent. 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: The PIHP must ensure its NOPP includes all required components as indicated in 45 CFR §164.520(b)(1)(i-viii).		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		

Standard VIII—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Standard IX—Grievance and Appeal Systems

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
2. A member may file a grievance with the PIHP at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) Contract Schedule A—M(1)(d) Appeal and Grievance Resolution Processes Technical Requirement—III Appeal and Grievance Resolution Processes Technical Requirement—VIII(B)(2)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • System screenshot of the field where the individual who filed the grievance is documented • System screenshot of the field where written consent of the member is documented • Three case examples of a grievance filed by someone other than the member, including the member's written consent • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • S9_E2_Case Example 1_Written Consent • S9_E2_Form Written Consent • S9_E2_Grievance and Appeals Policy_written consent_page 12 • S9_E2_Grievance and Appeals procedure_page 1 • S9_E2_Guide to Services_page 15 • S9_E2_Screenshot Member Verification	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: If someone other than the beneficiary would like to file a grievance, written consent is obtained by the beneficiary for the person to file a grievance on the beneficiary's behalf.		
HSAG Findings: The case file review identified two records in which the grievance was filed by someone other than the adult member. During the site review, HSAG requested evidence of guardianship for both records. After the site review, the PIHP submitted the same screenshots that were already provided. For one record (Sample 2), the screenshot indicated that the authorized representative verification was verified via "EMR/EHR." For the second record (Sample 5), the screenshot indicated that the individual was the member's guardian, but the authorized representative fields were blank. The PIHP did not submit evidence of guardianship as requested. The PIHP also submitted two additional case examples after the site review. One example was a grievance filed by the parent of a minor, which does not require the member's written consent, and therefore, is not applicable to the case examples		

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
requested. For the second example, the grievance was filed by the guardian and while screenshots of the authorized representative verification fields were submitted, evidence of guardianship was not provided as requested. **Recommendations:** The member handbook included the following language: "A provider may file a grievance on your behalf (with verified written consent by you/your legal representative)." However, any individual (provider, family member, friend, etc.) is required to obtain the member's written consent to file a grievance on the member's behalf, not just providers. As such, HSAG recommends that the PIHP update the member handbook accordingly. Additionally, while the PIHP submitted a consent form template, the PIHP explained that this form is specific to the PIHP. HSAG recommends that the PIHP ensure its delegates have appropriate processes, including a consent template, to obtain the written consent of the member when an individual (e.g., family member, friend) files a grievance on the member's behalf. Further, if the PIHP receives a grievance from an individual who is not an authorized representative, the PIHP may contact the member directly and if the member verbally confirms that the member is requesting to file the grievance, the grievance should be documented as a member-initiated oral grievance. In this instance, all communication (e.g., acknowledgement and resolution notices) must occur with the member and not the individual who initially filed the grievance as the individual can only act as a representative of the member with the written consent of the member. 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: The PIHP must verify an authorized representative (e.g., guardianship, written consent of the member) when an individual files a grievance on behalf of the member. This verification must be documented in each applicable grievance record.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
4. The PIHP acknowledges receipt of each grievance, *within five business days.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) Contract Schedule A—M(2)(e) Appeal and Grievance Resolution Processes Technical Requirement—VIII(C)(2)	**HSAG Required Evidence:** • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms • System screenshot of the field where the date of receipt of the grievance is documented • System screenshot of the field where the date of oral/written acknowledgement and the acknowledgement notice/call notes are documented • Report of all appeals during the review period, including the date of receipt of the appeals and the date of acknowledgement • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • S9_E4_Beneficiary Grievance and Appeals procedure_page 2 • S9_E4_E6_E7_Grievance Tracking and Reporting • S9_E4_Screenshot_date received	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The PIHP sends a notice of receipt of grievance to the beneficiary within 5 business days of the receipt of complaint. The PIHP tracks the compliance of this standard through the quarterly grievance report sent to MDHHS.		
HSAG Findings: HSAG required a report of all grievances during the review period, including the date of receipt of the grievance and the date of acknowledgement; however, this report was not submitted as evidence for HSAG's desk review. After the site review, the PIHP submitted a report of all grievances for the PIHP and one CMHSP. However, the CMHSP report identified one grievance which was not acknowledged until six business days after receipt. Additionally, a report for the remaining CMHSPs was not provided. Further, while two reports were provided after the site review, it is unclear if the PIHP is actively monitoring adherence to acknowledgement time frames (e.g., monitoring reports of acknowledgement time frames, case file reviews). Lastly, the SUD provider manual incorrectly informed providers that grievances would be acknowledged within 10 business days as opposed to the required five business days. **Recommendations:** The case file review identified one record (Sample 1) which did not include evidence of acknowledgement of the grievance (i.e., screenshot of the date of acknowledgement field and the acknowledgement notice). After the site review, the PIHP submitted a document titled "Notice of Receipt"; however, the notice was the notice of grievance resolution and not the notice of receipt. While the PIHP did not provide additional clarification, as		

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Requirement	**Supporting Documentation**	**Score**
the resolution notice was dated five business days after receipt of the grievance and as the PIHP has five business days to acknowledge receipt of the grievance, HSAG is assuming that the resolution notice served as both the acknowledgement and resolution notice. The PIHP must thoroughly review all grievance case files and be able to explain such anomalies during future compliance reviews. Additionally, HSAG recommends that the PIHP implement mechanisms to monitor adherence to this requirement by reviewing periodic reports on acknowledgement turnaround times (TATs). 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: The PIHP must acknowledge receipt of each grievance within five business days and implement processes (e.g., monitoring reports of acknowledgement time frames) to monitor adherence to the acknowledgement time frame standard.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
6. The PIHP resolves each grievance and provides *written* notice of resolution, as expeditiously as the member's health condition requires, within MDHHS-established time frames that do not exceed the time frames specified in 42 CFR §438.408. a. The PIHP resolves the grievance and sends written notice to the affected parties within 90 calendar days from the day the PIHP receives the grievance. 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1)	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • System screenshot of the field where the date of receipt of the grievance is documented • System screenshot of the field where the date of oral/written resolution and the resolution notice/call notes are documented • HSAG will also use data reported on the grievance universe file/MDHHS reporting template • HSAG will also use the results of the Grievances File Review	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1260(e)(12) Contract Schedule A—M(1)(e)(v) Appeal and Grievance Resolution Processes Technical Requirement—VIII(D)(1)	**Evidence as Submitted by the PIHP:** • S9_E4_E6_E7_Grievance Tracking and Reporting • S9_E6_Grievance and Appeals policy_page 7 • S9_E6_Grievance Resolution Template • S9_E6_Screenshot_call notes documented • S9_E6_Screenshot_DOR Grievance • S9_E6_Screenshot Resolution Date	
PIHP Description of Process: The PIHP resolves each grievance and provides *written* notice of resolution, as expeditiously as the member's health condition requires, within MDHHS-established time frames that do not exceed the time frames specified, which will not exceed 90 days from date of receipt.		
HSAG Findings: The case file review confirmed that for three grievances, the member was requesting a different provider. While the member was assigned to a new provider in all cases, the record did not include clear documentation that the grievances were reviewed. The cases documented the reason for why the member was requesting a new provider (i.e., provider was not a good fit, member needed more convenient appointment times, member wanted a provider with more knowledge) but there was no actual review into the basis of the complaint (i.e., was the provider providing appropriate care, did the provider have adequate appointment times available, did the provider have the appropriate credentials to treat the member and rendered treatment that met acceptable standards of care). During the site review, the PIHP staff members explained that the PIHP's expectation is for the grievance reviewer to reach out to the involved staff member and supervisor to ensure the member's reason for wanting a new provider is fully addressed. However, this documentation was not included in the case file. As part of the grievance review, the PIHP should request specific details from the member, and collect and review medical records and statements from the provider to determine the validity of the member's complaint. Should a failure in the system be identified (e.g., lack of appointment availability, treatment below acceptable standards of care), corrective actions to prevent a reoccurrence should be taken. Of note, the PIHP received a similar finding during the SFY 2022 compliance review. **Recommendations:** HSAG has recommended to MDHHS to establish an expedited review process (e.g., 72-hour resolution time frame) for when a grievance resolution time frame should be completed on an expedited basis (e.g., clinically urgent grievances, grievances related to a denied request for an expedited appeal, grievances related to resolution extension time frames). HSAG recommends that the PIHP implement any future guidance or policy changes implemented by MDHHS. 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: The PIHP must fully review and resolve each grievance. The review process and results of the review must be documented in each record.		

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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
8. If the PIHP extends the grievance resolution time frame not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days 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. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) Contract Schedule A—M(1)(e)(vi) Appeal and Grievance Resolution Processes Technical Requirement—VIII(D)(2)(a)	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • System screenshot of field where oral notice of the extension is documented • System screenshot of field where written notice of the extension is documented, including the date of the notice • Three case examples of a grievance with an extension applied, including oral and written notice of the extension • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the PIHP:** • S9_E7_E8_Screenshot_Grievance Extension Info • S9_E8_Grievance and Appeals Policy_page 8	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: In the instance of a grievance extension, the PIHP will make reasonable efforts to give the beneficiary prompt oral notice of the delay and provide a written notice of the extension within 2 calendar days, informing the beneficiary they have the right to file another appeal if they disagree with the extension.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: While the PIHP confirmed that it had no grievance resolution time frame extensions during the time period of review, the PIHP did not initially provide a grievance extension notice template as requested by HSAG. After the site review, the PIHP submitted an extension letter template; however, the document appeared to be created on May 23, 2025. Therefore, without further explanation from the PIHP, HSAG was unable to verify the template was effective during the time period of review. Further, while the template informed members to call "***** at *****", if they do not agree with the extension, the template did not specifically inform members that they have grievance rights if they do not agree with the extension. Lastly, as the notice was on the PIHP's letterhead, it is unclear whether the PIHP's delegates were required to use this template or were responsible for creating their own template. **Recommendations:** The PIHP's system did not have a dedicated reportable field to track oral and written notice of extensions and could only document extension notices in the notes section of the module. While the PIHP had no grievance resolution time frame extensions, as it is a contractual requirement (for the PIHP to apply an extension and for members to request an extension), HSAG recommends that the PIHP enhance its system to track and report on the extension provisions. 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: If the PIHP extends the grievance resolution time frame not at the request of the member, it must make reasonable efforts to give the member prompt oral notice of the delay, and within two calendar days give the member 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):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

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Requirement	**Supporting Documentation**	**Score**
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If an appeal is submitted by a third party but does not include a signed document authorizing the third party to act as an authorized representative for the member, the 30-day time frame begins on the date an authorized representative document is received by the PIHP. The PIHP must notify the member that an authorized representative form or document is required. For purposes of section Schedule A—1(M)(1)(e)(vii), "third party" includes, but is not limited to, health care providers.* 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) Contract Schedule A—1(M)(1)(d) Contract Schedule A—1(M)(1)(e)(vii) Contract Schedule A—1(M)(8)(b)(i) Appeal and Grievance Resolution Processes Technical Requirement—III Appeal and Grievance Resolution Processes Technical Requirement—VII(A)(2)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • System screenshot of the field of where the individual who filed the appeal is documented • System screenshot of the field where written consent of the member is documented • System screenshot of the field where the filing mode is documented (i.e., orally or in writing) • Three case examples of an appeal filed by someone other than the member, including the member's written consent • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E14_Appeal Written Consent • S9_E14_Grievance and Appeals Procedure_page 5 • S9_E14_Member Handbook_member consent_page 15 • S9_E14_Screenshot Consent • S9_E14a_filing mode • S9_E14a_screenshot appellant	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The PIHP accepts the beneficiary's request for an appeal both orally and in writing, and also accepts written consent from a beneficiary for someone other than the beneficiary to file the appeal on their behalf. The PIHP will notify the beneficiary that an authorized form is needed in order for a representative (someone other than the beneficiary) to file the appeal, including but not limited to, health care providers.		
HSAG Findings: The case file review identified one record (Sample 4) which included conflicting information about who requested the appeal (i.e., member or authorized representative). During the site review, HSAG requested confirmation for who requested the appeal, and if the appeal was requested by an individual who was not the member, evidence of the verification of the authorized representative. After the site review, the PIHP staff members		

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Requirement	**Supporting Documentation**	**Score**
explained that there was no additional documentation reported, and the PIHP will work with its CMHPS on regular monitoring and appeal cases and provide additional training. Additionally, the PIHP also submitted two additional case examples after the site review. While one example included evidence of guardianship, the second example only included a screenshot indicating that the appeal was filed by a provider and the authorized representative was verified via email; however, the email or confirmation of the authorized representative consent form from the member were not provided. Further, the case file review identified one record (Sample 5) in which the appeal was requested by a provider; however, HSAG was unable to locate the written consent of the member for the provider to appeal on the member's behalf. Documentation in the record also suggested that the case may have been a provider payment dispute as the member had already received the service and/or was a retro-authorization request. After the site review, the PIHP confirmed that the CMHSP considers these cases as appeals since the provider is disputing the clinical length of stay; therefore, this is a clinical issue and not a billing issue. However, if these cases are considered an appeal and processed as a member appeal, the PIHP and its CMHSP must follow all member appeal processing guidelines (i.e., obtain the member's written consent for the provider to appeal on the member's behalf). However, it was also unclear whether this case was truly an appeal as the request from the provider was for a retro-authorization and no ABD notice was submitted with the case file. An appeal is a review of an ABD; therefore, if there was no initial ABD, it does not appear that this case qualified as an appeal. **Recommendations:** HSAG recommends that the PIHP update policy to include the requirements of sub-element (b). Additionally, as the PIHP proceeds with conducting additional training on the requirements of this element, HSAG recommends that it include an emphasis on verifying an authorized representative when an appeal is filed by an individual who is not the member. This may include verification of guardianship or obtaining the member's written consent. As an alternative, the PIHP could contact and speak directly with the member. If the member verbally requests that he or she wants to file the appeal, the PIHP should document this case as an appeal verbally requested by the member. However, if the PIHP is accepting the verbal request for the appeal by the member, the individual who initially requested the appeal cannot be a party to the appeal (i.e., authorized representative) without the member's written consent. Therefore, all appeal communications (e.g., acknowledgement and resolution notices) must occur directly with the member.		
Required Actions: The PIHP must obtain the written consent of the member, a provider or an authorized representative to request an appeal on behalf of the member.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted	

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Requirement	**Supporting Documentation**	**Score**
		☐ Accepted With Recommendations ☐ Not Accepted
15. If the PIHP denies a request for expedited resolution of an appeal, it: a. Transfers the appeal to the time frame for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follows the requirements in 42 CFR §438.408(c)(2), including: i. Makes reasonable efforts to give the member prompt oral notice of the delay. ii. Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution time frame and informs the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f) Contract Schedule A—1(M)(8)(b)(v) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(2)(c)(i–iii)	**HSAG Required Evidence:** • Policies and procedures • Denied expedited resolution letter template • System screenshot of the field where the type of appeal request is documented (i.e., standard versus expedited) • System screenshot of the field where the denial of an expedited appeal resolution time frame is documented • System screenshot of the field where oral and written notice of the denied request for an expedited appeal resolution time frame is documented • Three case examples of a denied request for an expedited appeal resolution time frame, including oral and written notice of the denied request • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E15_System Screenshots_type_denial ex_oral notice • S9_E15a.Grievance and Appeals Policy_standard timeframe_page 5 • S9_15a_Grievance and Appeals Policy_page 5 • S9_E15b._Grievance and Appeals Policy_disagree_page 5 • S9_E15b_Grievance and Appeals Policy page 3 • S9_E15b_Grievance and Appeals Policy page 4	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: When the PIHP denies the request for an expedited appeal, the appeal timeframe automatically transfers to the standard appeal timeframe of 30 days. The PIHP must make reasonable efforts to give the beneficiary prompt oral notice of the decision and follow up with written notice within 2 calendar days, also informing the beneficiary that they have the right to file a grievance if they disagree with the decision to deny expedited request.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: While the PIHP confirmed that it had no denied requests for an expedited appeal resolution time frame during the time period of review, the PIHP did not initially provide a denied expedited appeal notice template as requested by HSAG. After the site review, the PIHP submitted a letter template; however, the document was created on May 28, 2025. Therefore, without further explanation from the PIHP, HSAG was unable to verify the template was effective during the time period of review. Further, the file name of the template included reference to "2025," supporting that the template was not applicable to the review period. The template was also specific to one CMHSP; therefore, it is unclear whether the PIHP and the remaining CMHSPs have an appropriate notice for use. **Recommendations:** The PIHP did not demonstrate having the system capability to report on denied requests for expedited appeal resolution time frames, as the only place to document this scenario was in a narrative note. HSAG recommends that the PIHP enhance its system to identify, track, and report on denied requests for expedited appeal resolutions including the date of oral and written notice of the denied request. 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 If the PIHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the time frame for standard resolution in accordance with 42 CFR §438.408(b)(2); make reasonable efforts to give the member prompt oral notice of the delay; and within two calendar days, give the member written notice of the reason for the decision to deny the expedited appeal resolution time frame and inform the member of the right to file a grievance if the member disagrees with that decision.		
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**
16. The PIHP acknowledges receipt of each appeal. a. *Standard appeals are acknowledged within 5 business days of receipt.* b. *Expedited appeals are acknowledged within 72 hours of receipt.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) Contract Schedule A—1(M)(2)(e) Appeal and Grievance Resolution Processes Technical Requirement—VII(B)(2)	**HSAG Required Evidence:** • Policies and procedures • Appeal acknowledgment template • Tracking and reporting mechanisms • System screenshot of the field where the date of receipt of the appeal is documented • System screenshot of the field where the date of oral/written acknowledgement and the acknowledgement notice/call notes are documented • Report of all appeals during the review period, including the date of receipt of the appeal and the date of acknowledgement • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E13_E16_E21_E22_E23_E25_Appeal Tracking and Reporting • S9_E16_Appeal Acknowledgement Template • S9_E16_Screenshot Receipt and Oral Notice • S9_E16_Screenshot Receipt • S9_E16a_Grievance and Appeals procedure_page 2 • S9_E16b. Beneficiary Grievance and Appeals Procedure_page 3	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The PIHP acknowledges the receipt of each appeal within 5 business days for standard appeal and 72 hours for an expedited appeal.		
HSAG Findings: The PIHP did not initially submit a report of all appeals during the review period, including the date of receipt of the appeal and the date of acknowledgement as requested by HSAG. After the site review, the PIHP submitted a report of all appeals for two CMHSPs. However, HSAG was unable to locate the acknowledgement date on one CMHSP report. The second CMHSP report included an "Appeal Notice Date" which HSAG assumed was the acknowledgement date. While most appeals listed on the report were acknowledged timely, one case had no acknowledgement date and one appeal had an acknowledgement date 75 days after receipt of the appeal. Additionally, a report for the remaining CMHSPs was not provided. Further, while one report was provided which could be used to monitor timely acknowledgements, it is unclear whether the PIHP is actively monitoring adherence to		

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Requirement	**Supporting Documentation**	**Score**
acknowledgement time frames (e.g., monitoring reports of acknowledgement time frames, case file reviews). The PIHP should also review reports for data anomalies like those identified in the CMHSP report. Further, while the PIHP included the five-business day acknowledgement time frame for standard appeals, it did not include the 72-hour acknowledgement time frame for expedited appeals. Of note, the MDHHS model notice effective during the time period of review for the case files included incorrect information regarding requesting a State fair hearing (SFH) and continuation of benefits. MDHHS' model notice effective October 1, 2024, has been updated and remediates this finding. **Recommendations:** HSAG recommends that the PIHP implement mechanisms to monitor adherence to timely acknowledgements by reviewing periodic reports on acknowledgement TATs. Additionally, HSAG recommends that the PIHP update policy to include the 72-hour acknowledgement TAT for expedited appeals and clarify in policy its process for acknowledging expedited appeals within 72 hours (i.e., whether a separate acknowledgement notice is required or whether the resolution notice serves as both the acknowledgement notice and resolution notice since both must be issued within 72 hours). 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: The PIHP must acknowledge receipt of each appeal within five business days of receipt.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
18. The PIHP treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) Contract Schedule A—1(M)(2)(g)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E18_ Grievance and Appeals Procedure page 2	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Appeal and Grievance Resolution Processes Technical Requirement—VII(A)(2)	• S9_E18_Guide to Services_page 15	
PIHP Description of Process: The PIHP accepts oral appeal requests.		
HSAG Findings: According to the *Grievance and Appeals Procedure*, "The enrollee may request an appeal either orally or in writing. Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal."; and according to the SUD provider manual, "The Recipient Rights Advisors may also take a verbal request over the phone. However, an attempt to confirm the request in writing must be made unless the client requests expedited resolution."; and according to the Northeast Michigan Community Mental Health Authority *Grievance and Disputes over Decisions regarding Services and Supports* policy, "The request may be oral or in writing. If oral, the request must be confirmed in writing unless expedited resolution was requested." However, CMS removed the federal rule that required a written signed appeal following an oral request for a verbal appeal in the 2020 update to the Medicaid managed care rule. During the SFY 2022 compliance review activity, HSAG also noted that the PIHP's policy was incorrect and recommended that it be updated. While the case file review verified that the PIHP accepted verbal requests for appeals, given that the PIHP produced three documents that included inaccurate information and that HSAG's prior recommendations were not addressed, a *Not Met* score was warranted for this element.		
Required Actions: The PIHP treats oral inquiries seeking to appeal an ABD as appeals. The PIHP must ensure all applicable PIHP and CMHPS documents are reviewed and updated to include an accurate reflection of the federal Medicaid managed care rule.		
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**
23. The PIHP may extend the standard or expedited appeal resolution time frames by up to 14 calendar days if: a. The member requests the extension; or b. The PIHP shows (to the satisfaction of the MDHHS agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) Contract Schedule A—1(M)(1)(e)(iv) Appeal and Grievance Resolution Processes Technical Requirement—VII(C)(3)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • System screenshot of the field where the date and time of receipt of the appeal is documented • System screenshot of the field documenting that an extension was applied • System screenshot of the field where the date the extension was applied is documented • System screenshot of the field where the reason for the extension is documented • Three examples of appeals with an extension applied, including the date of receipt of the appeal and the date of the extension • HSAG will also use data reported on the appeal universe file/MDHHS reporting template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E23_Date of Appeal Receipt • S9_E23_E24_Letter 1 - Appeal Ext. • S9_E23_E24_Letter 2 - Appeal - Ext. • S9_E23_E24_NOD - Appeal Ext. • S9_E23_E24_NOE - Appeal - Ext. • S9_E23_E24_NOR - Appeal Ext. • S9_E23_Screenshot_Extension Information • S9_E23ab_Grievance and Appeals Procedure_page 3 S9_13_E16_E21_E22_E23_E25_Appeal Tracking and Reporting	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: At the request of the beneficiary or if the PIHP is able to satisfactorily prove that an extension is in the best interest of the beneficiary, The PIHP will provide an appeal extension of 14 days.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The case example of an appeal extension confirmed that the appeal resolution time frame was extended; however, the appeal resolution time frame expired on June 14, 2024, but the extension did not occur until June 20, 2024. An extension must be applied prior to the expiration of the appeal resolution time frame. To complete the appeal, a member consultation with a CMHSP physician was scheduled; however, it was scheduled six days after the appeal resolution time frame had already expired. During the SFY 2022 compliance review, HSAG recommended that the PIHP conduct ongoing education to ensure staff have a complete understanding of the extension provisions. This year's findings confirm a continued need for staff training. Further, the universe file reported no appeals with an extension; however, the case example of the appeal extension confirmed that this case was incorrectly reported as an appeal without an extension.		
Required Actions: The PIHP may extend the standard or expedited appeal resolution time frames by up to 14 calendar days if the PIHP shows (to the satisfaction of the MDHHS agency, upon its request) that there is a need for additional information and how the delay is in the member's interest. The appeal time frame must be extended prior to the expiration of the appeal time frame.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:		☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
25. In the case that the PIHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • Three case examples of an appeal that was denied due to an untimely resolution • HSAG will also use data reported on the appeal universe file/MDHHS reporting template	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
Contract Schedule A—1(M)(7)(c)(i) Appeal and Grievance Resolution Processes Technical Requirement—VII(B)(8) Appeal and Grievance Resolution Processes Technical Requirement—IX(A)(2)	• HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** • S9_E25_ Grievance and Appeals Procedure_page 3 • S9_E25_Guide to Services_page 17 S9_13_E16_E21_E22_E23_E25_Appeal Tracking and Reporting	
PIHP Description of Process: In the case that the PIHP does not meet timeframe requirement for notice, the PIHP will notify the beneficiary of their right to initiate a State Fair Hearing.		
HSAG Findings: The case example of an appeal extension confirmed that the appeal resolution time frame was extended; however, the appeal resolution time frame expired on June 14, 2024, but the extension did not occur until June 20, 2024. To complete the appeal, a member consultation with a CMHSP physician was scheduled; however, it was scheduled six days after the appeal resolution time frame had already expired. When the PIHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process, and the member must be informed of SFH rights. Of note, during the SFY 2022 compliance review activity, HSAG recommended that the PIHP conduct ongoing education to ensure staff have a complete understanding of the requirements of this element. This year's findings confirm a continued need for staff training. After the site review, the PIHP indicated it had no additional documentation to provide and will work with its CMHSP for regular monitoring of appeal cases and provide additional training to staff.		
Required Actions: In the case that the PIHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PIHP's appeals process, and the member may initiate a SFH. The PIHP must inform the member of the PIHP's failure to render the decision timely and provide the member with SFH rights.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard IX—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
34. If the PIHP or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i) Contract Schedule A—1(M)(5)(j) Appeal and Grievance Resolution Processes Technical Requirement—VI(F)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Three case examples of an overturned appeal/SFH, including the date and time of the decision and the date and time services were authorized or provided (e.g., evidence of the date/time when authorization was added to system) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the PIHP:** S9_E34 Grievance and Appeals Procedure page 7	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The PIHP will reinstate services that were denied, limited or delayed, within 72 hours of the reversal notice or as expeditiously as the beneficiary's condition requires.		
HSAG Findings: The case file review identified one record (Sample 2) which did not include documentation confirming that the overturned service was reinstated within 72 hours. After the site review, the PIHP indicated that it had no additional documentation to provide and will work with its CMHSP for regular monitoring of appeal cases and provide additional training to staff. **Recommendations:** While the PIHP's system documented the date of the appeal decision, it did not capture both the date and time of the appeal decision. The system also did not include a dedicated reportable field to document, track, and report the date and time that services were either provided or authorized. As such, monitoring of adherence to the 72-hour TAT for reinstatement of services is a manual process. HSAG recommends that the PIHP enhance its system to document, track, and report TATs for reinstating services (i.e., for appeals: date and time of the appeal decision to the date and time services were provided or authorized; for SFHs: the date and time the PIHP was notified of the SFH decision to the date and time services were provided or authorized). The PIHP should also consider system enhancements to document how the services were reinstated (e.g., evidence when the authorization was entered and the effective dates of the authorization). System enhancements could better assist the PIHP in reporting and monitoring adherence to this metric. 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: If the PIHP or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		

Standard IX—Grievance and Appeal Systems		
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

Standard XI—Practice Guidelines

Standard XI—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
5. The PIHP disseminates the guidelines to: a. All affected providers. b. Members and potential members, upon request. 42 CFR §438.236(c) 42 CFR §457.1233(c) Contract Schedule A—1(L)(5)	**HSAG Required Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the PIHP:** • SXI_E4_E5_Practice G_pg3 • SXI_E5_clinical network • SXI_E5_E6_NMREtraining • SXI_E5_E7_ MAILER POSTCARD • SXI_E5_PG_NeMCMH	☐ Met ☒ Not Met ☐ NA
PIHP Description of Process: The NMRE disseminates practice guidelines to: • All affected providers. • Members and potential members by an annual mailing which will direct them to the NMRE website. • The public by posting to the NMRE website.		
HSAG Findings: The PIHP provided a copy of an email communication that was sent to all CMHSPs on October 14, 2024, which included the PIHP's clinical practice guidelines. However, it did not appear that this email communication was also sent to the PIHP's contracted SUD providers. Additionally, based on meeting minutes, the clinical practice guidelines were reviewed and adopted in March 2024, which was seven months prior to the CMHSPs being notified of the adopted clinical practice guidelines through email communication. Although requested during the site review, the PIHP did not provide evidence that all affected contracted providers, including SUD providers, were provided with the PIHP's adopted clinical practice guidelines upon approval of those guidelines in March 2024 as required.		
Required Actions: The PIHP must ensure that it has a process to disseminate the clinical practice guidelines to all affected providers upon adoption of the guidelines.		

Standard XI—Practice Guidelines		
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

Standard XII—Health Information Systems

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
6. The PIHP implements and maintains an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the PIHP. Information is made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed. b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments. c. All data classes and data elements included in a content standard in 45 CFR §170.213 (United States Core Data for Interoperability [USCDI]) that are maintained by the PIHP no later than one business day after the PIHP receives the data. d. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing and monitoring plan/results • Member educational materials, website materials, etc. • Informational materials for developers on website • Programming language that includes required information (e.g., parameters for claims, USCDI data elements) • Mechanisms to ensure data is updated within one business day of receipt • List of registered third-party applications • HSAG will use the results from the API demonstration **Evidence as Submitted by the PIHP:** • https://www.nmre.org/data-sharing/ • PIX_9_4_API_Documentation.pdf • Payer Data Exchange – PCE User Manual.pdf • NMRE MAILER 012125.pdf	☐ Met ☒ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
42 CFR §457.1233(d) 45 CFR §170.213 Contract Schedule A—1(R)(18)		

PIHP Description of Process: In our ongoing effort to meet CMS interoperability standards, NMRE collaborates with our EHR vendor, PCE Systems. Together, we ensure the secure and compliant sharing of healthcare information in a way that meets the needs of our beneficiaries while protecting their privacy. Our website has information about both APIs including links to the API and documentation.

HSAG Findings: While the PIHP implemented a Patient Access API, it could not speak to how it conducted routine testing of the API and did not provide this documentation prior to or after the site review as requested by HSAG. Additionally, the PIHP submitted its *PIX_9_4_API_Documentation.pdf* document, which included the required USCDI data elements used for the Patient Access API; however, the PIHP did not provide evidence for which specific USCDI fields would be housed and transmitted through the PIHP's Patient Access API. During the site review, the PIHP indicated its system was different from the CMHSPs' system, and while it did have a patient chart, it only contained authorizations and encounter data but did not have any clinical information. Further, following the site review, the PIHP referenced page 8 of *PIX_9_4_API_Documentation.pdf,* and reported that its API did consider these data elements. However, this was a conflicting statement from what was reported during the site review. Without further explanation, HSAG could not confirm that the PIHP was fully compliant.

Recommendations: HSAG strongly recommends that the PIHP develop its own policies and procedures for its Patient Access API. Within these policies and procedures, the PIHP should include:

- All Patient Access API federal provisions under 42 CFR §431.60 and any applicable cross references.
- A description of how the PIHP's API meets the intent of each federal provision.
- A table that includes all USCDI data elements and a cross-reference to which data elements the PIHP has available within its system and the specific data fields that these data elements are being extracted from (and therefore accessible via the API).
- A description of how the PIHP oversees PCE to ensure the Patient Access API meets all federal provisions, including timeliness requirements.
- A description of how the PIHP incorporates a mechanism to conduct routine testing of the API.
- All new requirements outlined under the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

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: The PIHP's Patient Access API must comply with all data elements in the CMS interoperability final rules.

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
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 maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information) which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR §431.60(d), and is accessible via a public-facing digital endpoint on the PIHP's website. 42 CFR §438.242(b)(6) 45 CFR §431.60(c–d) 42 CFR §431.70 42 CFR §438.10(h)(1–2) 42 CFR §457.1233(d)	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing and monitoring plans/results • Stakeholder educational materials, website materials, etc. • Informational materials for developers on website • Mechanisms to ensure data is updated within 30 calendar days of receipt of updated provider information • Programming language that includes required information (e.g., parameters for all information included in 42 CFR §438.10(h)(1–2)) • List of registered third-party applications • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the PIHP:** • https://www.nmre.org/data-sharing/ • PIX_9_4_API_Documentation.pdf	☐ Met ☒ Not Met ☐ NA

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
	• Payer Data Exchange – PCE User Manual.pdf • NMRE MAILER 012125.pdf	
PIHP Description of Process: In our ongoing effort to meet CMS interoperability standards, NMRE collaborates with our EHR vendor, PCE Systems. Together, we ensure the secure and compliant sharing of healthcare information in a way that meets the needs of our beneficiaries while protecting their privacy. Our website has information about both APIs including links to the API and documentation.		
HSAG Findings: While the PIHP implemented the Provider Directory API, the CMS Interoperability and Patient Access Final Rule requires the Provider Directory API to include all information specified in 42 CFR §438.10(h)(1-2), which includes: • The provider's name as well as any group affiliation. • Street address(es). • Telephone number(s). • Website uniform resource locator (URL), as appropriate. • Specialty, as appropriate. • Whether the provider will accept new members. • 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. • Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment. HSAG reviewers could not verify the provider information available via the API and requested confirmation of the specific data elements that were available. During the site review, the PIHP was able to demonstrate various data elements that were available via the API, such as the provider's name, street address, and telephone number; however, while the PIHP indicated the provider's cultural linguistic capabilities and whether the provider's office/facility had accommodations for people with physical disabilities, it did not maintain the capability to translate this information to the Provider Directory API. After the site review, the PIHP provided an *SXII Element 3 API Follow up PCE* screenshot and indicated, "We now have the ability to include 'language spoken' on the Payer Provider Directory [and] there is a new 'Accessibility' section which can be included on your 'provider' record/screen, which will also be shared via provider directory…It looks like a few more may still be missing such as URL & 'Specialty'. We will be working on adding those into the 'capabilities', at which point we could add it to the individual systems." Based on HSAG's desk review, discussion during the site review, and the explanation provided by the PIHP after the site review, the PIHP was not compliant with all Provider Directory API requirements. **Recommendations:** HSAG strongly recommends that the PIHP develop its own policies and procedures for its Provider Directory API and includes a description of how it implements the federal provisions. Additionally, the PIHP must ensure it implements all new requirements outlined under the CMS		

Standard XII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
Interoperability and Prior Authorization Final Rule (CMS-0057-F). 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: The PIHP's provider directory must comply with all data elements required by 42 CFR §438.242(b)(6) and 42 CFR §438.10(h)(1–2).		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	

Standard XIII—Quality Assessment and Performance Improvement Program

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
15. *At a minimum, sentinel events as defined in the MDHHS contract are reviewed and acted upon as appropriate.* a. *The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event.* b. *If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analysis of the event.* Contract Schedule A—1(L)(2)(a) Contract Schedule A—1(O)(12) QAPIPs for Specialty PIHPs—VIII(A)	**HSAG Required Evidence:** • Policies, procedures, and workflows • QAPI program description • Tracking and reporting mechanisms • Three examples of the review of critical incidents/sentinel events (date of incident, date incident determined to be a root cause event, and date root cause analysis completed must be provided) **Evidence as Submitted by the PIHP:** • SXIII_E14-E20_pg2,3,5,9,15,20,27 • SXIII_E14-21_CISE Reporting • SXIII_E15_ FY2024 • SXIII_E15_ Sentinel Events Process • SXIII_E15_ WV SE Notification Example 1 • SXIII_E15_Sentinel Events Initial Report - Example 2 • SXIII_E15_Example 3 • SXIII_E15_E16_E17_WV Root Cause Analysis Notes Example A • SXIII_E15_E16_E17_WV Root Cause Analysis 1-18-24 Example B • SXIII_E15_E16_pages1,2 • SXIII_E15_E16_pages2,4,6 • SXIII_E15_E17 WV Sentinel Event Log • SXIII_E15_E17 WV Sentinel Event Log1 • SXIII_E15_FY2025 • SXIII_E15_Incident QIP Log • SXIII_E15_reporting NMRE system	☐ Met ☒ Not Met ☐ NA

Standard XIII—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• SXIII_E15_Sentinel Events Testing • SXIII_E15_Summary notification • SXIII_E15_tracking	
PIHP Description of Process: New reporting system is uniformed and allows higher accuracy and efficiency.		
HSAG Findings: The sentinel event examples did not demonstrate that the PIHP was determining critical incidents to be sentinel events within three business days after the critical incident occurred as required. For Example 1, the PIHP was notified of the critical incident on December 3, 2024, but the PIHP did not determine this to be a sentinel event until December 13, 2024. Additionally, it is unclear when the root cause analysis was initiated, as the record was not added into the information system until January 21, 2025. For Example 2, the critical incident was determined to be a sentinel event within the three allowable business days. However, although the critical incident was identified to be a sentinel event on September 3, 2024, the root cause analysis was not added to the system until October 1, 2024, which far exceeds the allowed two subsequent business days requirement. If the root cause analysis was started prior to this date, no documentation of this was provided. For the third example, the PIHP was informed of the member's death on November 27, 2023, and the root cause analysis discussion did not appear to occur until January 18, 2024. No additional documentation was provided to confirm whether the root cause analysis was initiated prior to January 18, 2024.		
Required Actions: The PIHP or its delegate must determine whether a critical incident is a sentinel event within three business days after a critical incident occurred. If the critical incident is classified as a sentinel event, the PIHP or its delegate must commence a root cause analysis of the event within two subsequent business days.		
PIHP Corrective Action Plan		
Root Cause Analysis:		
PIHP Remediation Plan:		
Responsible Individual(s):		
Timeline:		
MDHHS/HSAG Response:	☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted	